Trust
Alaska Mental Health Trust Authority

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Anchorage, AK 99508
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www.mhtrust.org

Community Connections
Therapeutic Foster Care Expansion & Sustainability
Supporting Documents
April 2023

- Therapeutic Foster Care Infographic
- Children's Mental Health Program Diagram Therapeutic Foster Care
- Children's Mental Health Program Organizational Chart
- 2022 Therapeutic Foster Care Parent Satisfaction Survey Results
- Letters of Support for Community Connections and Memorandums of Agreement with Community Connections
- Community Connections Matching Board Resolution
- Youth Services Survey
- DOJ Report, Investigation of the State of Alaska's Behavioral Health System for Children, 2022
- CARF International Letter of Support
- CARF Therapeutic Foster Care STFC
- Child and Adolescent Service Intensity Instrument (CASH) Scoring

Therapeutic Foster Care (TFC) Expansion

Out of all the services we provide, our CARF Accredited Therapeutic Foster Care (TFC) program has consistently yielded the most positive impact on kid's lives, for 23 years. The stable, consistent environment provided by trained foster providers in combination with psychotherapy and skill teaching provided by direct care staff in the community, often has a transformative impact on youth and their families. These factors, along with the staggering need for this service, is the impetus for expanding at this time.

Impacting More Youth: Projected Growth

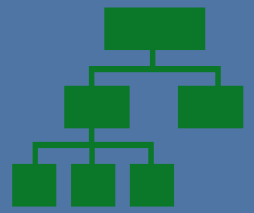
Now — 22 TFC youth served

September 2023 — 28 youth

March 2024 — 36 youth

The planned expansion will increase the number of youth impacted by 33% by March 2024.

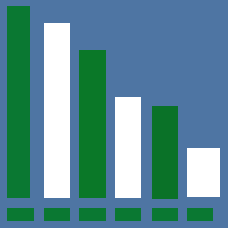
Additional Staff Dedicated to Therapeutic Foster Care



3 Full - Time Staff

We have tripled the TFC management Staff from 2019 to 2023. Their tasks include recruitment, licensing, training, and supporting to increase successful placements.

DOJ Says-Too Many Youth in Institutions: TFC Can Help



800 AK kids in out of community facilities

"Ensuring that community-based services. Like TFC. are accessible and available with sufficient intensity can prevent unnecessary institutionalization." (DOJ, 2022)

Committed, Amazing Foster Parents

5 Yrs

Our specially trained and licensed Therapeutic Foster Parents stay with Community Connections for 5 years on average. 75% of these contractors are either satisfied or very satisfied with their relationship with Community Connections

We Calibrate Success: we learn from data

18 + outcome indicators collected

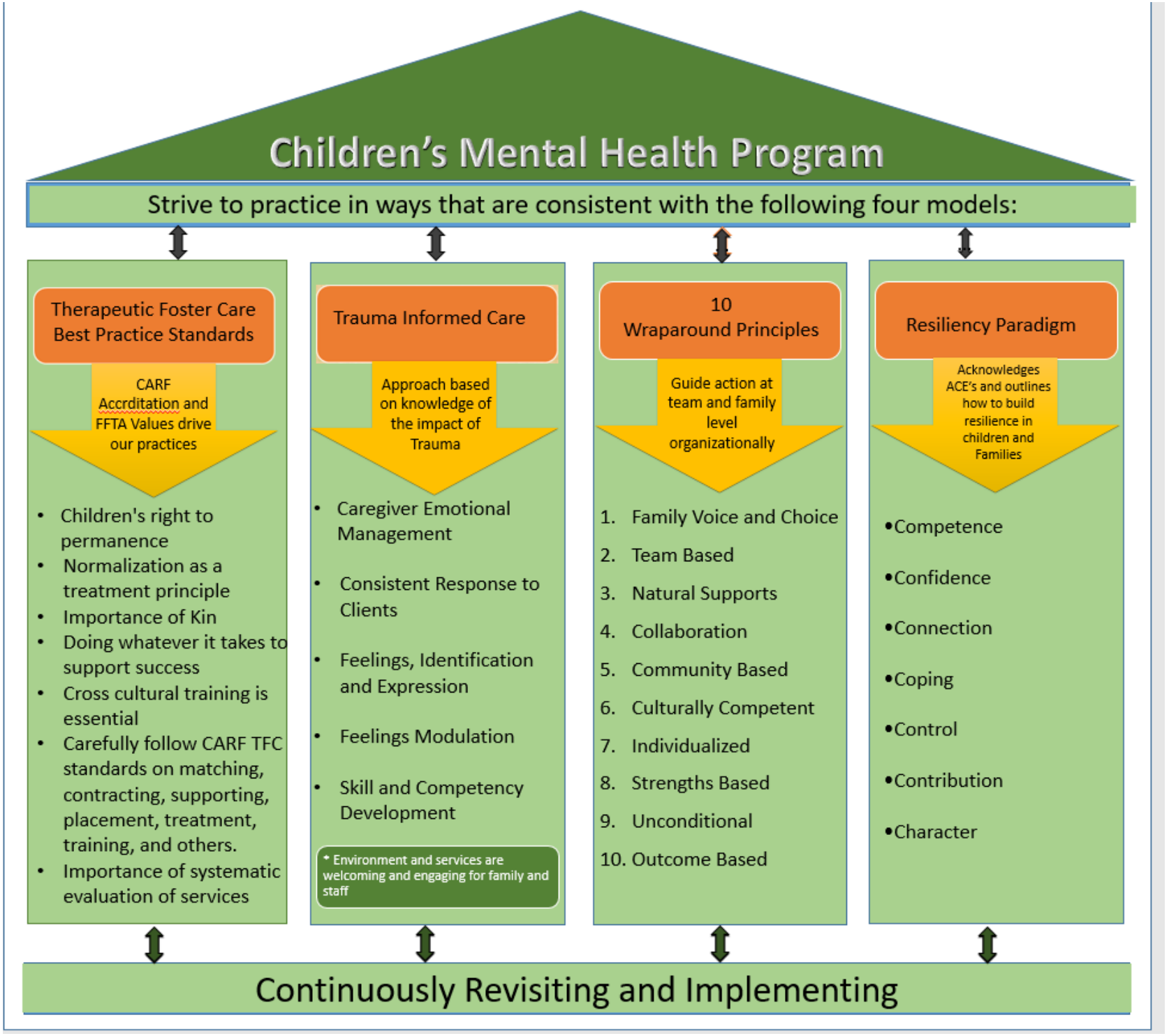
We collect data from our youth and families every 90 days while in Treatment. We survey our foster providers and staff annually. We use information to improve outcomes for kids.

Impacting Lives SUCCESS RATE

85%

Over the last 3 years, 85% of youth were discharged successfully from TFC (e.g. adopted, returned to blo families, or transitioned to adulthood, etc..)

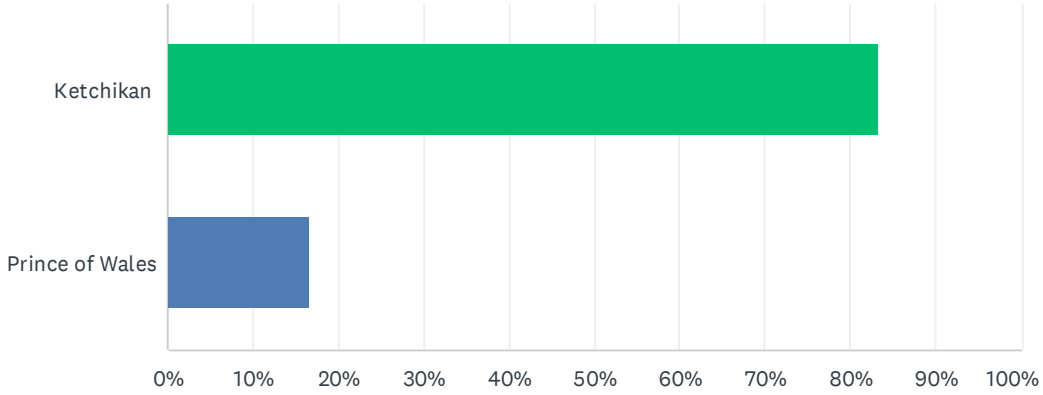
Providing TFC from more agency-owned homes will stabilize the TFC program, reduce challenges we have experienced, and will increase the number of children and families we impact.


Children's Mental Health Program
Strive to practice in ways that are consistent with the following four models:
Therapeutic Foster Care Best Practice Standards
CARF Accrditation and FFTA Values drive our practices
Children's right to permanence
Normalization as a treatment principle
Importance of Kin
Doing whatever it takes to support success
Cross cultural training is essential
Carefully follow CARF TFC standards on matching, contracting, supporting, placement, treatment, training, and others.
Importance of systematic evaluation of services
Trauma Informed Care
Approach based on knowledge of the impact of Trauma
Caregiver Emotional Management
Consistent Response to Clients
Feelings, Identification and Expression
Feelings Modulation
Skill and Competency Development
* Environment and services are welcoming and engaging for family and staff
10 Wraparound Principles
Guide action at team and family level organizationally
1. Family Voice and Choice
2. Team Based
3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent
7. Individualized
8. Strengths Based
9. Unconditional
10. Outcome Based
Resiliency Paradigm
Acknowledges ACE's and outlines how to build resilience in children and Families
•Competence
•Confidence
•Connection
•Coping
•Control
•Contribution
•Character
Continuously Revisiting and Implementing

Children's Mental Health Program

Q1 Select your location

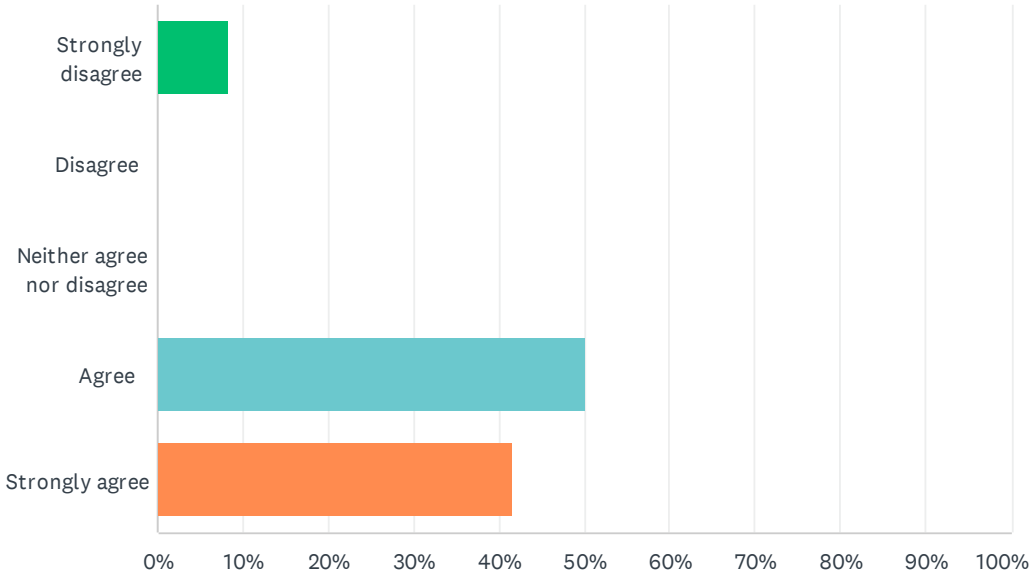
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Ketchikan	83.33%	10
Prince of Wales	16.67%	2
TOTAL		12

Q2 Your responsibilities as a Therapeutic Foster Care Parent, as outlined in the contract, were clearly explained and understood by you.

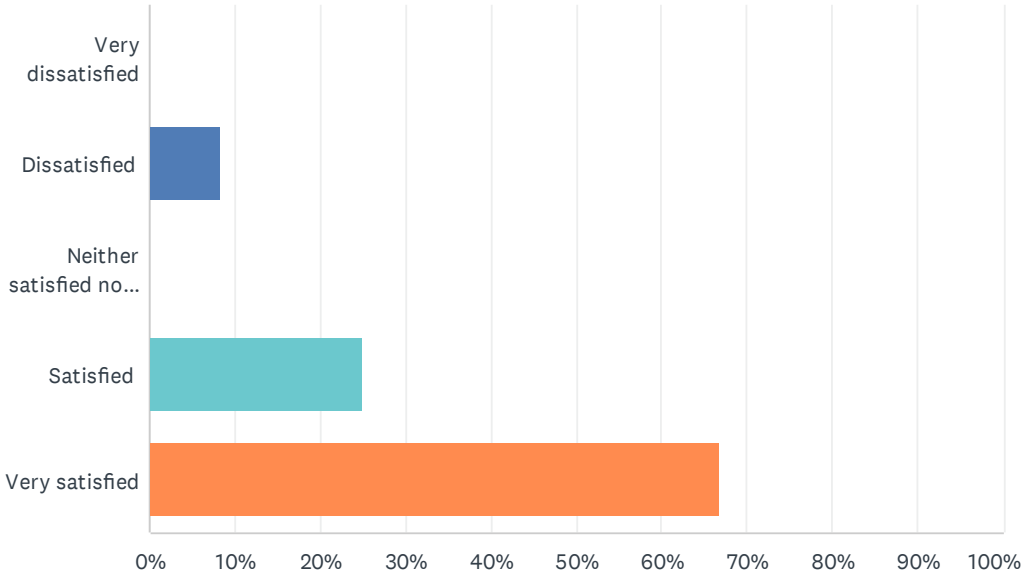
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	8.33%	1
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	50.00%	6
Strongly agree	41.67%	5
TOTAL		12

Q3 How satisfied are you with the licensing support you received from your Foster Care Manager?

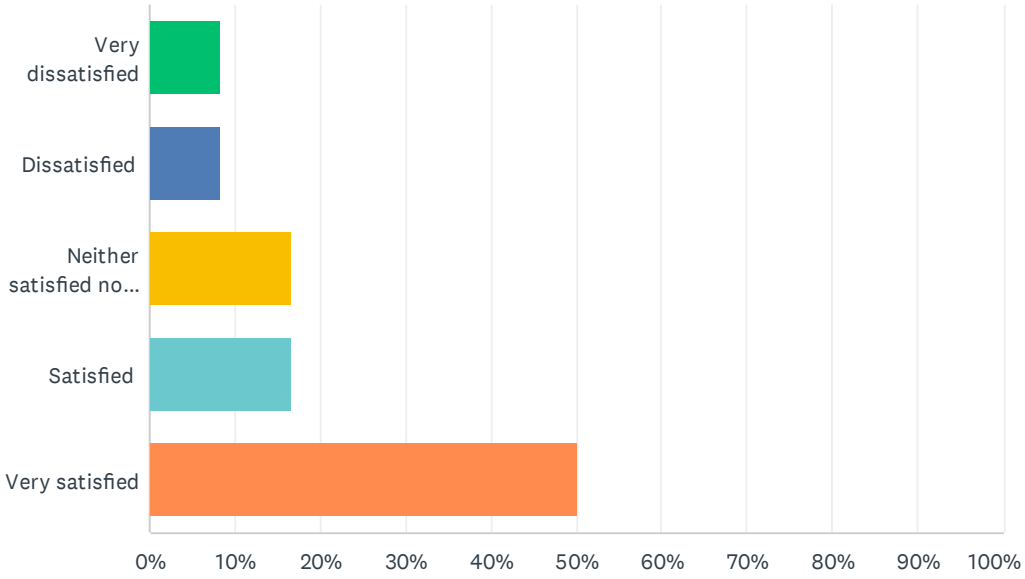
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very dissatisfied	0.00%	0
Dissatisfied	8.33%	1
Neither satisfied nor dissatisfied	0.00%	0
Satisfied	25.00%	3
Very satisfied	66.67%	8
TOTAL		12

Q4 How satisfied are you with the clinical support you and your family (parents, children, foster children etc) have received from your clinical team at Community Connections?

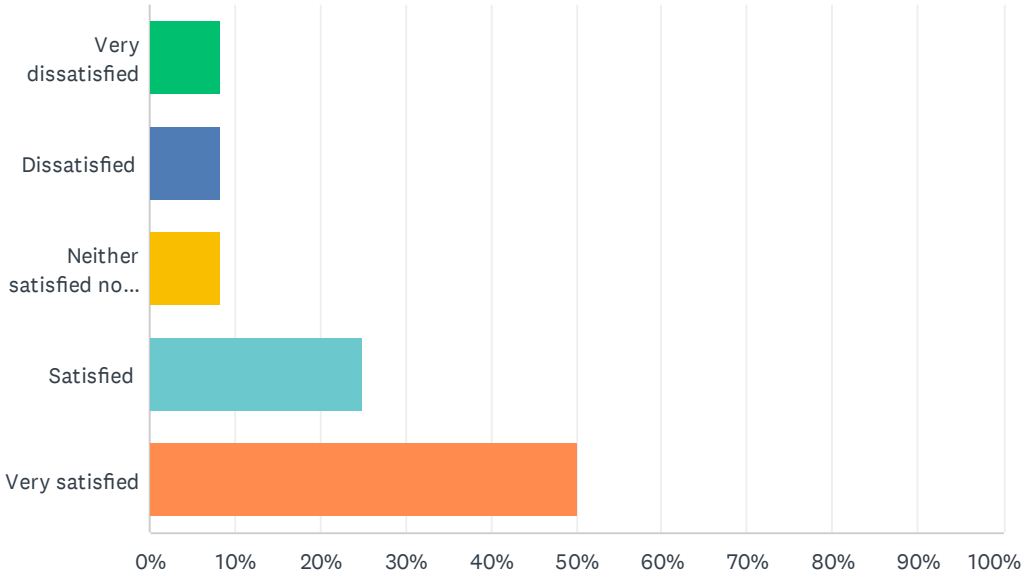
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very dissatisfied	8.33%	1
Dissatisfied	8.33%	1
Neither satisfied nor dissatisfied	16.67%	2
Satisfied	16.67%	2
Very satisfied	50.00%	6
TOTAL		12

Q5 How satisfied are you with the amount and quality of the communication you have with your clinical treatment team at Community Connections?

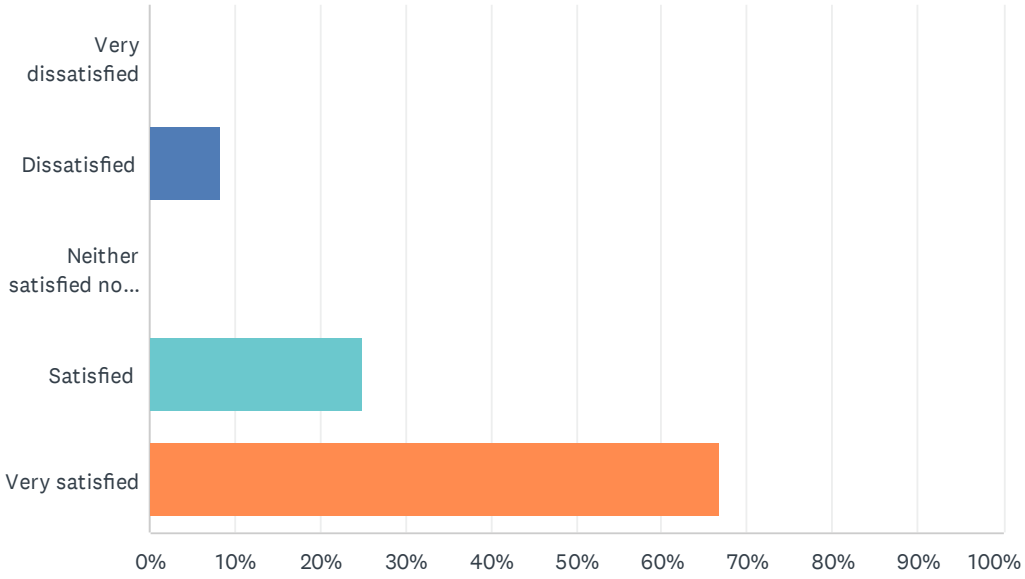
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very dissatisfied	8.33%	1
Dissatisfied	8.33%	1
Neither satisfied nor dissatisfied	8.33%	1
Satisfied	25.00%	3
Very satisfied	50.00%	6
TOTAL		12

Q6 How satisfied are you with how connected you feel to Community Connections Child Placement Agency as a whole?

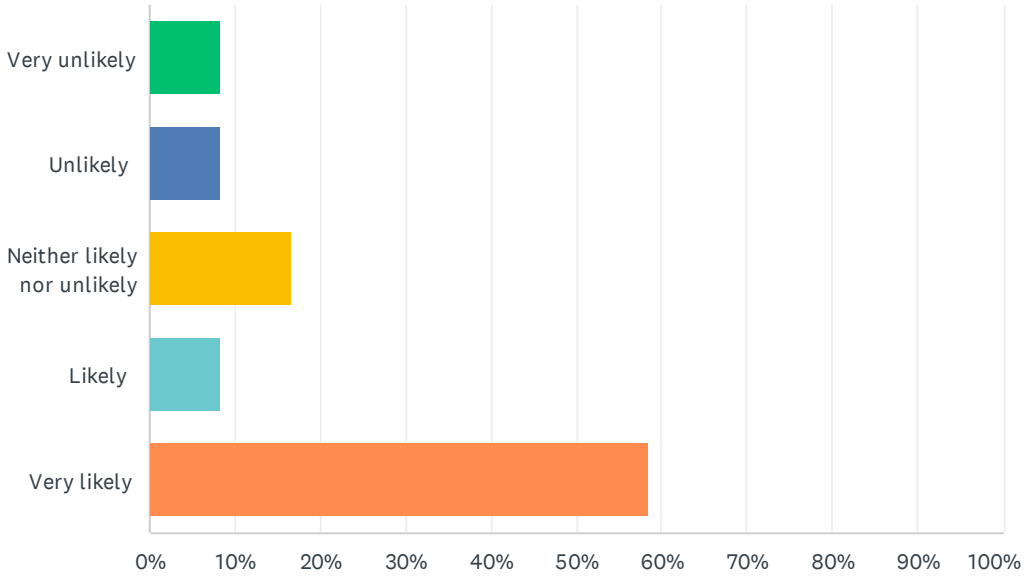
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very dissatisfied	0.00%	0
Dissatisfied	8.33%	1
Neither satisfied nor dissatisfied	0.00%	0
Satisfied	25.00%	3
Very satisfied	66.67%	8
TOTAL		12

Q7 How likely are you to recommend a friend or family member interested in becoming a foster parent to Community Connections?

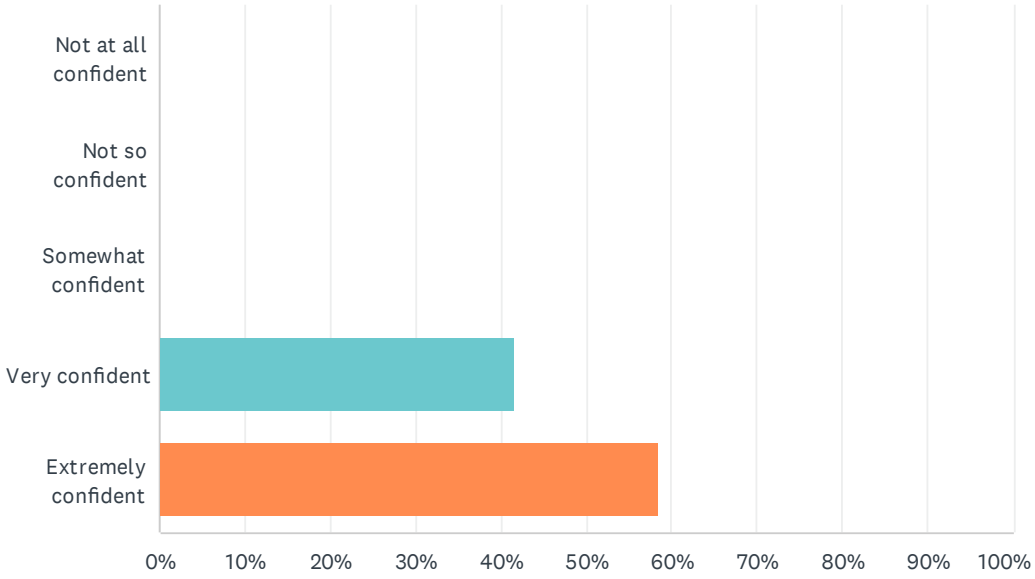
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very unlikely	8.33%	1
Unlikely	8.33%	1
Neither likely nor unlikely	16.67%	2
Likely	8.33%	1
Very likely	58.33%	7
TOTAL		12

Q8 How confident do you feel about understanding the basics of regulation requirements for your licensed home (such as fire escape, smoke alarms, medication storage, etc)?

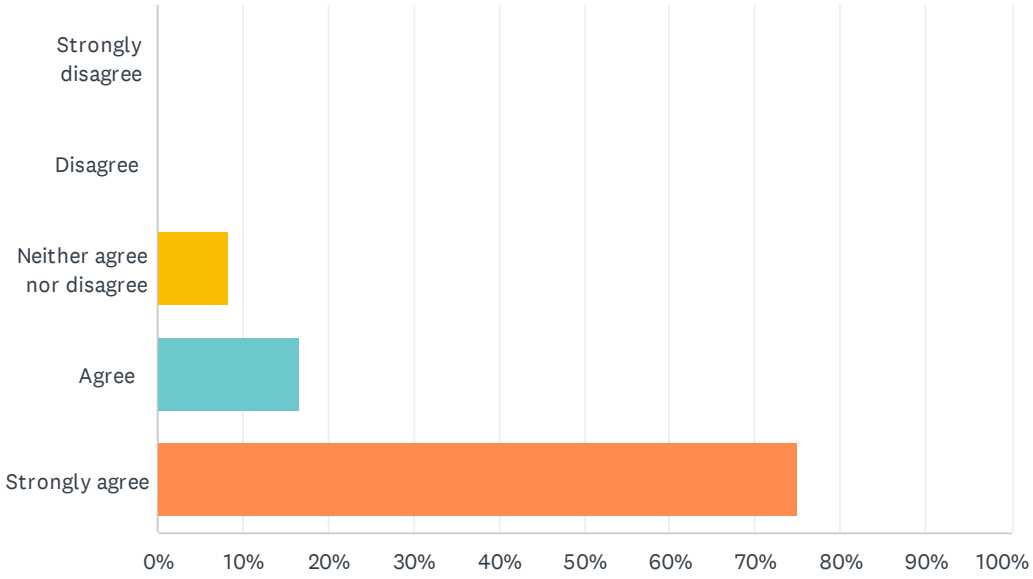
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Not at all confident	0.00%	0
Not so confident	0.00%	0
Somewhat confident	0.00%	0
Very confident	41.67%	5
Extremely confident	58.33%	7
TOTAL		12

Q9 Community Connections provided and coordinated adequate orientation and training for you as a Therapeutic Foster Care Parent.

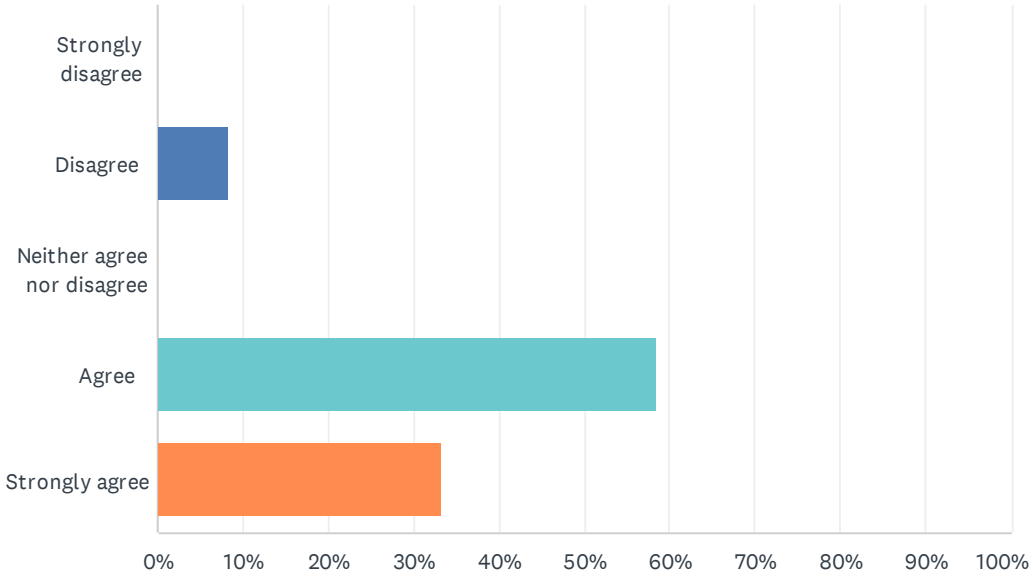
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	8.33%	1
Agree	16.67%	2
Strongly agree	75.00%	9
TOTAL		12

Q10 Community Connections provided assistance in coordination between all needed parties.

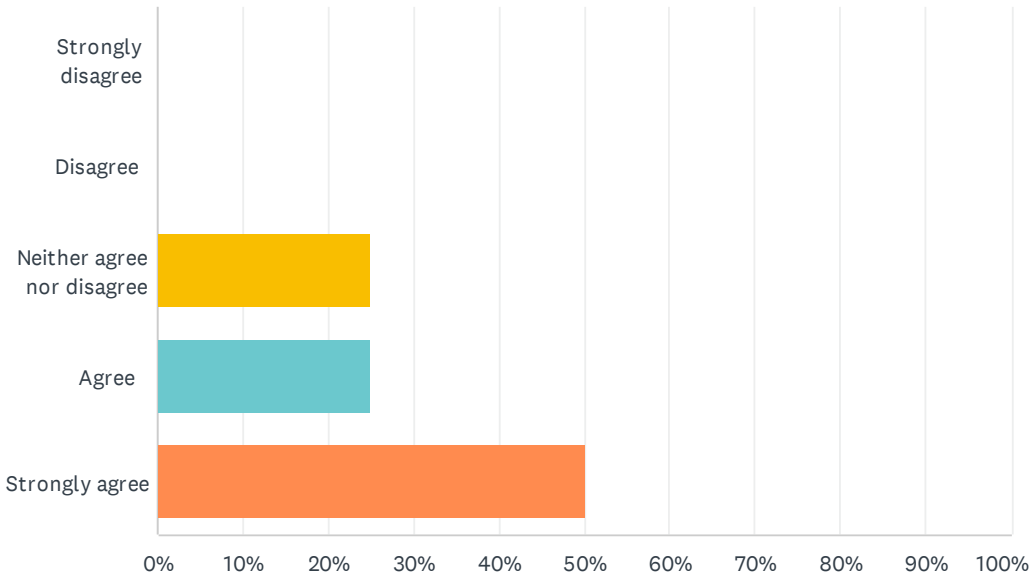
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	0.00%	0
Disagree	8.33%	1
Neither agree nor disagree	0.00%	0
Agree	58.33%	7
Strongly agree	33.33%	4
TOTAL		12

Q11 You received adequate training in the interdisciplinary team process.

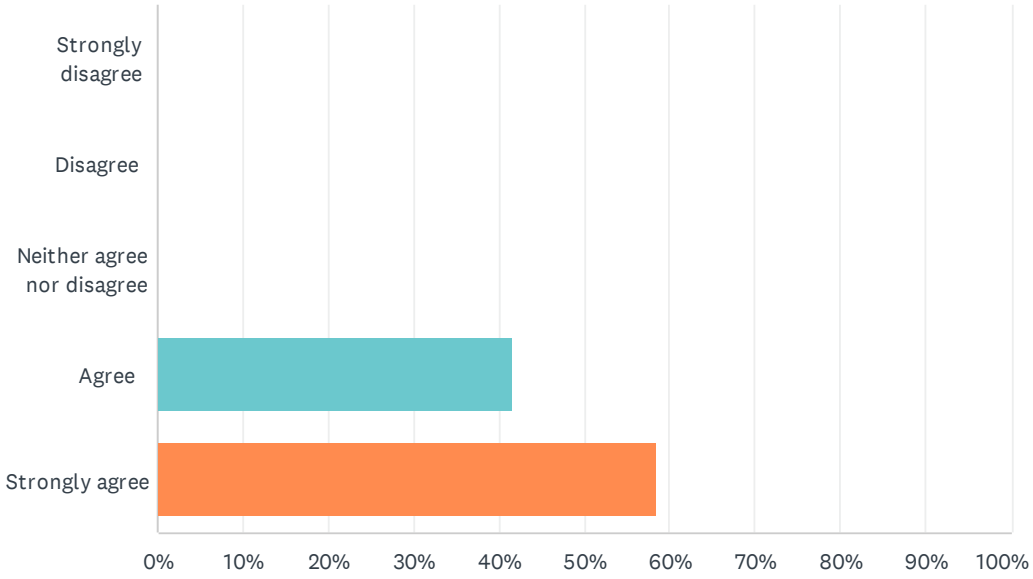
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	25.00%	3
Agree	25.00%	3
Strongly agree	50.00%	6
TOTAL		12

Q12 You were involved in making any changes to the individualized treatment plan(s) of the child.

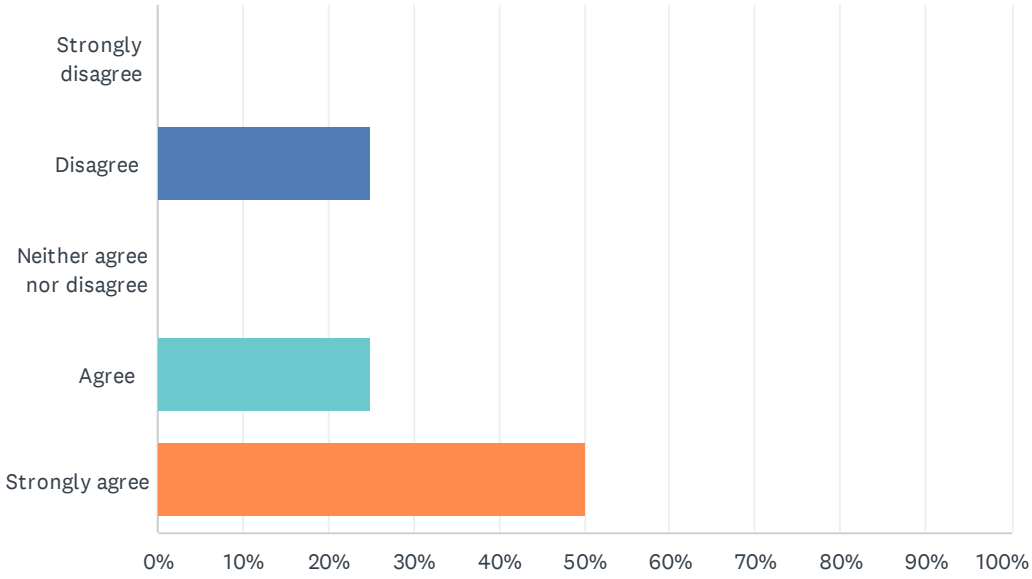
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	41.67%	5
Strongly agree	58.33%	7
TOTAL		12

Q13 You were promptly informed on any changes to be made in plans for the child(ren) in their home.

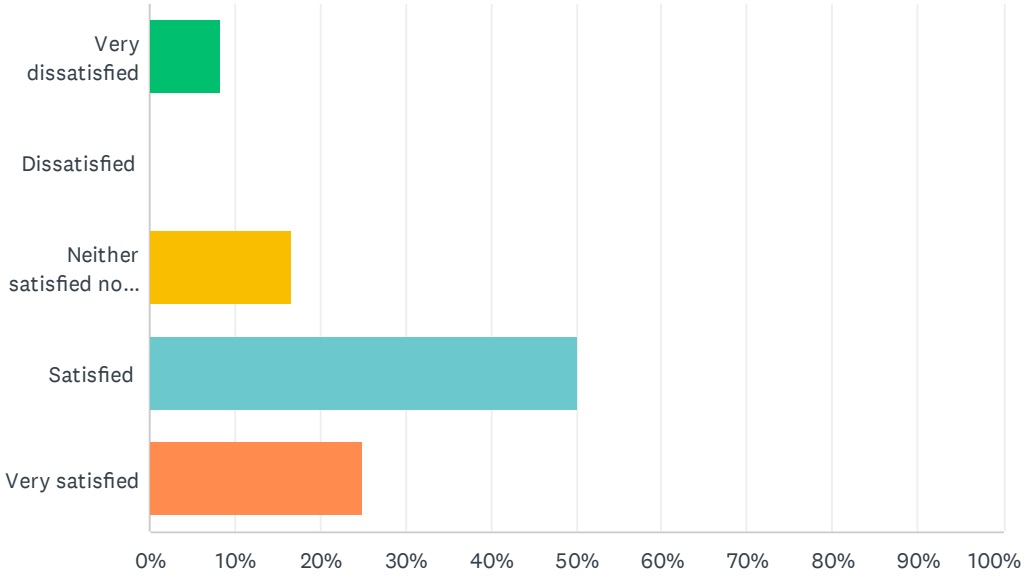
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly disagree	0.00%	0
Disagree	25.00%	3
Neither agree nor disagree	0.00%	0
Agree	25.00%	3
Strongly agree	50.00%	6
TOTAL		12

Q14 How satisfied are you with the consistency of services?

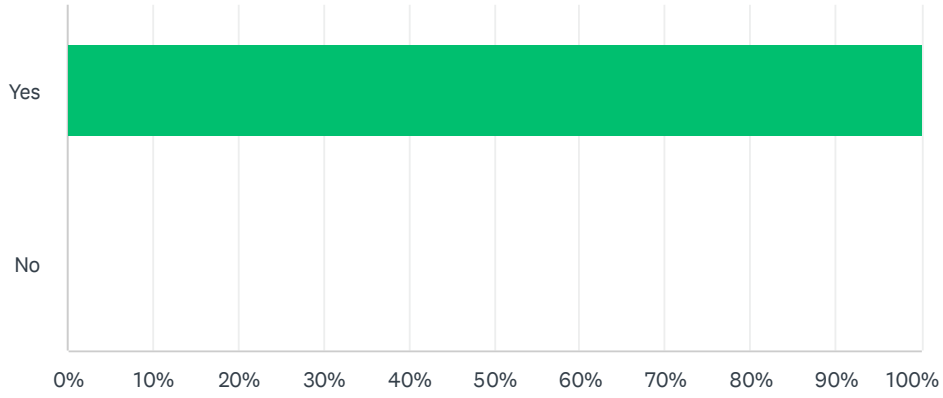
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very dissatisfied	8.33%	1
Dissatisfied	0.00%	0
Neither satisfied nor dissatisfied	16.67%	2
Satisfied	50.00%	6
Very satisfied	25.00%	3
TOTAL		12

Q15 You were provided copies of the Therapeutic Foster Care Payment and Placement Contract.

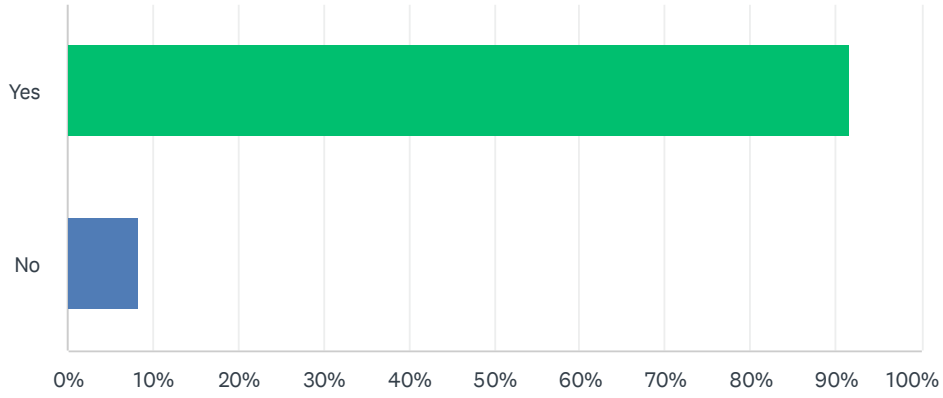
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	12
No	0.00%	0
TOTAL		12

Q16 You were provided copies of the Therapeutic Foster Care Operations Manual.

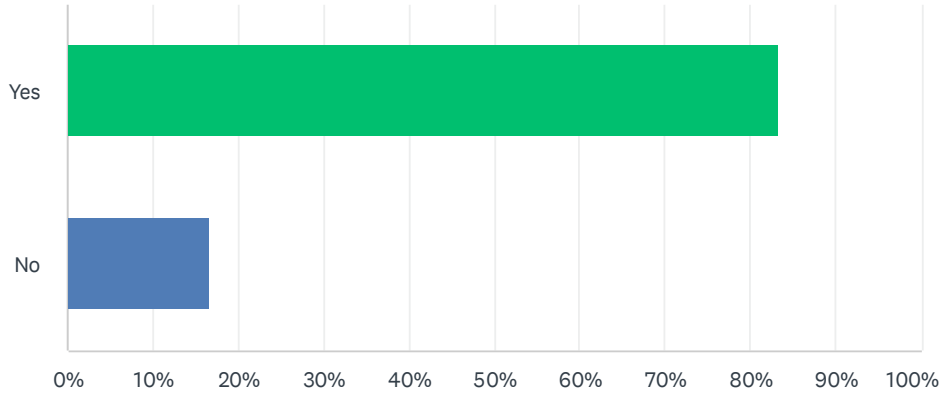
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	91.67%	11
No	8.33%	1
TOTAL		12

Q17 You were provided all necessary consents and release forms signed by the legal guardian, including consents for emergency medical care.

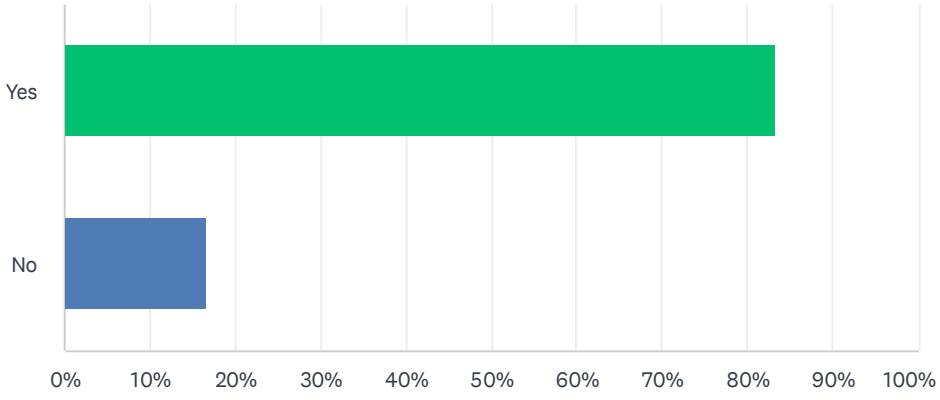
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	83.33%	10
No	16.67%	2
TOTAL		12

Q18 You were provided copies of all individualized treatment plans (unless legal guardian did not consent).

Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	83.33%	10
No	16.67%	2
TOTAL		12

Q19 In your opinion, are there any areas for improvement that Community Connections could utilize to better meet your needs and the needs of the child(ren) in Therapeutic Foster Care?

Answered: 12 Skipped: 0

#	RESPONSES	DATE
1	Transitioning children out of the home.	2/4/2022 9:07 AM
2	I feel the SS's need to focus more on the children's goals.	2/3/2022 10:27 PM
3	It would be helpful if all members of a child's treatment team were invited to each TTM. We have had issues with GAL's and ICWA workers being forgotten.	2/3/2022 9:09 PM
4	Consistency with clinician's sessions with clients	2/3/2022 8:40 PM
5	Keep OCS in team decision making meetings	2/3/2022 8:33 PM
6	Communication. Consistency of care. Follow through of treatment plan. Hiring enough staff to cover services.	2/1/2022 2:13 PM
7	Talk more about attachments! We've done ACES and now it's time to move up to attachments.	1/3/2022 1:01 PM
8	Teaching new families about ACES prior to becoming foster parents so they truly understand a child's needs.	12/25/2021 9:47 AM
9	I would like to see more services, but I know they're trying to hire folks so it's a problem everywhere.	12/22/2021 8:51 PM
10	Communication, consistency, staff turnover	12/22/2021 3:09 PM
11	More staff	12/22/2021 2:35 PM
12	The clinical support was very good. But the clear judgement on us as new foster parents was disappointing. The aversion to listening to our observations earlier, made later issues worse than they had to be.	12/20/2021 10:42 AM

Q20 In your opinion, what are some strengths of the services being provided by Community Connections?

Answered: 12 Skipped: 0

#	RESPONSES	DATE
1	Consistency.	2/4/2022 9:07 AM
2	My therapist is very involved and does weekly check ins	2/3/2022 10:27 PM
3	Kara Thomas is a fantastic asset to CC! The efficiency of Dawn and Corey working to help get answers and communicating with foster parents is so wonderful! Knowing that if we have a question or concern that we can always reach one of them and they work to get us the answers or solutions we are looking for and make sure we feel heard and understood is an incredible relief.	2/3/2022 9:09 PM
4	Strong Team work. Building a treatment plan that fits each individual.	2/3/2022 8:40 PM
5	Making connections and attachments with kids!	2/3/2022 8:33 PM
6	It is there providing services, that’s a strength. But the services provided leave much to be desired.	2/1/2022 2:13 PM
7	We teach about family and making the children better.	1/3/2022 1:01 PM
8	Community Connections has a strong sense for a child’s well being. The connections between children and staff is so important! We see it because staff are caring and teach kids to heal.	12/25/2021 9:47 AM
9	They have some very good staff who understand and appreciate foster parents. Their counselors are top notch. And service staff and absolutely incredible with kids.	12/22/2021 8:51 PM
10	Care for the children in placement	12/22/2021 3:09 PM
11	The constant feeling of being supported really helps!!	12/22/2021 2:35 PM
12	Licensing and note support was phenomenal, para support was equally great	12/20/2021 10:42 AM

February 8, 2023

Letter of Support

To: Grant Administrator

Re: Community Connections grant proposals for Children's Mental Health programming

To Whom it May Concern,

We are writing to express our support for Community Connections and their efforts to strengthen the Children's Mental Health Program. Community Connections provides high quality children's services in Ketchikan, Saxman, and on Prince of Wales Island.

The Children's Mental Health Program helps children with significant behavioral and emotional concerns more fully participate in community life. Counselors provide much needed psychotherapy and direct care staff help children to learn new social and communication skills while at home, at school, and in the community. Additionally, Community Connections' Therapeutic Foster Care program provides an essential service that keeps local youth in the community and prevents costly, undesirable institutional stays.

PeaceHealth Ketchikan Medical Center leadership and caregivers have long collaborated with Community Connections on the care local children and their families through these programs. Like Community Connections, we believe successful services need to be highly coordinated and help youth in all the aspects of their life. Community Connections achieves this level of success through their skillful recruitment, licensing, training, and support of therapeutic foster providers. We hope they can expand services to meet the needs of even more youth and families. Funding will go a long way towards ensuring services can continue to be available to all who are in need and can benefit from the Therapeutic Foster Care program.

For over 38 years, Community Connections has been a pillar in the community providing these vital services. Programs like the Children's Mental Health Program and Therapeutic Foster Care make a clear and measurable difference in the lives of youth and families impacted by mental illness.

Thank you for considering grant support of this invaluable community partner.

Sincerely,

Charles Prosper MSPT, MBA
Chief Executive
PeaceHealth Northwest Network

PeaceHealth Ketchikan Medical Center
3100 Tongass Avenue
Ketchikan, AK 99901

Letter of Support

FEBRUARY, 2023

Grant Administrator

State, Federal, or Foundation Grant Maker

Dear Grant Evaluation Committee:

I am writing to support Community Connections grant proposals aimed at strengthening their Children's Mental Health Program. Their organization provides high quality children's services in Ketchikan, Saxman, and on Prince of Wales Island. The Children's Mental Health Program at Community Connections helps children with significant behavioral and emotional concerns to more fully participate in community life. Their counselors provide much needed psychotherapy and direct care staff help children to learn new social and communication skills while at home, at school, and in the community. Their Therapeutic Foster Care program is making a huge difference and helps to keep kids from being sent out of the community to costly institutions.

At Residential Youth Care, we appreciate Community Connections' willingness to be flexible and to do what is necessary to keep children in the community, where they can socialize with their family and peers and where the community can enjoy the benefit of their citizenship. Like Community Connections, we believe successful services need to be highly coordinated and help youth in all the aspects of their life. Community Connections is also doing a good job by recruiting, licensing, training, and supporting therapeutic foster providers. We hope they can expand services to meet the needs of even more youth and families.

It's heartening that Community Connections been such a pillar of the community for over 38 years. They make a difference in the lives of youth and families impacted by mental illness. Their program makes a big difference in Southern Southeast Alaska and we strongly urge you to fund their proposal.

Thank you in advance for providing Community Connections with funding they need to continue to make services available to those who cannot pay and those who can benefit from their Therapeutic Foster Care program.

Cordially,

Dustin Larna

Chief Executive Officer

Residential Youth Care, Inc.

Healing Hearts Counseling Center

540 Water Street Suite 303~Ketchikan, Alaska~99901 | 907-220-6602 | rebecca@healingheartscc.org

2/4/2022

Dear Grant Evaluation Committee:

I am the owner of Healing Hearts Counseling Center, a private practice agency for mental health services in Ketchikan, Alaska. I have personal experience working with Community Connections and their Children's Mental Health (CMH) Program. Community Connection's fulfills a unique and vital role in our community. Clients serviced by the CMH program are among the most vulnerable youth and families. The needed services they provide include individual, family and group psychotherapy, direct care wraparound community services, and therapeutic foster care. The CMH program is deeply impactful and makes it possible for children to stay in their home communities by providing substantial and meaningful supports.

As a therapist in this small community, I have personally seen the impact that Community Connections has made. Whether it is helping families access resources in the community, working with schools to provide 1 on 1 behavioral supports in classrooms, finding supportive therapeutic foster homes, or providing therapy for complex cases, Community Connections CMH is the only program in Ketchikan that will work with all families who need services for the most challenging situations impacting children's mental health. Please know that any grant funding you provide to this program will meet the needs of our community in essential and profound ways.

Cordially,

Rebecca Moon, LCSW

Rebecca Moon, LCSW

Owner, Healing Hearts Counseling Center

Ketchikan Gateway Borough School District
333 Schoenbar Rd. • Ketchikan, Alaska 99901
Ph. (907) 247-2109 Fax: (907) 247-3820
Michael Robbins, Superintendent • Melissa Johnson, Deputy Superintendent
David Means, Acting Business Manager • Alonso Escalante, Curriculum Director
Rayna Bird, Human Resources Manager

February 9, 2023

Grant Administrator

State, Federal, or Foundation Grant Maker

Dear Grant Evaluation Committee:

I am writing to support Community Connections grant proposals aimed at strengthening their Children's Mental Health Program. Their organization provides high quality children's services in Ketchikan, Saxman, and on Prince of Wales Island. The Children's Mental Health Program at Community Connections helps children with significant behavioral and emotional concerns to more fully participate in community life. Their counselors provide much needed psychotherapy and direct care staff help children to learn new social and communication skills while at home, at school, and in the community. Their Therapeutic Foster Care program is making a huge difference and helps to keep kids from being sent out of the community to costly institutions.

At the Ketchikan Gateway Borough School District, we appreciate Community Connections willingness to be flexible and to do what is necessary to keep children in the community, where they can socialize with their family and peers and where the community can enjoy the benefit of their citizenship. Like Community Connections, we believe successful services need to be highly coordinated and help youth in all the aspects of their life. Community Connections is also doing a good job by recruiting, licensing, training, and supporting therapeutic foster providers. We hope they can expand services to meet the needs of even more youth and families.

It's heartening that Community Connections have been such a pillar of the community for over 38 years. They make a difference in the lives of youth and families impacted by mental illness. Their program makes a big difference in Southern Southeast Alaska, and we strongly urge you to fund their proposal.

Thank you in advance for providing Community Connections with funding they need to continue to make services available to those who cannot pay and those who can benefit from their Therapeutic Foster Care program.

Cordially,

Melissa Johnson

Deputy Superintendent

Ketchikan Gateway Borough School District

Melissa Johnson, Deputy Superintendent, (907) 247-2136, Melissa.Johnson@k21schools.org

Community Connections, Ketchikan Alaska
School-Based Mental Health Services
Memorandum of Agreement

This Memorandum of Agreement is entered into between

Klawock Schools

and Community Connections, Children Mental Health (CMH) program.

Hereafter collectively referred to as "the parties." This agreement aims to clarify roles and responsibilities and enhance effective collaboration.

SECTION I:

Purpose: The purpose of this agreement is to promote a smooth and effective service delivery system for the children we mutually serve. This agreement will establish guidelines for the CMH program and school district to follow and reflects our commitment to increasing collaboration between the schools and Community Connections. The intent is to keep all parties well-informed, provide high-quality services, reduce duplication of effort, and ensure that each child's priorities, resources, and concerns are at the center of each service.

Term: This agreements' effect date is **01/01/2023** to **12/31/2025.** This agreement shall remain in effect until either party requests a change in writing and with 30 days' notice. Both parties involved will review this agreement annually.

SECTION II:

General considerations:

1. Direct communication is encouraged by both parties. Both parties will work towards a mutual understanding of the scope and purpose of each other's role in the lives of enrolled students and their families.
2. Parties will directly and actively inquire if there is any confusion regarding the roles of CMH staff or School District personnel. Either party can call a meeting at any time to ensure the smooth delivery of services to children and families.
3. School District employees are encouraged to make referrals to CMH as necessary. The parent/Guardian application is attached.

SECTION III:

CHILDREN'S MENTAL HEALTH (CMH) will commit to the following:

1. CMH will provide school-based, routine, and urgent clinical services as needed and identified by CMH in consultation with school personnel.
2. CMH is committed to orienting classroom teachers to CMH services in person and via written communication before staff is placed in their classrooms. CMH staff should make face-to-face contact with the teacher before placing any staff in the classrooms.
3. CMH Clinicians will establish set hours in coordination with the building principal if on-site therapy is needed. CMH will provide professionally trained and clinically supervised direct-care staff where there is an identified need by the team.
4. CMH will attempt to provide absent direct-care staff replacement based on a priority needs basis in consultation with the identified school contact person. CMH will make every effort to find replacement staff promptly and commits to communicating rapidly if replacement staff cannot be identified.
5. CMH Support Specialists will assist students to whom they are assigned with services that include teaching behavioral skills, modeling socially appropriate behavior, providing guidance and structure, and coaching.
6. CMH support staff will work within Medicaid regulations and operational procedures.
7. CMH Service Coordinators and Clinicians will work collaboratively with educators and school administrators to prioritize available staff resources and time to students with the highest levels of need, provided that students have an open case with CMH.
8. CMH will ensure their staff members are directed to abide by school and district guidelines for conduct within school grounds.
9. CMH will utilize the appropriate chain of command when there are concerns or questions related to the conduct of staff employed by the School District.
10. CMH will actively seek the input of School District staff into the treatment planning process, and school personnel will act in kind when developing or planning IEP services.
11. CMH will maintain all behavioral health records and release information to the school.
12. CMH staff will sign in and out and be prepared to show identification on school grounds when requested.
13. CMH will provide the school and the teacher with specific names and contact information for each child we serve.
14. CMH will ensure that background checks are completed for all staff before working on school property. CMH will provide the School District's Human Resources with a copy of background checks upon request.
15. CMH will provide clinical consultation as necessary as identified and agreed upon between the educators, school administrators, and CMH.

16. CMH staff will inform school personnel as soon as possible when the student is being considered for discharge from mental health services. Schools also understand that mental health services are entirely voluntary, so legal guardians are in charge of whether mental health services are provided in the school.

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The School District will commit to the following:

1. School District will do its best to inform CMH about long-term subs and absent paraprofessionals.
2. School District will provide all academic instruction and materials necessary for regular academic activities.
3. School District personnel will utilize the appropriate chain of command when there are questions, concerns, or disagreements regarding the mental health services, interventions, or conduct of CMH Staff.
4. School Districts will encourage their personnel to participate in CMH's annual satisfaction survey, wherein they can give CMH feedback about improving our services in the school setting.
5. School District will provide a private setting where a CMH staff can provide individualized mental health care, when requested, for therapy.
6. Involved school personnel will be actively involved as treatment team members for children who receive CMH services within the school system and expect active involvement from CMH in educational planning if invited.

Bess Clark, Executive Director, Community Connections — Date: 2/28/22

Tandra Thompson, Program Director, Community Connections — Date: 2/27/23

Superintendent — Date: 2/15/23

Community Connections, Ketchikan Alaska
School-Based Mental Health Services
Memorandum of Agreement

This Memorandum of Agreement is entered into between

Ketchikan Gateway Borough School District

and Community Connections, Children Mental Health (CMH) program.

Hereafter collectively referred to as "the parties." This agreement aims to clarify roles and responsibilities and enhance effective collaboration.

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Bess Clark, Executive Director, Community Connections — Date: 2/8/23

Tandra Thompson, Program Director, Community Connections — Date: 2/8/23

Superintendent — Date: 2/8/23

Community Connections, Ketchikan Alaska
School-Based Mental Health Services
Memorandum of Agreement

This Memorandum of Agreement is entered into between

Craig City School District

and Community Connections, Children Mental Health (CMH) program.

Hereafter collectively referred to as "the parties." This agreement aims to clarify roles and responsibilities and enhance effective collaboration.

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Bess Clark, Executive Director, Community Connections — Date: 3/8/23

Tandra Thompson, Program Director, Community Connections — Date: 2/7/23

Superintendent — Date: 2/7/23

Ketchikan, Alaska Service Matrix - FY2023

Agency	Emergency Services				Family Services			
	Emergency Mental Health Adult Services 24/7 Emergency Response	Emergency Mental Health Youth Services 24/7 Emergency Response	Emergency Shelter MH Crisis / Homeless Youth	Domestic Violence Shelter Housing / Women & Children	ICWA Parenting: Classes & Support groups, Resource Library, Referral and Advocacy for BAIA *Parenting Classes: Parenting with Love and Limits, Parenting Difficult Teens, School Success, Positive Discipline, Strengthening Families	Prenatal Classes	Family Preservation & Reunification	Public Awareness: Information, School Education, Red Ribbon Campaign: Drug Free Youth, Youth Challenge Day, Cultural Academic Services
Akeela/Gateway	X	X						X
Ketchikan Indian Community					X			X
Ketchikan Gateway Borough School District								X
Ketchikan Police Department								X
Ketchikan Wellness Coalition								X
PeaceHealth Ketchikan Regional Medical Center	X	X				X		
Residential Youth Care, Inc.		X	X		X			X
Tongass Substance Screening								X
Women In Safe Homes				X	X		X	X
Community Connections								

Ketchikan, Alaska Service Matrix - FY2023

Agency	Early Intervention				Detoxification
	Adult Alcohol / Drug Intervention: Individual & Group Counseling Education	Prime For Life: Group Adolescent Alcohol / Drug Early Intervention	Early Childhood Services: Home -Based Services	JASAP Court Screening & Monitoring: ASAP / JASAP (Referral to Kenai)	Medically Monitored Inpatient: Evaluation, Treatment, & Referral
Community Connections			X		
Akeela/ Gateway	X			X	
Head Start			X		
Ketchikan Trial Court					
Ketchikan Youth Court		X			
Rural Cap Head Start			X		
Tlingit & Haida Head Start			X		
PeaceHealth Ketchikan Regional Medical Center					X
Ketchikan Indian Community	X				
Women In Safe Homes			X		

Ketchikan, Alaska Service Matrix - FY2023

Agency	Outpatient & Intensive Outpatient Services									
	Evaluations, Adult Mental Health & Substance Abuse: Dual Diagnosis Capable: ASAM I	Screening & Assessment: Mental Health and Substance Use: SASSI, POSIT	Case Management: Medical Monitoring	Youth Substance Abuse: Individual & Group Counseling Clinical Staff Development	Adult Therapeutic Court: Specific Groups	Adult and Child Mental Health – Dual Diagnosis Capable & Rehabilitation Services: Psychiatric, Nursing, Therapy, and Case Management for SMI & Co-Occurring Clients	Psychiatric Assessments & Treatment	Elder Services: Case Management & Services for an Aging Population	Adult and Child Mental Health	Adult Substance Abuse / Dual Diagnosis Capable ASAM II: Individual & Group Counseling, Care Management, Rehab Treatment, MRT, Early Recovery, Gender Groups, & Social Support
Community Connections		X				X	X	X	X	
Annette Island Service Unit							X		X	
Bill Hardy 225-7448	X									
Catholic Community Services - SE Senior Services								X		
Dr. Snow 220-9948							X			
Akeela/ Gateway	X	X	X			X	X		X	X
Ketchikan Indian Community	X	X	X	X	X	X	X	X	X	X
Ketchikan Trial Court					X					
Patty Houser 225-5858	X									
PeaceHealth Ketchikan Regional Medical Center			X				X		X	
Rendezvous								X		
Residential Youth Care, Inc.		X		X			X		X	
Roseann Lynch 225-4474	X									
Women In Safe Homes									X	

Ketchikan, Alaska Service Matrix - FY2023

Agency	Residential Treatment Services					
	Partial Hospitalization (12-19 years)	Children's Residential: Emergency & Long-Term Residential Treatment: 10-18 Years Old	Therapeutic Treatment Homes	Residential Education Program: Education	Adult Co-occurring Transitional Housing: Horizon House: 7 Beds Short-Term for Adults. The Garage: 3 beds Short Term for Adults Recovering Substance Use Disorder	Adult Substance Abuse: Co-Occurring Residential Treatment: Evaluation, Individual, Group, & Family Counseling, Family Program, Gender-Specific Groups, Case Management, Life Skills, & Referrals: KAR House
Community Connections			X			
Akeela/Gateway			X		X	X
Ketchikan Gateway Borough School District				X		
Residential Youth Care, Inc.	X	X	X	X		

Ketchikan, Alaska Service Matrix - FY2023

Agency	Other Local Services									
	Anger Management, Women's Life Stage, Men's Issues, Men's & Women's MRT Groups	Batterers' Intervention Group	Community Alcoholics Anonymous & Narcotics Anonymous	NAMI Group Advocacy & Support Meetings	Tobacco Cessation program	Marijuana Youth Early Prevention Education: Healthy Lifestyles Curriculum (Grades 6-8)	Fingerprinting	Food Stamps	Adult Employment Help / Job Search/ Vocational Rehabilitation	Youth Employment Help/ Job Search/ Vocational Rehabilitation
Akeela/ Gateway	X									
Ketchikan Indian Community		X			X				X	X
Ketchikan Wellness Coalition					X					
Private Providers			X	X						
Bill McGlauphlin 254-2420							X			
Rain City Tattoo 225-8840							X			
Residential Youth Care, Inc.					X	X	X			
Public Assistance Ketchikan Office 225-2135								X		
Ketchikan Job Center 225-2828									X	
PeaceHealth- Ketchikan Regional Medical Center					X					

Community Support Groups (All In Ketchikan)

Alcoholics Anonymous **Location**: 433 Missions Street - St. John's Episcopal **Phone**: 225-5154 **Meeting Time**: Daily, 12pm	**Depression & Bi-Polar Support Alliance** Support for individuals and family and friends **Location**: 3100 Tongass Avenue (KGH) Walt Shuham Board Room **Phone**: 225-5887 **Meeting Time**: Every Saturday, 4:30pm	**National Alliance on Mental Illness (NAMI)** Uniquely structured community mental health movement for prevention and rehabilitation **Location**: 3100 Tongass Avenue (KGH) – Walt Shuham Board Room **Phone**: 225-5887 **Meeting Time**: Every Saturday, 4:30pm
Alcoholics Anonymous **Location**: 1736 Tongass Avenue **Phone**: 225-5154 **Meeting Times**: • Nightly, 8pm • Sunday, 10am	**Diabetes Education Support Group** Ketchikan Public Health **Location**: 3054 Fifth Avenue **Phone**: 228-7685 or 254-5103 **Meeting Time**: Second Thursday of each month, 6:30-8pm	**Nutrition & Alternative Health** **Location**: 3100 Tongass Avenue (KGH) – Walt Shuham Board Room **Phone**: 225-5171 (Elise Berger) **Meeting Time**: Call Elise for info
Bereavement Support Group **Location**: 3100 Tongass Avenue (KGH) Walt Shuham Board Room **Phone**: 225-8914 **Meeting Time**: Tuesday, 5-6pm	**Grow Anonymous** **Location**: 141 Bryant Street (Pioneer's Home) – Meeting in the Conference Room **Meeting Time**: Every Sunday, 3pm	**Older Blind Alaskans Support Group** **Location**: 141 Bryant Street (Pioneer's Home) – Second Floor Meeting Room **Phone**: 225-4735 **Meeting Time**: Third Monday of the month, 10:30am
Childbirth Education A class for pregnant women and supporters **Location**: 3100 Tongass Ave (KGH) **Phone**: 225-5171, ext 320 **Meeting Time**: Call for info on next class	**Low Vision & Blindness Support Group** **Location**: SAIL Office – – 2417 Tongass Avenue, Suite 222 **Contact**: Brenda (*loughmanb@kpunet.net*) **Meeting Time**: 1st Monday of the Month, 1:00-2:30pm	**Stroke Survivors Support Group** **Location**: 3100 Tongass Avenue (KGH) – Walt Shuham Board Room **Phone**: 247-8276 or 225-0939 **Meeting Time**: First Tuesday of the month, call for time
Compassionate Friends Support Group A support group for people who have lost a child no matter what age or how long ago **Location**: 141 Bryant Street (Pioneer's Home) **Phone**: 225-4111 **Meeting Time**: Second Thursday of the month, 7-9pm	**Low Vision & Blindness Support Group - Virtual** **Location**: Virtual, open to anyone in Southeast! **Contact:** Linda (*lnewman@sailinc.org*) **Meeting Time**: 3rd Tuesday of the Month, 1:00-2:30pm	

Agency Contact Information

Community Connections 721 Stedman St. Ketchikan, AK 99901 907-225-7825 www.comconnections.org	**Akeela/ Gateway** 3050 5th Ave. Ketchikan, AK 9901 907-225-4135 https://akeela.org/ketchikan/	**Ketchikan Trial Court** 415 Main St. #400 Ketchikan, AK 99901 907-225-3195 https://courts.alaska.gov/courtdir/1ke.htm	**Residential Youth Care, Inc.** 2506 1st Avenue Ketchikan, AK 99901 907-225-4664 1-866-838-1861 www.rycalaska.com
Annette Island Service Unit 563 Brendible St Metlakatla, AK 99926 907-886-4741 www.facebook.com/AnnetteIslandSU	**Head Start Center** 1001 Schoenbar Rd. Ketchikan, AK 99901 907-225-7499	**Ketchikan Wellness Coalition** 602 Dock St #108 Ketchikan, AK 99901 907-225-9355 www.ktnkwc.org	**Tongass Substance Screening** 120 Carlanna Lake Rd. Ketchikan, AK 99901 907-247-1431 www.tss-safety.com
Catholic Community Services - SE Senior Services 1803 Glacier Highway Juneau, AK 99801 907-463-6100 www.ccsjuneau.org	**Tlingit & Haida Head Start** 2456 Raven St. Ketchikan, AK 99901 907-225-8728	**Ketchikan Youth Court** 2417 Tongass Avenue, Suite No. 210 Ketchikan, AK 99901 907-225-2293 www.ketchikanyouthcourt.com	**Women In Safe Homes** 2002 1st Ave. Ketchikan, AK 99901 907-225-9474 www.wishak.org
Division of Behavioral Health 3601 C St. Suite #878 Anchorage, AK 99503 907-269-3600 www.dhss.alaska.gov	**Ketchikan Indian Community** 2960 Tongass Ave. Ketchikan, AK 99901 907-228-4900 www.kictribe.org	**Office of Children's Services-Ketchikan** 415 Main St. #201 Ketchikan, AK 99901 907-225-6611 https://www.dcfoffices.org/office/ketchikan-ocs-office	**First City Homeless Services – Day Shelter** 400 Main St. Ketchikan, AK 99901 907-225-0888
Division of Juvenile Justice - Ketchikan 415 Main St. Court Building Room 203 Ketchikan, AK 99901 907-225-9639 https://dfcs.alaska.gov/djj	**Ketchikan Gateway Borough School District** 333 Schoenbar Rd. Ketchikan, AK 99901 907-225-2118 www.kgbsd.org	**PeaceHealth Ketchikan Regional Medical Center** 3100 Tongass Ave. Ketchikan, AK 99901 907-225-5171 https://www.peacehealth.org/hospitals/ketchikan-medical-center	**First City Homeless Services – Night Shelter** 628 Park Ave. Ketchikan, AK 99901 907-225-4194
Dr. Wynelle R. Snow 21 Jefferson St. Suite 201 Ketchikan, AK 99901 907-220-9948	**Ketchikan Police Department** 361 Main St. Ketchikan, AK 99901 907-225-6631 or 911 https://www.ktn-ak.us/police	**Rendezvous Senior Day Services** 2441 1st Ave. Ketchikan, AK 99901 907-247-1961	**Ketchikan Wellness Coalition** 602 Dock Street Suite 108 Ketchikan, AK 99901 907-225-9355 www.ktnwc.org

Agency	Programs
Community Connections	Parenting Classes Early Childhood Services Therapeutic Court Program: Referral & Support Integrated SA Evaluations, Adult MH, ASAM 1 Capable Screening & Assessment: MH and SA SASSI, POSIT Adult & Child MH Dual Diagnosis, Psychiatric, Nursing, Therapy, Case Management Psychiatric Screening, Assessment, & Treatment Elder Services: Home & Community Based Services Adult and Child Mental Health Therapeutic Foster Care
Akeela/ Gateway	Emergency Mental Health Services 24/7 Adult SA Intervention Individual & Group Counseling Evaluations, Adult MH, ASAM 1 Capable Screening & Assessment: MH and SA SASSI, POSIT Case Management: Medical Monitoring Youth SA Individual & Group Counseling Adult & Child MH Dual Diagnosis SMI & Co-Occurring Clients Psychiatric Assessment & Treatment Adult & Child Mental Health Adult Substance Abuse ASAM II, Rehab Treatment, MRT, Early Recovery, Social Support Therapeutic Foster Care Adult Co-occurring Transitional Housing- Horizon House 7 Beds Adult Transitional Housing – Recovering with SUD- The Garage 3 Beds Adult Substance Abuse / Co-Occurring Residential Treatment KAR House Anger Management Women’s Life Stage Men’s & Women’s MRT Groups Adult Employment/ Job Search

Ketchikan Indian Community	ICWA Parenting Classes & Support Cultural Heritage Academic Services Integrated SA Evaluations, Adult MH, ASAM 1 Capable Screening & Assessment: MH and SA SASSI, POSIT Case Management: Medical Monitoring Youth SA Individual & Group Counseling Adult Therapeutic Court Adult & Child MH Dual Diagnosis SMI & Co-Occurring Clients Psychiatric Assessment & Treatment Elder Services: Case Management Batterer's Intervention Group Tobacco Cessation Program Vocational Rehabilitation
Ketchikan Wellness Coalition	Public Awareness: Information & School Education Red Ribbon Campaign Suicide Prevention TCFA Financial Literacy Task Force Drug Free Communities Prevention Program
Residential Youth Care, Inc.	Emergency Shelter MH Crisis / Homeless Youth Parenting Classes for Difficult Teens Screening & Assessment: MH and SA SASSI, POSIT Youth Substance Abuse: Individual, Group, and Family Counseling Psychiatric Assessments & Treatment Child Mental Health Children's Residential: Short or Long-Term Treatment Coed 10-18 Partial Hospitalization Therapeutic Treatment Homes (TFC) Residential Education Program Tobacco Cessation Education Marijuana Early Prevention: Healthy Lifestyles Curriculum (Grades 6-8) Youth Transitional Living Support services 15-25 Fingerprinting Youth Employment Help/ Job Search

Resolution No. 2023-2

A RESOLUTION OF THE BOARD OF DIRECTORS AT COMMUNITY CONNECTIONS ENDORSING A GRANT PROPOSAL TO THE RASMUSON FOUNDATION AND THE ALASKA MENTAL HEALTH TRUST AUTHORITY TO PURCHASE TWO FOSTER HOMES (1 in Ketchikan and 1 on Prince of Wales Island)

WHEREAS, according to the Department of Justice (2022), Alaska relies too heavily on out of community/state institutions to serve youth with significant mental health concerns, which requires children to leave their communities to receive treatment in excessively restrictive settings,

WHEREAS, there is tremendous demand in Ketchikan and on Prince of Wales Island for community based alternatives to institutional care, such as Therapeutic Foster Care, that allow youth to remain close to their families, schools, and community while receiving effective treatment,

WHEREAS, the number of licensed foster homes in Southeast Alaska has decreased 30% in the last three years,

WHEREAS, for over 20 years Community Connection's accredited Therapeutic Foster Care program has consistently yielded positive impacts on the lives of youth with significant mental health concerns,

WHEREAS, our children's mental health program has prioritized Therapeutic Foster Care services as a sustainable area for growth and expansion,

WHEREAS, increasing the number of agency owned foster homes will: allow our Children's Mental Health program to more effectively match the homes with the needs of youth, ensure that the home(s) are permanently dedicated to the provision of Therapeutic Foster Care, enable the purchase of higher capacity homes which can serve more youth, and will allow agency maintenance staff to maintain and improve the homes according to licensing standards.

WHEREAS, Providing TFC from more agency-owned homes will stabilize the TFC program, reduce the challenges we have experienced, and will increase the number of children and families we impact.

NOW THEREFORE BE IT RESOLVED BY COMMUNITY CONNECTIONS BOARD OF DIRECTORS:

Section 1. Community Connections formally endorses a joint grant proposal to the Rasmuson Foundation (for $400,000) and the Alaska Mental Health Trust Authority (for $400,000) towards the purchase of two (2) 3-5 bedroom homes, one (1) in Ketchikan and one (1) on Prince of Wales Island.

Section 2: Contingent on successful funding, with Community Connections will contribute up to $400,000 towards this project.

Approved this 9th day of February, 2023.

ATTEST:

Scott Brant-Erichsen, Board President

2/9/2023

Date

Youth Services Survey - Parent/Caregiver Questions

Respondent ID
Collector ID
Start Date
End Date
IP Address
Email Address
First Name
Last Name
Please select your location.
Please select the appropriate age group
Please enter the name of the client's therapist.
Would you like to keep the results of this survey anonymous? (If you check yes we will not share these results with the client's therapist)
Ethnicity (select one)
Races (select all that apply):
Sex:
In therapeutic foster care
Overall, I am satisfied with the services my child received
I helped to choose my child's services
I helped to choose my child's treatment goals
The people helping my child stuck with us no matter what
I felt my child had someone to talk to when he/she was troubled
I participated in my child's treatment
The services my child and/or family received were right for us
Services were available at times that were convenient for us
My family got as much help as we needed for my child
Staff treated me with respect
Staff respected my family's religious/spiritual beliefs
Staff spoke with me in a way that I understood
Staff were sensitive to my cultural/ethnic background
As a result of the services received, my child is better at handling daily life
As a result of the services received, my child gets along better with family members
As a result of the services received, my child gets along better with friends and other people
As a result of the services received, my child is doing better in school and/or at work
As a result of the services received, my child is better able to cope when things go wrong
As a result of the services received, I am satisfied with our family life right now
As a result of the services received, my child is better able to do things he or she wants to do
As a result of the services received, I know people who will listen and understand me when I need to talk
As a result of the services received, I have people that I am comfortable talking with about my child's problems
As a result of the services received, I would have the support I need from family of friends in a crisis
As a result of the services received, I have people with whom I can do enjoyable things
What has been the most helpful thing about thee services you and your child received over the last 6 months?
What would improve the services here?
Please provide comments here. We are interested in both positive and negative feedback.

Youth Services Survey- Youth Receiving Service - Questions

Respondent ID
Collector ID
Start Date
End Date
IP Address
Email Address
First Name
Last Name
Please select your location.
Please select your appropriate age group
Please enter the name of the therapist you are working with.
Would you like to keep the results of this survey anonymous? (If you check yes we will not share these results with your therapist)
Ethnicity (select one)
Races (select all that apply):
Sex:
In therapeutic foster care
Overall, I am satisfied with the services I received
I helped chose my services
I helped chose my treatment goals
The people helping me stuck with me no matter what
I participated in my own treatment
I felt I had someone to talk to when I was troubled
I received services that were right for me
The location of services was convenient for me
Services were available at times that were convenient for me
I got the help I wanted
I got as much help as I wanted
Staff treated me with respect
Staff respected my religious/spiritual beliefs
Staff spoke with me in a way that I understood
Staff were sensitive to my cultural/ethnic background background
As a result of the services received, I am better at handling daily life
As a result of the services received, I get along better with family members
As a result of the services received, I get along better with friends and other people
As a result of the services received, I am doing better in school and/or work
As a result of the services received, I am better able to cope when things go wrong
As a result of the services received, I am satisfied with my life right now
As a result of the services received, I am better able to do things I want to do
As a result of the services received, I know people who will listen and understand me when I need to talk
As a result of the services received, I have people that I am comfortable talking with about about my problem(s)
As a result of the services received, I would better have the support I need from family or friends in a crisis
As a result of the services received, I have people with whom I can do enjoyable things
What has been the most helpful thing about the services you and your child received over last six months?
Please provide any feedback here. We are interested in both positive and negative feedback
What would improve the services here?

INVESTIGATION OF THE STATE OF ALASKA'S BEHAVIORAL HEALTH SYSTEM FOR CHILDREN

United States Department of Justice
Civil Rights Division

December 15, 2022

SUMMARY OF FINDINGS

After an extensive investigation, the United States Department of Justice (DOJ) concludes there is reasonable cause to believe that the State of Alaska violates Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, by failing to provide services to children with behavioral health disabilities[1] in the most integrated setting appropriate to their needs. Consistent with Title II regulations, 28 C.F.R. § 35.172, we provide this Report to notify Alaska of DOJ's conclusions, the facts supporting those conclusions, and the minimum remedial measures necessary to address the deficiencies identified.

In Alaska, children with behavioral health disabilities are institutionalized at high rates and for long periods because the State does not ensure that community-based services are available and accessible. Hundreds of children, including Alaska Native children in significant numbers, receive treatment in institutional settings within Alaska each year, often far from their homes and communities. Hundreds more are sent to segregated facilities in states as distant as Texas and Missouri.

Many of these children are eligible and appropriate for community-based services and supports that Alaska offers through its Medicaid program. Indeed, Alaska has made commendable efforts in recent years to bolster its community-based behavioral health service array, most notably through implementation of a Section 1115 Medicaid demonstration waiver.[2] Still, Alaska's system of care is heavily biased toward institutions, and key services and supports are often unavailable to children in their communities. As a result, many children with behavioral health disabilities who are appropriate for community-based services are forced to endure unnecessary and unnecessarily long admissions to psychiatric hospitals and psychiatric residential treatment facilities. This unnecessary segregation violates the ADA.

Alaska can fulfill its obligation to serve children in the most integrated setting appropriate to their needs by making reasonable modifications to its service system that are aligned with the State's own policies and objectives.

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[1] Children with behavioral health disabilities are individuals up to the age of 21 who have a diagnosable serious emotional disturbance, mental illness, and/or substance use disorder. This population includes children with co-occurring intellectual or developmental disabilities.

[2] Under Section 1115 of the Social Security Act, the Secretary of the U.S. Department of Health and Human Services has authority to approve demonstration projects to promote the objective of the Medicaid program. The purpose of these waivers, which give states additional flexibility to design and improve their programs, is to "demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations." Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html [https://perma.cc/GDM5-H7AE].

I. INVESTIGATION

On December 17, 2020, DOJ notified Alaska of DOJ's intent to investigate whether the State unnecessarily institutionalizes children with behavioral health disabilities, in violation of Title II of the ADA.

Our investigation included extensive outreach to facility-based and community-based service providers and administrators, both across Alaska and at out-of-state facilities where Alaskan children receive services. We conducted numerous interviews of State officials and met with representatives of more than a dozen tribal organizations, spanning almost every region of the state. Along with a clinical expert, we spoke directly with children receiving State-funded behavioral health services in segregated facilities at or around the time of the investigation, both within and outside Alaska. In some instances, we had the opportunity to interview the parents or guardians of children receiving such services.

We conducted two in-person visits to Alaska, in April and May 2022. During those visits, we toured segregated facilities that serve children with behavioral health disabilities, including two facilities operated by Alaska's Division of Juvenile Justice. We also met with key State officials, service providers and administrators in multiple regions of Alaska, and other stakeholders.

In addition, DOJ attorneys and retained experts[3] reviewed thousands of documents and extensive data produced by the State, including medical records for a random sample of children who received State-funded behavioral health services in psychiatric hospitals or residential treatment facilities between 2019 and 2022.

We would like to thank the State for the assistance and cooperation extended to us throughout our investigation, and to acknowledge the courtesy and professionalism of all the State officials and counsel involved in this matter. We also thank the advocates, service providers, and other stakeholders across Alaska who spoke with us. We are particularly grateful to the children and families who trusted us with their stories.

II. LEGAL FRAMEWORK

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[4] Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with

[3] We retained three experts to consult us on this investigation: a clinical psychologist with over 20 years of professional experience and formal training in the fields of education and child and adolescent psychology; a medical anthropologist with extensive research and clinical experience in the areas of American Indian and Alaska Native behavioral health; and a clinical psychologist with more than 25 years of experience working with states and tribal entities to develop and implement community-based behavioral health services for children and families.

[4] 42 U.S.C. § 12101(b)(1).

disabilities continue to be a serious and pervasive social problem."[5] Accordingly, the "ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them."[6]

Under Title II of the ADA, public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[7] The most integrated setting appropriate is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[8] The regulations also require public entities to make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that such modifications would fundamentally alter the nature of the service, program, or activity.[9]

In *Olmstead v. L.C.*, the Supreme Court applied these authorities and held that public entities are required to provide community-based services to people with disabilities when (a) such services are appropriate; (b) the affected people do not oppose community-based services; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities.[10] The Court explained that unnecessary institutionalization "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[11] The Court also recognized the harm caused by unnecessary institutionalization when it found that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[12] The ADA's integration mandate applies both to people who are currently institutionalized and to people who are at serious risk of unnecessary

[5] 42 U.S.C. § 12101(a)(2).

[6] *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

[7] 28 C.F.R. § 35.130(d). *See also* 42 U.S.C. § 12101(b).

[8] 28 C.F.R. Pt. 35, App. B.

[9] 28 C.F.R. § 35.130(b)(7).

[10] 527 U.S. 581, 607 (1999).

[11] *Id.* at 600.

[12] *Id.* at 601.

institutionalization.[13] A State's failure to provide community-based services may create a risk of institutionalization.[14]

Courts have found proposed modifications that expand existing services to be reasonable, particularly when the modifications align with the jurisdiction's own stated plans and obligations.[15] States may also be required to implement reasonable modifications—such as expanding community-based services—even if that requires increased financial resources in the short term.[16] If a state fails to reasonably modify its service system to provide alternatives to institutional care, it violates Title II of the ADA.[17]

Under the Early, Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provisions of the Medicaid Act, the State has a separate legal obligation to provide children under the age of 21 with mental health screening tests to detect potential problems and identify any coverable services necessary to correct or ameliorate a mental illness or condition, regardless of whether that service is included in its State Plan or Medicaid waiver programs.[18] This obligation requires Alaska to provide comprehensive health care services, including in-home and community-based behavioral health treatment, to children in the Medicaid program.[19]

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[13] *M.R. v. Dreyfus*, 663 F.3d 1100, 1115–18 (9th Cir. 2011), *opinion amended and superseded on denial of reh'g*, 697 F.3d 706 (9th Cir. 2012); *Steimel v. Wernert*, 823 F.3d 902, 911-12 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 262-64 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321-22 (4th Cir. 2013); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1180-82 (10th Cir. 2003); *United States v. Mississippi*, 400 F. Supp. 3d 546, 553-55 (S.D. Miss. 2019).

[14] *Pashby*, 709 F.3d at 322. *See also Mississippi*, 400 F. Supp. 3d at 579.

[15] *See, e.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 280-81 (2d Cir. 2003) (upholding as a reasonable modification an order requiring agency to follow existing law and procedures); *Guggenberger v. Minn.*, 198 F. Supp. 3d 973, 1030 (D. Minn. 2016) (providing Medicaid waiver services to eligible people, particularly from existing waiver funds, is a reasonable modification); *Hiltibran*, 793 F. Supp. 2d at 1116 (a state providing a specific Medicaid service for people in institutions must provide it for Medicaid enrollees who need it in the community); *Haddad v. Arnold*, 784 F. Supp. 2d 1284, 1304-05 (M.D. Fla. 2010) (providing a service already in state's service system to additional people is not inherently a fundamental alteration); *Messier v. Southbury Training School*, 562 F. Supp. 2d at294, 344-45 (D. Conn. 2008) (plaintiffs' requested service expansion, which was consistent with defendants' publicly stated plans, was reasonable).

[16] *Frederick L.,. v. Dep't of Pub. Welfare*, 364 F.3d at487, 494-96 (3d. Cir. 2004) (collecting cases); *Mississippi*, 400 F. Supp. 3d at 577 (collecting cases).

[17] *Olmstead*, 527 U.S. at 607; 28 C.F.R. § 35.130(b)(7).

[18] 42 U.S.C. § 1396d(r)(5).

[19] *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52-53 (D. Mass. 2006) ("[T]he EPSDT provisions of the Medicaid statute require, by their very language, comprehensive assessments of children with SED [serious emotional disturbance] . . . the EPSDT provisions of the Medicaid statute require provision of adequate in-home behavioral support services for SED children"). *See also Katie A. v. L.A. Cnty.*, 481 F.3d 1150, 1159-60 (9th Cir. 2007) (agreeing that states have an obligation under the EPSDT mandate to provide effective in-home behavioral support services to children with mental illness, but overturning the lower court's requirement that the services be

III. ALASKA'S SERVICE SYSTEM FOR CHILDREN WITH BEHAVIORAL HEALTH DISABILITIES

Alaska's Division of Behavioral Health (DBH)[20] is primarily responsible for overseeing and administering the State's publicly funded programs and services—including Medicaid-funded services—for children with qualifying behavioral health disabilities. Through DBH, Alaska funds and administers those services in home- and community-based settings as well as in facility-based settings.

A. The State of Alaska Relies on Psychiatric Hospitals and Psychiatric Residential Treatment Facilities to Serve Children with Behavioral Health Disabilities.

Children receive State-funded behavioral health services alongside other children with disabilities in facilities both within and outside Alaska. Those facilities include two psychiatric hospitals in Anchorage – North Star Hospital, operated by North Star Behavioral Health, and the Alaska Psychiatric Institute, operated by the State. In addition, either directly or through its contractors, the State approves placements of Medicaid-enrolled children in private psychiatric residential treatment facilities (PRTFs).[21]

In Fiscal Year 2020, more than 800 children received State-funded behavioral health services in a psychiatric hospital or PRTF. At least one third of those children are Alaska

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bundled); U.S. Department of Health and Human Services, *Center for Medicaid and CHIP Services Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth*, at 3, 7 (Aug. 18, 2022), https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf [https://perma.cc/B49P-GF6Q] (noting that "the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for mental health" and that states can further the goal of the EPSDT benefit "by designing a robust benefit package . . . that includes coverage of intensive community-based services, crisis stabilization, and intensive care coordination to meet the needs of high-risk children and youth").

[20] In March 2022, pursuant to an Executive Order by the Governor of Alaska, the State restructured the Department of Health and Social Services (DHSS) into two departments—the Department of Health (DOH) and the Department of Family and Community Services (DFCS). The State's Division of Behavioral Health is housed in DOH, and its Office of Children's Services is under DFCS. State of Alaska Department of Health and Social Services, *DHSS Reorganization,* https://dhss.alaska.gov/Commissioner/Pages/reorganization/overview.aspx [https://perma.cc/BUW8-K7EF].

[21] Psychiatric residential treatment facilities (PRTFs)—also known in Alaska as residential psychiatric treatment centers—provide "highly structured, campus-based, long-term programs for children" who may have more intensive behavioral health needs. State of Alaska Division of Behavioral Health and Alaska Mental Health Trust Authority, *Caring for Alaska's Children and Youth in Out-of-Home Behavioral Health Care*, at 19 (March 19, 2019), https://alaskamentalhealthtrust.org/wp-content/uploads/2019/03/DBH-Conference-Presentation_FINAL-2019-03-19.pdf [https://perma.cc/FH39-JACH]. To be eligible to receive payment from the State for PRTF services, providers must meet the requirements—including licensing and certification requirements and capacity restrictions—set under 7 Alaska Admin. Code § 140.400. The federal Medicaid agency also sets requirements for such facilities, outlined at 42 C.F.R. Subpart D. Many, but not all, of the residential treatment facilities that serve children with behavioral health needs are PRTFs.

Native. Even as admissions to these congregate facilities have declined during the COVID-19 pandemic, children are staying at the facilities longer. All told, the State's Medicaid system paid over $83 million to serve children with behavioral health disabilities at a psychiatric hospital or PRTF in 2020.

To receive treatment in a psychiatric hospital or PRTF, children in Alaska frequently move hundreds or thousands of miles from their communities. For months and even years, they live apart from their families, friends, schools, and culture. Some children are discharged home without adequate community supports, leading to further admissions to these congregate facilities.

1. Psychiatric Hospitals

Every year, hundreds of children receive State-funded behavioral health services at psychiatric hospitals, where they live in close quarters with other children with behavioral health disabilities on locked units. Based on the State's reporting, 425 children were treated in psychiatric hospitals through Alaska's Medicaid program in Fiscal Year (FY) 2020. Many of those children were treated in general hospitals[22] in Alaska before entering psychiatric hospitals. Of the 654 children whom the State reports received acute psychiatric services at a general hospital or psychiatric hospital through Alaska's Medicaid program in FY2020, at least 300 children are Alaska Native.

At the State-run Alaska Psychiatric Institute (API), the Chilkat Unit provides in-patient treatment for adolescents with intensive behavioral health needs. After closing it in 2019, the State re-opened the Chilkat Unit in May 2021. It currently has capacity to serve up to 10 youth at one time. In FY2021, 55 Medicaid-enrolled youth were treated at the Chilkat Unit. Average lengths of stay at the facility have increased, from 17 days in FY2021 to over 42 days in the first half of FY2022.

North Star Hospital, in Anchorage, is the largest psychiatric hospital for children in Alaska, serving youth ages 5-18. It admits children from across the state, including directly from emergency rooms. North Star Hospital has two units, each with capacity to serve 20 children at any given time. At North Star Hospital, all aspects of daily life—including sleeping, eating, roommate selection, clothing, learning, recreation, and treatment—are controlled by the facility. Children are rarely permitted to leave. "Once you're in North Star, you don't go anywhere," we heard from a youth treated at the hospital in 2018. Another child interviewed at North Star Hospital in May 2022 reported that "we don't leave" the facility. Twelve years old at the time of the interview, that child had been at North Star Hospital for four months.

Children admitted to North Star Hospital between 2021 and 2022 have stayed, on average, for 40 days or longer. Inpatient service providers and administrators in Alaska report

[22] General hospital settings in Alaska where children receive acute psychiatric services include emergency rooms and dedicated psychiatric units.

that lengths of stay at North Star Hospital have increased because of the lack of appropriate community-based services and supports for children in the state. When they stay for weeks and months in settings like North Star Hospital, children who are able to return to the community, but nevertheless remain, can get discouraged and regress in their behaviors, further prolonging their hospital stays according to inpatient clinical staff in Alaska.

For some children in Alaska, like one Alaska Native child from Bethel, the weeks and months have turned into years. That child had been in congregate settings, almost continuously, for over four years when we reviewed her records. Her first admission to North Star Hospital occurred when she was 12 years old. At the time, she was feeling sad and irritable, and exhibiting some aggression toward her younger siblings. Our clinical expert found that she very likely could have been served in her own home, despite these symptoms, if she had received appropriate community-based services, such as Intensive Case Management, available in theory through the State's Medicaid program. *See infra* at 9-12. Instead, she remained at North Star for three weeks, only to return to the facility later that year for a five-week stay. After the second stay, rather than going home to her grandmother, she was transferred to the Alpine Academy, North Star's PRTF for adolescent girls, where she stayed for 18 months. She returned to North Star Hospital in 2019 and again in 2020, culminating in another placement to the Alpine Academy PRTF that was ongoing at the time of our review. Now approaching 18 years old, she appears to be more accustomed to life in an institution than at home.

In 2020, through its Medicaid program, the State paid over $56 million to treat children in psychiatric hospitals and an additional $14.5 million for acute psychiatric care for children in general hospitals. By comparison, Alaska's paid Medicaid claims for *all* community-based behavioral health services for children in 2020—excluding services provided in residential settings[23]—totaled under $32 million. While the number of children in psychiatric hospitals in Alaska declined during the COVID-19 pandemic, lengths of stay are increasing and the State is spending more on these institution-based services.

For many children in Alaska, hospitalization at North Star or API is a gateway to longer-term placement at psychiatric residential treatment centers, including out of state. Between July 2018 and February 2021, North Star alone referred at least 150 youth—including children as young as 8 years old—for out-of-state placement at PRTFs thousands of miles from their communities.

2. Psychiatric Residential Treatment Facilities

Through its Medicaid program, Alaska certifies more than 20 PRTFs where, collectively, hundreds of children receive State-funded behavioral health services each year. In addition to

[23] Our analysis shows that in 2020 the State funded, through its Medicaid program, more than $17 million in services at non-PRTF-level residential facilities in Alaska. We draw no conclusions with respect to those facilities in this Report.

four PRTFs located within Alaska, the State relies on 17 out-of-state PRTFs, including facilities in Texas, Utah, and Missouri, to serve Medicaid-enrolled children.

Each year from 2017 to 2021, at least 330 children received behavioral health services in a PRTF through the State's Medicaid program. Again, the burden falls substantially on Alaska Native children. Reflecting deep gaps in the State's community service system, *see infra* at 18-22, children dually diagnosed with behavioral health disabilities and intellectual and developmental disabilities are particularly vulnerable to placement in PRTFs and psychiatric hospitals.

While the total number of children in Alaska entering PRTFs has declined during the COVID-19 pandemic, as with psychiatric hospitalizations, lengths of stay at PRTFs have increased. Placements of between six months and one year are common. Some children remain in a PRTF for years.

Life in a PRTF, as described by youth in Alaska who have experienced it and by their parents and advocates, can be isolating, frightening, and chaotic. Children stay in locked buildings exclusively with other youth with behavioral health disabilities, often thousands of miles from their families and communities. Some children experience repeated residential placements, at times in quick succession, leading to sustained periods of institutionalization that have long-term effects on them and their families.

The experience of PRTF placement can be devastating for children—and uniquely so for Alaska Native children, compounding the trauma of past generations when Alaska Native youth were routinely taken from their communities and sent to boarding schools, including some run by the State or the federal Bureau of Indian Affairs.[24] Alaska Native children confined to PRTFs and other institutional settings are disconnected from their culture, losing opportunities to learn from elders, learn Native languages, learn how to live off the land, and participate in cultural traditions that affirm their identity. They frequently progress more slowly in treatment, stay at facilities longer, and sometimes run away because they do not want to be there. These children lose their sense of identity while in institutions, we heard from community leaders when visiting Alaska Native communities in western Alaska. After months or years in a highly regimented environment, they often struggle to adjust when returning to their communities.

Some children, like one 14-year-old Alaska Native child reviewed by our clinical expert, get caught in a cycle of restrictive placements. At the time of our review, that child had already experienced two placements to out-of-state PRTFs, totaling more than 13 months, in addition to at least three admissions to North Star Hospital. He was 10 years old the first time that he was removed from his Alaska Native community, a small village in the Northwest Arctic Borough, and sent to North Star. After nearly a month at the facility, he returned home to live with foster parents, but never received the services and supports he needed to manage his behavioral health symptoms effectively. Indeed, those services—including Home-Based Family Treatment,

[24] *See* Diane Hirshberg & Suzanne Sharp, *Thirty Years Later: The Long-Term Effects of Boarding Schools on Alaska Natives and Their Communities* (2005), available at https://iseralaska.org/static/legacy_publication_links/boardingschoolfinal.pdf [https://perma.cc/YDD5-9Q6Z].

Intensive Case Management, and Crisis Services—are not available in his community. During his first out-of-state placement at a PRTF in Utah, and while he was in the custody of the State's Office of Children's Services (OCS), the child was put in seclusion or restraints at least eight times. Staff at the PRTF reported that his discharge was delayed because OCS was slow in coordinating aftercare. The following year, during his second admission to North Star Hospital, the child reportedly stabbed himself in the leg with a pencil when he learned that he was being sent to another out-of-state PRTF, in Missouri. The more time he spent in congregate facilities, the more he seemed to struggle with transitioning back to community settings and managing his behavioral health symptoms. In 2021, he was held for three months at McLaughlin Youth Center, the State's juvenile justice facility in Anchorage, before he was adjudicated delinquent and placed in foster care.

As required by Alaska law, the State reviews all referrals for out-of-state placement of Medicaid-enrolled children, including from private facilities like North Star Hospital. Alaska Stat. § 47.07.032. Typically, within 48 hours of receiving a referral for out-of-state placement, staff at DBH and OCS meet to determine whether, based on the information provided by the referring entity, "services that are consistent with [the child's] clinical diagnoses and appropriately address their needs are unavailable in the state." In cases involving children in the State's custody, OCS convenes and leads the meeting. Staff document their determination for each child referred, checking a box to indicate whether "[a]pproval [is] given for out of state placement."

Records produced by OCS for approximately 160 of these meetings between 2016 and 2020 involving children in the State's custody did not contain a single instance where the committee denied approval for out-of-state placement. The majority of the referrals were from North Star, and a significant number concerned Alaska Native children. The average age of the children referred was just 13. Treatment summaries included in these records often reflect a long history of congregate facility placement. One child, 11 years old at the time and being considered for placement at a PRTF in Texas, had already been placed at the same facility twice before. In determining that no appropriate in-state alternatives were available, the committee noted that the child's earlier discharge to his family was unsuccessful because he did not receive "necessary supports."

In 2021, Alaska's Medicaid program paid nearly $37 million for PRTF services, up from just under $30 million in 2018. Most of that money goes to out-of-state PRTFs, which collectively served 172 Medicaid-enrolled children from Alaska in 2021.

B. The State Funds and Administers Community-Based Services and Supports That Can Divert Children from Unnecessary Institutionalization.

The kinds of community-based behavioral health services and supports needed to help children avoid unnecessary institutional placement are part of the State's existing Medicaid program. Some interventions, such as Therapeutic Treatment Home Services, have long been available in some form to Medicaid-enrolled children in Alaska. With the implementation of its Section 1115 Medicaid behavioral health waiver in 2019, Alaska added a number of community-based services for children, including Home-Based Family Treatment, Intensive Case

Management, and Crisis Services. Medicaid-enrolled service providers in Alaska have the flexibility to offer culturally appropriate activities and interventions for Alaska Native youth—such as traditional counseling—under the State's existing service menu.[25]

Research has shown that services and supports like those included in Alaska's Medicaid program, when provided consistently and with sufficient intensity, can effectively address the needs of children with behavioral health disabilities while maintaining their connection to their families and communities.[26] Community-centered behavioral health programs have had success in preventing institutionalization and producing better outcomes for children and families. With access to timely and appropriate services, even children with intensive behavioral health needs and a history of congregate facility placement are able to return to or remain in family homes where they are more likely to have improved clinical and functional outcomes, better school attendance and performance, and increased behavioral and emotional strengths compared to children receiving care in institutions.

Alaska acknowledges that community-based behavioral health services and supports are effective in maintaining children in a home environment and preventing unnecessary hospitalizations and residential facility placements—indeed, that was a central premise for its Section 1115 waiver. Through the waiver, Alaska seeks to implement a series of "strategies and evidence-based interventions aimed at more effectively addressing the needs of each of the target populations," including youth with behavioral health disabilities and their families. It chose to offer the following services[27]—among others introduced under the Section 1115 waiver or established years prior through its Medicaid State Plan—to "reduce Alaska's over-reliance on . . . institutional care."[28]

1. Home-Based Family Treatment

Home-Based Family Treatment is "a community-based early intervention service" that offers "wrap-around services" in the home to reduce the need for hospitalization and residential services for children and adolescents with behavioral health disabilities. There are three levels of Home-Based Family Treatment under the State's Section 1115 waiver, depending on the needs

[25] Tribal Health Organizations strive to incorporate aspects of Alaska Native culture. Restoring lost connections to tribal culture and addressing historical trauma are seen as important parts of treatment.

[26] *See, e.g.,* Carrie W. Rishel, et al., *Preventing the Residential Placement of Young Children: A Multidisciplinary Investigation of Challenges and Opportunities in a Rural State*, 37 W. Va. Univ. Children & Youth Servs. Rev. 9 (2014), available at http://dx.doi.org/10.1016/j.childyouth.2013.11.027.

[27] Service descriptions are based on the State's publicly available standards and administrative procedures for behavioral health service providers. State of Alaska Department of Health and Social Services, *Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider* Services (June 30, 2021), available at https://health.alaska.gov/dbh/Documents/1115/Standards-and-Administrative-Procedures-for-Behavioral-Health-Provider-Services.pdf [https://perma.cc/WMZ5-4P5M].

[28] State of Alaska Department of Health and Social Services, *Medicaid Section 1115 Behavioral Health Demonstration Application*, at 32 (Jan. 31, 2018), available at https://perma.cc/R5JW-N65G.

of the child; Level III targets children at "imminent risk of out of home placement" or who have been discharged from a psychiatric hospital, residential treatment facility, or juvenile detention facility. Across all three levels, service components for Home-Based Family Treatment include case coordination and referrals; crisis diversion and intervention planning; comprehensive family assessment, group and individual therapy, and other clinical services; peer support services and navigation;[29] and ongoing monitoring for safety and stability in the home. Staff eligible to provide Home-Based Family Treatment, either individually or as part of an inter-disciplinary team, include physicians and physician assistants, registered nurses, Community Health Aides and Behavioral Health Aides, substance use disorder counselors, and peer support specialists.

2. Crisis Services

Seeking to fill a widely acknowledged gap in its behavioral health service continuum, Alaska rolled out three Crisis Services for children—as well as adults—through its Section 1115 waiver in 2019.[30]

Mobile Outreach and Crisis Response Services are provided to children to (1) prevent a behavioral health crisis from escalating; (2) stabilize the youth during or after a behavioral health crisis; or (3) refer and connect the youth to other appropriate services needed to resolve the crisis. These services also include skills training, medication services, and assisting with creating a safety plan and other crisis planning. Mobile Outreach and Crisis Response Services programs must be available 24/7, coordinate with law enforcement and crisis stabilization center staff, and have capacity to provide a face-to-face response within an hour in urban areas or a "rapid" response in rural areas of the state. Programs must also document their attempts to follow up with a client within 48 hours of a response, to "ensure support, safety, and confirm linkage with any referrals."

23-Hour Crisis Observation and Stabilization Services provide a secure environment where youth experiencing acute behavioral health symptoms can receive individual assessment, psychiatric evaluation, medication, and other clinical services in addition to crisis intervention and stabilization services for up to 23 hours and 59 minutes. The State requires that providers of 23-Hour Crisis Observation and Stabilization Services coordinate with local law enforcement and with a crisis stabilization center, where available.

[29] Peer Support is available in Alaska as a component of other services, including Home-Based Family Treatment and Community Recovery Support Services, and on a standalone basis through the State's Peer-Based Crisis Service. Services are provided by peer support specialists – often individuals with lived experience with mental illness. In Alaska, key components of Peer Support can include crisis diversion and support services, resiliency services, and facilitating transition to other community-based resources or natural supports.

[30] Coinciding with the roll-out of its Section 1115 behavioral health waiver, the State partnered with the Alaska Mental Health Trust Authority to support improvements to Alaska's behavioral health crisis response system by implementing the nationally recognized Crisis Now framework. *See* Alaska Mental Health Trust Authority, *Behavioral Health Crisis Response*, https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/ [https://perma.cc/SQU9-C4D8].

Crisis Residential and Stabilization Services offer 24/7 psychiatric stabilization services, medication services, and referrals to appropriate ongoing services and supports. Lengths of stay beyond seven days at Crisis Residential and Stabilization programs require a service authorization. Stabilization services are also available in home settings under the State's Medicaid program, most notably through Home-Based Family Treatment. *See supra* at 10-11.

3. Therapeutic Treatment Home Services

Therapeutic Treatment Home Services for children include individual assessment and other trauma-informed clinical services, crisis intervention services, and case coordination. Provided by licensed foster parents in their homes and under the direction of a mental health clinician, Therapeutic Treatment Home Services are designed for youth who have severe mental, emotional, or behavioral health needs and who cannot be stabilized in a less intensive home setting. Foster parents are licensed and trained by the State or through community service provider organizations certified by the State.

4. Community Recovery Support Services

Community Recovery Support Services help to improve self-sufficiency and promote recovery for children and adolescents with behavioral health disabilities. Components of Community Recovery Support Services include coaching and referrals to build daily living skills; linking children and families to community resources; family psychoeducation and training; peer support for children and families; and assistance with level-of-care transitions. As with other community-based services offered through Alaska's Medicaid program, Community Recovery Support Services are designed to be culturally and linguistically appropriate and to assist youth and families in sustaining recovery and promoting stability.

5. Intensive Case Management

Intensive Case Management is designed for children at risk out-of-home placement who would benefit from more assertive care coordination and regular monitoring of their safety, stability, and behavioral health services. Intensive Case Management services include evaluation, outreach, support services, patient advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching youth to become self-sufficient. Alaska requires that Intensive Case Management services be available and provided in the community as often as needed, and that providers be in contact with clients as frequently as "2-to-3 times a day."

C. Alaska Has Not Addressed Long-Standing Gaps in Available Community-Based Services and Supports.

As the State recognized in its 2018 application for the Section 1115 waiver, "[h]istorically, Alaska has not provided a comprehensive continuum of behavioral health care"[31] The State wrote that the community prevention and early intervention services available to children at risk of out-of-home placement are "very limited."[32] For children already receiving residential services, the State recognized that there are very few options "for sub-acute services designed to (a) provide services within the child's home or in the child's community and (b) prevent repeated placement in residential and inpatient services far from the child's community and home."[33] The State also acknowledged that limited services in Alaska contribute to facility-based placements, stating that each month, an average of 130 children and youth reside in foster care or inpatient psychiatric treatment outside of Alaska due to a shortage of available therapeutic foster care placements and insufficient capacity of other community-based services.[34]

This is not a new problem. The State has long recognized that its community-based behavioral health service system does not meet the needs of children at serious risk of institutionalization. A 2009 report commissioned by the State captured the dire state of affairs:

> Alaska's current system of care does not include the appropriate continuum and array of services for individuals with . . . complex behaviors. Because of this, many of these individuals are served by the Alaska Psychiatric Institute (API), where they languish in an unnecessarily restrictive environment for extended periods of time, or they are inappropriately held in places such as . . . emergency rooms. Many are ultimately sent out of state for care, where in many cases they remain indefinitely. [] The result of the lack of appropriate services in Alaska is significant financial cost to the State and personal cost to the individuals and their families.[35]

More than 10 years later, the State acknowledges that it still has limited capacity to provide timely, appropriate services and supports to prevent institutional placement of children

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[31] State of Alaska Department of Health and Social Services, *Medicaid Section 1115 Behavioral Health Demonstration Application*, at 11 (Jan. 31, 2018), available at https://perma.cc/R5JW-N65G.

[32] *Id.*

[33] *Id.*

[34] *Id.* at 18.

[35] Western Interstate Commission for Higher Education, *Alaska Complex Behavior Collaborative*, at 3-4, available at https://health.alaska.gov/dbh/Documents/TreatmentRecovery/CBC-Executive-Summary.pdf [https://perma.cc/H7M5-BXDV].

with behavioral health disabilities.[36] Statewide gaps in community-based services, according to the State, contribute to a "tendency for individuals to move into residential settings."[37] Children with behavioral health disabilities "remain in crisis longer, wait for long periods in a setting not designed to help them, do not receive adequate care, and are discharged with no effective plan for long-term improvement" because of the State's fragmented system of care.[38]

Against this backdrop, the State has sought to use its 1115 Medicaid waiver to "reduce Alaska's over-reliance on . . . institutional care" by creating "a more robust continuum of behavioral health care services," emphasizing early interventions, crisis services, and other community-based services.[39] But with the initial demonstration period set to expire in 2022, the State's waiver program has not meaningfully improved access to community-based services for children at serious risk of institutionalization in Alaska. Key services needed to help children remain in their communities remain in short supply. *See infra* at 18-22. In some communities, youth cannot access these services regardless of need because there are no enrolled providers.

Access to community-based services in Alaska is particularly limited in rural areas, where approximately a sixth of the state's population and a significant number of children with behavioral health disabilities live.[40] Tribal Health Organizations[41] are often the only providers

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[36] Alaska Department of Health and Social Services and Alaska Mental Health Trust Authority, *Strengthening the System: Alaska's Comprehensive Integrated Mental Health Plan (2020-2024)*, at 41 (July 2019), available at https://health.alaska.gov/Commissioner/Documents/MentalHealth/StrengtheningSystem-CompPlan_2020-24.pdf [https://perma.cc/9TXJ-XUHY].

[37] Alaska FY2022-2023 Combined MHBG/SABG Application, *Step 2: Identify the unmet service needs and critical gaps within the current system*, 6 (August 16, 2021) available at https://health.alaska.gov/dbh/pages/default.aspx [https://perma.cc/FV68-FVS5].

[38] Alaska State Hospital and Nursing Home Association, *Acute Behavioral Health Improvement Project: Report and Recommendations for Positive Change in Alaska's Communities and Hospitals*, 16 (April 2019), available at https://www.alaskahha.org/_files/ugd/ab2522_26376a6bb0b54a85bcf0381aff984a75.pdf [https://perma.cc/9RD6-5QPY].

[39] State of Alaska Department of Health and Social Services, *Medicaid Section 1115 Behavioral Health Demonstration Application*, at 16, 32 (Jan. 31, 2018), available at https://perma.cc/R5JW-N65G.

[40] A 2016 study commissioned by the State estimated that 5,550, or 6 percent of, children aged 9 to 17 had a severe emotional disturbance (SED) the year before, and that rates of SED were highest in the rural northern and Yukon-Kuskokwim Delta regions. Also, by this estimate, more children with SED lived in a rural area like the Yukon-Kuskokwim Delta than in the city and borough of Juneau. Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc., *Alaska Behavioral Health Systems Assessment Final Repo*rt, at 85 (Jan. 22, 2016), available at https://perma.cc/WB8L-F7N4.

[41] Altogether, there are about 30 Tribal Health Organizations (THOs) in Alaska that collectively serve about 228 federally recognized tribes. THOs operate tribally managed facilities, including hospitals, health centers, community health aide clinics, and residential treatment centers. Each THO functions independently. Behavioral health providers are located in about 15 of 17 regions comprising Alaska's tribal health system, and about 10 of them operate community health centers that provide an opportunity for integration of physical and health services. When Medicaid services are provided to American Indian and Alaska Native beneficiaries, the Federal Medical Assistance Percentage (FMAP) rate is 100 percent, meaning that the federal government reimburses the

of behavioral health services in rural areas of Alaska—some as large as the State of Oregon and with places accessible only by air or water. Alaska faces unique challenges in ensuring access to community-based services in such vast rural areas.[42] But there are opportunities for the State to build on existing programs and approaches to service delivery that offer viable, effective alternatives to institutional care, even for children and families living in remote parts of Alaska. *See infra* at 21-24.

IV. DISCUSSION

There is reasonable cause to believe that the State fails to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs as required by the ADA.[43] Alaska plans, administers, and funds its public healthcare service system in a manner that unnecessarily segregates children in psychiatric hospitals and PRTFs, both within and outside the state, rather than providing these services in the communities where children and their families live.[44]

A. Alaska's Administration of Its Behavioral Health Service System Results in Many Children Experiencing Needless Institutionalization

1. Alaska Relies on Institutions to Serve Children Who Are Appropriate for Services in Their Own Homes and Communities and Whose Families Do Not Oppose Community-Based Services

Many children in Alaska who are confined to psychiatric hospitals or PRTFs could be served appropriately in their own homes and communities. After reviewing extensive medical records for a random sample of children institutionalized between 2019 and 2022, interviewing children in institutions at the time of the investigation, and in some instances interviewing their facility-based treating professionals, our clinical expert concluded that the needs of children with behavioral health disabilities in Alaska who receive services in institutions are not materially different from those of other children who are thriving in community-based settings in other states. She further concluded that the types of services established through the State's Medicaid program, if provided and staffed consistently with the State's standards, would meet the needs of many children in Alaska who are placed in psychiatric hospitals or PRTFs.

State for 100 percent of the cost of Medicaid direct care services. The 100 percent FMAP rate applies to services that are directly provided by tribal providers as well as, under certain circumstances, services that are provided by non-tribal providers after a referral from a tribal provider. *See* Alaska Department of Health, *Tribal Refinancing*, https://health.alaska.gov/dhcs/Pages/Tribal-Health/Tribal-Refinancing.aspx [https://perma.cc/5JEQ-T8BF].

[42] *See*, *e.g.*, State of Alaska Department of Health and Social Services, *Alaska Substance Use Disorder and Behavioral Health Program 1115 Evaluation Design for FY2019-FY2024*, at 5 (2019).

[43] *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999).

[44] *See* 28 C.F.R. § 35.130(b), (d).

One child, just 12 years old at the time of our review, very likely could live in his home community of Kenai, Alaska if he received Therapeutic Treatment Home Services, Home-Based Family Therapy, Crisis Services, and other services that he is eligible for through the State's Medicaid program. Instead, the child had been living at out-of-state PRTFs for more than two years—the latest in a string of institutional placements that started with his admission to North Star Hospital in 2018, when he was eight years old. During the intake for that 2018 admission, he asked staff: "Do you know when I am leaving?" He was discharged from North Star after more than a month, only to return to the facility on three separate occasions between October 2018 and January 2020, typically staying for at least a month. When preparing to discharge from North Star after one of those stays in 2019, he told staff that he was happy to be leaving. Despite being in the custody of OCS, he never received the appropriate behavioral health services and supports he needed to remain at his community-based foster care placements. Ultimately, with the State's approval, he moved from North Star Hospital to a PRTF in Oregon, nearly 3,000 miles from his mother and home community.

Another child—15 years old and living at a PRTF in Utah when we interviewed her in 2022—could very likely return to her home near Bethel, Alaska with appropriate community-based services, specifically including Community Recovery Support Services and Crisis Services. But the services she needs and is eligible for through the State's Medicaid program are not available in or near her village. Like many other children in Alaska, her first experience receiving behavioral health services was at an institution, North Star Hospital. She was 12 years old. After another multi-month admission to North Star, and despite receiving only limited individual therapy services in the community, she was placed at the PRTF in Utah. At the time of our interview, she had been there for nearly eight months. The child, who is Alaska Native, told us that she wants "to go back home," that she misses "being free," and that the most important people to her are her father and siblings. At the PRTF, she is allowed to call them three times a week, for no more than 10 minutes per call.

Stories like these are far too common in Alaska. Among the children we reviewed during our investigation, few received the community-based services for which they are eligible and appropriate. These services—including Intensive Case Management, Crisis Services, Therapeutic Treatment Home Services, Community Recovery Support Services, and Home-Based Family Treatment—are offered through the State's Medicaid program, but are not available to the children who need them to avoid institutionalization, particularly in rural communities. *See infra* at 18-22. As the director of a community-based provider organization in Alaska commented, "service need does not wait for services to be available." With nowhere to turn, children who could otherwise stay in their homes and communities are subjected to unnecessary and unnecessarily long institutional placements, often repeatedly. This is apparent not only from our review of medical records and interviews with youth, parents, advocates, and community service providers, but also from our conversations with facility-based treatment staff, some of whom acknowledged that youth from Alaska stay in institutions longer than necessary because the services and supports they need are scarce or nonexistent in their home communities. Prolonged institutional stays often cause children to regress in their behaviors because they become frustrated about being unable to leave, delaying their discharge even further.

Children with behavioral health disabilities in Alaska can and do achieve stability in the community when they receive timely and appropriate services, including after discharge from an institution. One provider from a small island community in southeastern Alaska told us that she "rarely" needs to refer children for treatment out of town, let alone outside the state. Another provider, based in Anchorage, has been successful in keeping children out of residential facilities—including children with a long history of institutional placement—by providing trauma-informed, family-based care. However, few children in our review population received these services when appropriate. What services they did receive often did not match their evolving needs, ultimately leading to institutional placements.

Almost without exception, the children whom we reviewed—and their parents—do not oppose receiving effective community-based services and supports—indeed, they strongly prefer them as an alternative to prolonged or repeated institutional placement. Their statements to facility staff and during our interviews reveal the emotional toll of institutionalization on youth and families. Children as young as six years old who were confined to psychiatric hospitals or PRTFs said that they want to go home, that they miss their parents, grandparents, and siblings, and that they miss going outside. One Alaska Native child told us that he wanted to learn his Native language and build a cabin with his grandfather, and that he missed celebrating holidays with family. Another child who had been living in a PRTF in Texas for nearly a year when we interviewed him asked us, "When will I get my visit from my mom?" He said it had been so long since they had seen each other that his mother did not know how much he had grown.

A child who was living at a PRTF in Utah during the investigation told us that he wants to return to his Alaska Native village and that his mother wants that, too. He loves taking care of his brothers and injured animals. With appropriate services and supports, our clinical expert found, this child very likely could be served in his community. Instead, he spent a month in North Star Hospital before being sent out-of-state for treatment in December 2021. He said that he felt scared when he learned that he would be leaving Alaska, and that he misses being home – in particular, hunting birds, fishing, spending time with his siblings, and seeing whales in the ocean. At the time of our interview, he expected to remain at the PRTF for six more months before finally returning to Alaska.

Being separated from their children for months or years is heart-wrenching for the families of Alaskan youth placed in institutional settings. Parents of children whom we reviewed said that they missed their children and wanted to be closer. Parents expressed concern about their children losing touch with their culture while in an institution. And parents worried that their children may be vulnerable to abuse in facilities too distant to visit more than once a year, if at all. Some parents resisted efforts, including by staff at North Star Hospital, to send their children to out-of-state PRTFs or to keep them there for months on end. Those parents ultimately took their children home against medical advice, without the benefit of appropriate discharge planning, rather than leave them in an institution.

One mother, whose ten-year-old daughter was living at a PRTF in Texas during the investigation, told us through tears: "I feel sad. I miss my baby so much. It has been really hard." She expressed frustration that "there are not services [in Alaska] for her."

2. Alaska Has Failed to Provide Community-Based Services and Supports for Children with Behavioral Health Disabilities at Serious Risk of Institutionalization

Community-based services that would enable children with behavioral health disabilities to live in their homes and communities are largely unavailable in Alaska. Shortages in community-based services are particularly acute in rural areas and for critical services like Home-Based Family Treatment, Crisis Services, and Therapeutic Treatment Home Services. The State's recent steps to reform its behavioral health service system have fallen short of addressing these deficiencies, which are widespread and ongoing.

a. Home-Based Family Treatment, Intensive Case Management, and Community Recovery Support Services

Home-Based Family Treatment, Intensive Case Management, and Community Recovery Support Services—designed by the State "to reduce use of inpatient hospitalization and residential services" by children with behavioral health disabilities—are not adequately available or provided across Alaska. In many rural communities, including places like Bethel, Nome, and Utqiagvik that serve as hubs for surrounding villages, there are no enrolled providers of one or more of these key services. Where the services are available, relatively few children receive them. In 2021, only 35 children in all of Alaska received Home-Based Family Treatment.

The dearth of community-based services in Alaska is so pronounced and widespread that institutional placement has become, for many behavioral health service providers in the state, the default option to which they refer children with long-term behavioral health needs. Multiple providers explained that, when recommending post-discharge services for children exiting institutions, they commonly find that children lack access to outpatient therapy, let alone to more intensive services like Home-Based Family Treatment. As a result, youth who may be appropriate for services in their own communities go to and remain in psychiatric hospitals longer than necessary, only to then be referred to PRTFs, often out of state. Some children, especially children in the State's custody, experience unnecessarily long PRTF stays because the post-discharge services they are able to receive in Alaska are limited. One provider observed that, once institutionalized, Alaskan children are forced to reach a higher-than-usual degree of stability before returning to the community because of the lack of community-based services available in the state.

Even children who are referred for appropriate community-based services in Alaska face significant barriers to actually receiving the care they need to remain in their homes. Children wait as long as three months for services from Medicaid-enrolled therapists and psychiatrists, and up to a year for a neuropsychological evaluation. Some children go into crisis while waiting for services, or experience more severe symptoms over time that contribute to longer stays in hospitals and residential treatment centers.

Deficiencies in community-based services are so longstanding in Alaska that, for some families, the experience of institutionalization is shared across generations. Parents admitted to a

psychiatric hospital or PRTF as a child have come to see their own children placed at an institution.

b. Crisis Services

Crisis Services for children are scarce in Alaska. Although there is a statewide crisis hotline, access to in-person services—including Mobile Outreach and Crisis Response Services, 23-Hour Crisis Observation and Stabilization Services, and Crisis Residential and Stabilization Services—remains limited more than two years after the State began implementing its Section 1115 behavioral health waiver. As of March 2022, there were only a handful of Medicaid-enrolled providers of each of the Crisis Services. In Fairbanks, the second most populous metropolitan area in Alaska, there were no enrolled providers of 23-Hour Crisis Observation and Stabilization Services or Crisis Residential and Stabilization Services, and the sole provider of Mobile Outreach and Crisis Response Services typically does not serve children younger than 13 years old.

Where Crisis Services are available, few children receive them. In 2021, only five children received Mobile Outreach and Crisis Services, and only 110 children received Crisis Services of any kind through the State's Medicaid program. Alaska's paid Medicaid claims for all Crisis Services for children in 2021 totaled around $750,000. By comparison, in 2020, the State's Medicaid program paid $14.5 million for acute psychiatric services for children in general hospitals alone.

In both urban and rural areas of the state, emergency rooms function as de facto crisis stabilization units and gateways to long-term institutionalization. Providers at general hospitals in Alaska recognize that emergency rooms are not designed to treat children with behavioral health disabilities, and yet across the state children are regularly admitted to these settings during a behavioral health crisis.

After days or weeks in the emergency room, many of these children go on to be placed in a psychiatric hospital or PRTF. The experience of staying in an emergency room itself can be traumatizing for children. As one hospital-based provider told us, "Imagine being in a dark room with nothing to do, no access to TV, without even windows to see the outside world."

c. Therapeutic Treatment Home Services

Long-standing gaps in the availability of Therapeutic Treatment Home Services—a critical intervention for children at risk of institutional placement, particularly children in the State's custody—persist in Alaska. The State has capacity to serve about 150 children in therapeutic foster homes, although many more children are appropriate for this service and unable to access it. Therapeutic foster homes are concentrated in the southcentral region, around Anchorage, and are rare or nonexistent in many rural communities. Therapeutic Treatment Home Services provided by Alaska Native foster parents, especially, are in short supply, even as Alaska Native children account for over 60 percent of children with behavioral health disabilities in OCS custody.

Due to insufficient therapeutic foster homes and other community-based service options, children who are in the custody of OCS are more likely than other children to move from one institution to the next and often experience unnecessarily long institutional placements, sometimes months past the point of therapeutic value. Lengths of stay in psychiatric hospitals for OCS-involved children exceed 80 days on average. In out-of-state PRTFs, according to facility staff, there are children in OCS custody who, though ready for discharge, remain at the PRTF because there are no community placements available for them in Alaska. We interviewed one child who was living at an out-of-state PRTF and had been waiting a year for OCS to secure a placement.

Children in OCS custody are also at heightened risk of experiencing inappropriate placements outside institutions when they cannot access Therapeutic Treatment Home Services. Some children end up sleeping on the floor of an OCS office or at a shelter. Others stay in a traditional foster home without appropriate services and supports until they experience a behavioral health crisis and are hospitalized. "Kids get lost" in the system, lamented a hospital-based provider who has struggled to keep children in OCS custody out of the emergency room.[45]

Therapeutic Treatment Home Services are often not available for children when they are most vulnerable to long-term or repeated institutional placement. Many therapeutic foster homes do not accept children discharging from a psychiatric hospital, even though they are appropriate for the service and have similar needs as children who are currently living in therapeutic foster homes, highlighting the need for changes in how the state manages its service system, including improved education, training, and recruitment of service providers.

d. Rural Alaska

The core services needed to support children with behavioral health disabilities in their own communities are especially scarce in rural areas of Alaska, even though the State could provide these services in many communities by leveraging existing community providers and infrastructure. At Tribal Health Organizations (THOs), often the sole source of behavioral services in rural Alaska, staff commented that community-based services are so limited in their regions that virtually *any* additional services would be helpful. The burden of these service gaps falls heavily on Alaska Native children and families, many of them living in remote villages off the road network. To see a behavioral health clinician, they sometimes must travel hundreds of miles to a regional hospital or clinic. Others wait weeks for an itinerant clinician to visit them in their village. In some rural communities, there are few alternatives to institutional placement for children who need intensive behavioral health services. "We have North Star [Hospital] and that's about it," according to staff at a THO serving a network of over 10 villages in northwest Alaska. Though THO providers widely acknowledge that culturally appropriate services are vital to promoting engagement by and better outcomes for Alaska Native children with

[45] Multiple providers in Alaska report that OCS keeps children in general hospitals because there are no safe places to maintain them, such as crisis or respite foster homes.

behavioral health disabilities, those services are rarely available in rural communities where many Alaska Native families live.

The State has recognized the need to support providers in the development of Mobile Outreach and Crisis Response Services, including through the expansion of telehealth services, but those services remain unavailable in some parts of Alaska.[46] For example, in the Yukon-Kuskowim Delta—an expansive region covering tens of thousands of square miles and home to around 25,000 people—there were no providers of Mobile Outreach and Crisis Response Services as of March 2022, including in the hub community of Bethel. While it may not be possible to ensure access to Mobile Outreach and Crisis Response Services in every village, the THO in that region has staff, including Behavioral Health Aides located in or near remote villages,[47] that are eligible to provide these services under the State's Section 1115 Medicaid waiver. Due to the lack of mobile crisis responders in rural areas, calls to a crisis hotline at times result in referrals to local law enforcement. In some cases, law enforcement responds to children in crisis by taking them to a general hospital or a jail. Children have stayed for days in local jails waiting for a flight to a hospital.

Services for children dually diagnosed with IDD and behavioral health disabilities, lacking across the State, are also practically nonexistent in rural areas outside congregate facilities. These children are frequently placed in out-of-state PRTFs where lengths of stay typically range between six and nine months, only to be discharged to the same lack of service access in their communities.

One mother from a rural community in southeastern Alaska told us that the closest provider of the integrated dual-disorder treatment her son needs is over 800 miles away. The mother said that she felt she had no choice but to send her son away from home, starting with an admission to North Star Hospital when he was just six years old. Her son has since experienced numerous hospitalizations and residential facility placements, including at a PRTF in Texas. After living for years in institutions, he has begun to feel like a stranger around his own family, according to his mother. She said that had appropriate community-based services been available to her son from the start, "it would have made all the difference."

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[46] State of Alaska Department of Health and Social Services, *Request for Proposals Mobile Outreach for FY 2023*. https://gems.dhss.alaska.gov/Solicitations/ShowSolicitation?entityId=789931b9-17bc-ec11-a99a-005056ae3c14 [https://perma.cc/3M8W-Y7JA].

[47] Behavioral Health Aides (BHAs) are certified paraprofessional staff trained to provide therapeutic services, respond to behavioral health crises, and "support the general mental health and wellbeing of individuals in rural and tribal areas." Kristin A. Neylon, *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.*, National Association of State Mental Health Program Directors, https://nri-inc.org/media/1679/2020paper10.pdf [https://perma.cc/BL4U-CYVP]. BHAs live in the communities where they work and are often identified by other community members to serve in the role. Rebekah Falkner, *How Alaska Supports Rural and Frontier Behavioral Health Services*, National Academy for State Health Policy, https://www.nashp.org/how-alaska-supports-rural-and-frontier-behavioral-health-services/ [https://perma.cc/Y89X-X94W]. *See also* Alaska Native Tribal Health Consortium, *Behavioral Health Aide Program,* https://www.anthc.org/behavioral-health-aide-program/ [https://perma.cc/RR9M-KAX6].

Even in rural areas of Alaska, there are opportunities for the State to implement and sustain the key community-based services that children and families need to avoid unnecessary institutionalization. Schools—for many children, the entry point for receiving behavioral services in their communities[48]—are an underutilized resource in rural Alaska. In some remote villages, school counselors in Alaska provide prevention-based services and connect students, as needed, to ongoing therapeutic services and supports, including through Behavioral Health Aides and itinerant clinicians operating out of regional hubs. But even then, for students with more significant behavioral health needs, services are not available or provided with the intensity necessary to maintain them in their homes and communities. The State has recognized the importance of building its capacity to provide school-based behavioral health services statewide, including by embedding behavioral health professional in schools and improving access to telehealth services.[49] There are substantial federal resources available to the State to support these initiatives.[50]

B. Alaska Can Reasonably Modify Its Service System to Serve Children with Behavioral Health Disabilities in Integrated Settings

The types of home- and community-based services and supports needed to sustain children with behavioral health disabilities in integrated settings already exist in Alaska, albeit often in scarce supply and only in parts of the state. The State has been funding and administering some of those services in one form or another for years. Under its Section 1115 waiver, the State added key behavioral health interventions to its service menu, most notably Home-Based Family Treatment and Crisis Services. *See supra* at 9-12. Since at least 2004, the State has acknowledged that "kids belong in their homes" and committed itself to building "an integrated, seamless system that will serve children in the most culturally competent, least

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[48] Susan Wilger, *Issue Brief: Special Considerations for Mental Health Services in Rural Schools*, Now is the Time Technical Assistance Center, https://rems.ed.gov/docs/resources/SAMHSA_Mental_Health_Services_Rural_Schools.pdf [https://perma.cc/ZD6V-UJPP].

[49] State of Alaska Department of Education and Early Development, *Press Release: DEED Awarded $9.1M Grant to Promote Student Mental Health* (September 29, 2020), https://education.alaska.gov/news/releases/092920%20DEED%20Awarded%20$9.1M%20Grant%20to%20Promote%20Student%20Mental%20Health.pdf [https://perma.cc/67QT-D9QU]; Alaska Mental Health Trust Authority, *Case Study: Telehealth School Counseling,* https://alaskamentalhealthtrust.org/wp-content/uploads/2022/09/01-Telehealth-BHinSchools-Phase2_REPORT.pdf [https://perma.cc/MPG5-BYN6].

[50] U.S. Department of Education, *U.S. Department of Education Approves Alaska's Plan for Use of American Rescue Plan Funds to Support K-12 Schools and Students, Distributes Remaining $119 Million to State* (August 27, 2021), https://www.ed.gov/news/press-releases/us-department-education-approves-alaskas-plan-use-american-rescue-plan-funds-support-k-12-schools-and-students-distributes-remaining-119-million-state [https://perma.cc/D76N-CVMW]; State of Alaska Department of Education and Early Development, *Press Release: DEED Awarded $9.1M Grant to Promote Student Mental Health* (September 29, 2020), https://education.alaska.gov/news/releases/092920%20DEED%20Awarded%20$9.1M%20Grant%20to%20Promote%20Student%20Mental%20Health.pdf [https://perma.cc/67QT-D9QU].

restrictive setting."[51] The State also acknowledges that treating children in psychiatric hospitals and PRTFs costs more than serving them in their homes and communities.[52] Expanding existing community-based services and supports to children and families who need them to avoid unnecessary, costly institutional placements is a reasonable modification of the State's service system.[53]

Additionally, as noted above, the State has a separate legal obligation under the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) provisions of the Medicaid Act to provide children under the age of 21 with any coverable services, including community-based behavioral health treatment, to the extent they are medically necessary.[54] Because the State already must offer medically necessary behavioral health services to children across Alaska who are enrolled in its Medicaid program, meeting this obligation is inherently reasonable.

To support the necessary service expansion, the State has at its disposal substantial Medicaid funds, in addition to state and federal grant funds and annual allocations by the Alaska Mental Health Trust Authority, a quasi-public corporation that administers a perpetual trust for the benefit of Alaskans with mental illness and developmental disabilities, among other individuals with disabilities.[55] Alaska directs tens of millions of dollars each year—overwhelming federally sourced[56]—toward serving children with behavioral health disabilities in institutions. *See supra* at 5-9. By boosting provider capacity and making the necessary

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[51] State of Alaska Department of Health and Social Services, Office of the Commissioner, *Bring the Kids Home*, available at http://dhss.alaska.gov/Commissioner/Pages/btkh/default.aspx [https://perma.cc/3SBX-SNJ4].

[52] State of Alaska Department of Health and Social Services, *Medicaid Section 1115 Behavioral Health Demonstration Application*, 3, 11-12, 21 (January 21, 2018), available at http://dhss.alaska.gov/dbh/Documents/1115/AK_1115_WaiverApplication.pdf [https://perma.cc/R5JW-N65G].

[53] *See, e.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 280-81 (2d Cir. 2003) (upholding as a reasonable modification an order requiring agency to follow existing law and procedures); *Guggenberger v. Minn.*, 198 F. Supp. 3d 973, 1030 (D. Minn. 2016) (providing Medicaid waiver services to eligible people, particularly from existing waiver funds, is a reasonable modification); *Hiltibran*, 793 F. Supp. 2d at 1116 (a state providing a specific Medicaid service for people in institutions must provide it for Medicaid enrollees who need it in the community); *Haddad v. Arnold*, 784 F. Supp. 2d 1284, 1304-05 (M.D. Fla. 2010) (providing a service already in state's service system to additional people is not inherently a fundamental alteration); *Messier*, 562 F. Supp. 2d at 344-45 (plaintiffs' requested service expansion, which was consistent with defendants' publicly stated plans, was reasonable).

[54] *See* 42 U.S.C. § 1396d(r)(5).

[55] The Alaska Mental Health Trust Authority authorizes approximately $20 million in grants each year, divided among State agencies and beneficiary-serving organizations. *See* Alaska Mental Health Trust Authority, *Our Mission*, https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/ [https://perma.cc/KQ95-NDSR].

[56] Federal funds accounted for 72 percent of total Medicaid spending on behavioral health services in Alaska in FY18. *FY2020 Operating Budget Overview*, State of Alaska Office of Management and Budget, 18 (2020).

infrastructure investments to support statewide implementation of its Section 1115 waiver, the State could leverage existing resources to fulfill its obligation under Title II of the ADA to serve children in the most integrated setting appropriate to their needs.

Specifically, Alaska should take the following remedial measures, all aligned with its stated plans and obligations:

- Ensuring that community-based services are accessible and available with sufficient intensity to prevent unnecessary institutionalization. Services the State should ensure are available and accessible include Home-Based Family Treatment, Crisis Services, Therapeutic Treatment Home Services, Community Recovery Support Services, and Intensive Case Management.

- Coordinate with community-based service providers, tribal stakeholders, and local governments in Alaska to ensure that service planning and implementation is culturally appropriate and responsive to the needs of Alaska Native children and families.

- Support implementation of community-based behavioral health services in school settings. As the Centers for Medicare and Medicaid recently stated, schools are "uniquely positioned"[57] to help ensure that Medicaid-enrolled children can access the services they need.

- Develop adequate system-wide protocols for identifying children at serious risk of institutional placement and connecting them to appropriate, timely community-based services as needed to avoid unnecessary institutionalization.

- Develop adequate system-wide protocols to ensure that children transitioning from institutions to the community receive appropriate, timely community-based services as needed to remain in their homes and communities to the maximum extent possible.

- Ensure adequate oversight of Administrative Service Organizations, State grantees, and Medicaid-enrolled service providers and effective coordination among those entities, hospitals, and law enforcement to avoid unnecessary institutionalization.

V. CONCLUSION

For the foregoing reasons, we conclude that there is reasonable cause to believe the State fails to provide services to children with behavioral health disabilities in the most integrated

[57] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *CMCS Informational Bulletin: Information on School-Based Services in Medicaid: Funding, Documentation, and Expanding Services,* at 1 (Aug. 18, 2022), https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf [https://perma.cc/SSJ3-B9FB].

setting appropriate to their needs, in violation of the ADA. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d). The State plans, administers, and funds its behavioral health service system in a manner that unnecessarily segregates children in psychiatric hospitals and PRTFs within and outside Alaska, rather than providing these services where people live, in their community. *See* 28 C.F.R. § 35.130(b), (d).

We look forward to working cooperatively with the State to reach a consensual resolution of our findings. We are obligated to advise you that if we are unable to reach a resolution, the United States may take appropriate action, including initiating a lawsuit, to ensure the State's compliance with the ADA. Please also note that this Report is a public document. It will be posted on the Civil Rights Division's website.

January 18, 2022

James M. Johnson
Community Connections, Inc.
721 Stedman Street
Ketchikan, AK 99901

Dear Mr. Johnson:

It is my pleasure to inform you that Community Connections, Inc. has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s)/service(s):

Outpatient Treatment: Mental Health (Children and Adolescents)
Specialized or Treatment Foster Care: Mental Health (Children and Adolescents)
Governance Standards Applied

This accreditation will extend through November 30, 2024. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The accreditation report is intended to support a continuation of the quality improvement of your organization's program(s)/service(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A Quality Improvement Plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (*customerconnect.carf.org*), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may order additional certificates from Customer Connect (https://customerconnect.carf.org).

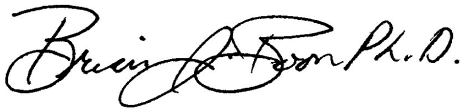
If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Vidal Ramirez by email at vramirez@carf.org or telephone at (888) 281-6531, extension 7131.

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

CARF encourages your organization to continue fully and productively using the CARF standards as part of its ongoing commitment to accreditation. CARF commends your organization's commitment and consistent efforts to improve the quality of its program(s)/service(s) and looks forward to working with your organization in its ongoing pursuit of excellence.

Sincerely,



Brian J. Boon, Ph.D.
President/CEO

Enclosures

activities, fitness and sports activities, support groups, and recreational activities.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Risk assessments of persons served
- Person-centered plans of service
- Daily activities schedules
- Written procedures for searches
- Written procedures that address visitation, mail, telephone use, and personal electronic devices
- Documentation of personnel training at orientation and regular intervals

R. Specialized or Treatment Foster Care (STFC)

Description

Specialized or treatment foster care programs use a community-based treatment approach for children/youth with emotional and/or behavioral issues. Children/youth who participate in the program may also have documented reports of maltreatment, involvement with juvenile justice, and/or co-occurring disorders. Intensive, clinically based treatment that is child/youth centered and family focused is delivered through an integrated team approach that individualizes services for each child/youth. Treatment foster parents are trained, supervised, and supported by program personnel and they fulfill a primary role in therapeutic interventions. Program personnel monitor the child's/youth's progress in treatment and provide adjunctive services in accordance with the individualized plan and program design. The program's goal is to provide clinically effective treatment to children/youth so they may return to their family or alternative community placement and avoid being removed from a community setting or placed in an inpatient or residential treatment setting.

The program may also be called intensive foster care, therapeutic family services, or therapeutic foster care.

Applicable Standards

An organization seeking accreditation for a specialized or treatment foster care program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.R. **1. The program implements a process for identifying, locating, and engaging family members, as appropriate, in services.**

Examples

The program demonstrates efforts to engage family, including extended family, in services.

This may include the use of internet-based search services to locate family members.

3.R. **2. The program provides or arranges for documented, competency-based training to meet the identified needs of the children/youth served:**

- **a. To:**
  - **(1) Personnel.**
  - **(2) Specialized or treatment foster care providers.**
- **b. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **c. That covers:**
  - **(1) Attachment theory.**
  - **(2) Trauma.**
  - **(3) Child/youth growth and development.**
  - **(4) Behavior management skills.**
  - **(5) Learning theory.**
  - **(6) Cultural competency and diversity.**
  - **(7) The effects of placement on children/youth.**
  - **(8) Applicable legal issues.**
  - **(9) Communication skills.**
  - **(10) Required medications and/or medical services.**
  - **(11) Other specialized training as needed.**

Intent Statements

The content of each subject area should consider the specific training needs of personnel and specialized/treatment foster care providers. The training provided to personnel and foster care providers may not be identical.

Examples

2.c.(3) Training may include brain development and social, emotional, and cognitive development.

2.c.(4) Training may include conflict resolution and management of violent, aggressive, or sexualized behaviors.

2.c.(6) Training about cultural competency may be specific and relevant to the diversity of the children and families served in the program and/or introduce or strengthen the concept of cultural humility, which includes both knowledge about various cultures and self-reflection to discover how one's own biases and perceptions may affect interpersonal relationships.

2.c.(8) Legal issues may include court processes if the program serves a child welfare/dependency population or children involved in the juvenile justice system.

2.c.(11) Specialized training needs may include health and nutrition, the need for and use of assistive technology, substance abuse or mental health issues, or delinquency.

Resources

Additional information on specialized or treatment foster care can be found at the following links:

- Family Focused Treatment Association: **www.ffta.org**
- Treatment Foster Care: Family-Based Care for Children with Severe Needs: **https://aspe.hhs.gov/treatment-foster-care-family-based-care-children-severe-needs**
- Child Welfare Information Gateway: **www.childwelfare.gov/topics/outofhome/foster-care/treat-foster**

3.R. **3. Documentation of training provided to foster care providers includes the:**

- **a. Type of training or information provided.**
- **b. Dates of training or information provided.**
- **c. Length of training or information provided.**

Examples

One approach to training would be to address relevant topics pre-service and in-service.

3.R. 4. **The program provides access to professionals trained in child/youth and family care, based on the needs of each person served, including:**

a. **A psychologist.**
b. **A counselor.**
c. **A family therapist.**
d. **A social worker.**
e. **A youth worker.**
f. **A psychiatrist.**
g. **Medical personnel.**
h. **Other specialists, as appropriate.**

Examples

4.g. May include a nurse, physical therapist, or speech-language pathologist, based on the needs of the child/youth served.

3.R. 5. **A referral network is established for the following:**

a. **Crisis intervention services.**
b. **Respite care.**
c. **Medical care.**
d. **Other services to meet the needs of the children/youth served.**

Intent Statements

The program maintains up-to-date contact information for other service providers currently working with the children/youth served and for providers of services that may potentially be needed.

3.R. 6. **The children/youth served have opportunities to participate, as appropriate, in:**

a. **Community activities.**
b. **Cultural activities.**
c. **Recreational activities.**
d. **Spiritual activities.**

Intent Statements

Specialized or treatment foster care programs are designed to provide treatment within a community setting to foster the development of and/or strengthen the child's/youth's skills to allow the child/youth to safely remain in the community and avoid a placement outside of the community. The program supports the foster treatment family to provide opportunities for the child/youth to access various community activities and to ensure that the child's/youth's cultural heritage is honored and preserved.

3.R. 7. **If the program selects specialized or treatment foster care providers, it implements a comprehensive plan for recruitment, selection, and maintenance that:**

a. **Is reflective of the larger community that the program serves.**
b. **Includes a broad selection of families to ensure that the needs of the children/youth served are met.**
c. **Meets the expressed criteria set in all applicable jurisdictional guidelines.**
d. **Includes procedures for the monitoring of each home.**

3.R. 8. **If the program is engaged in child placement activities, it has a comprehensive process for matching children/youth with available foster care providers that:**

a. **Considers the child's/youth's:**
   (1) **Needs.**
   (2) **Strengths.**
   (3) **Preferences.**
b. **Considers the foster care providers' assessed:**
   (1) **Skills.**
   (2) **Competencies.**
c. **Includes an assessment of the appropriateness of the match, including:**
   (1) **A familiar environment.**
   (2) **Identification of any gaps and how the gaps will be addressed.**

Intent Statements

The program facilitates placements that match the child/youth served with an appropriate family to promote placement stability.

Examples

8.c.(1) A familiar environment could include the type of residence, such as a single-family home or

a multi-family dwelling; the type of neighborhood, such as rural or urban; and the size of the household, among many variables.

3.R. **9. The program utilizes written agreements that clearly define:**

- **a. What the foster care providers can expect from the program, including:**
  - **(1) Rights of specialized or treatment foster care providers.**
  - **(2) On-call support 24 hours a day, 7 days a week.**
  - **(3) Initial and ongoing training.**
  - **(4) Communication about appropriate and known information about the child/youth and the family.**
  - **(5) Available support for managing issues that arise in the placement.**
  - **(6) Supervision and monitoring.**
  - **(7) Payments, as applicable.**
- **b. What is expected of the foster care providers, including:**
  - **(1) In collaboration with the program, implementation of specific service objectives of the individualized plan.**
  - **(2) Providing support to the child/youth in maintaining meaningful contact with family, as appropriate.**
  - **(3) Providing a high standard of daily care to the child/youth, including:**
    - **(a) Nutritious meals and snacks.**
    - **(b) A safe living environment.**
    - **(c) A comfortable living environment.**
    - **(d) Emotional support.**
    - **(e) Boundaries consistent with the needs of the child/youth served.**
    - **(f) Physical needs.**
  - **(4) Encouraging the child/youth to personalize the living space with individual possessions.**
  - **(5) Recognition and attention to any special needs of the child/youth, including:**
    - **(a) Dietary needs.**
    - **(b) Religious needs.**
    - **(c) Other identified needs.**
  - **(6) Refraining from the use of corporal punishment and other inappropriate means of disci line.**
  - **(7) Ensuring that the child's/youth's health-related needs are met.**
  - **(8) Providing a supportive learning environment to build the skill levels of the child/youth.**
  - **(9) Facilitating the child's/youth's engagement in developmentally appropriate peer and leisure activities.**
  - **(10) Clearly communicating what is expected of the child/youth in terms of household rules.**
- **c. The process of termination, if necessary.**
- **d. An appeal process, when applicable.**

Intent Statements

9.b.(1) This relates to the individualized plan components addressed in Standard 2.C.2.

Examples

9.a.(1) Rights may include items such as maltreatment allegations, placement decisions, and respite.

9.a.(6) Supervision and monitoring include supervision of the direct case worker and, on occasion, may include the treatment foster parents.

9.b.(3)(b) A safe living environment is a residence that is free from physical hazards such as lead paint, broken windows, mold, and other harmful agents that may cause injury and/or negatively affect the health of a child/youth. Safe living environments are also protective of

an individual's emotional and/or psychological well-being.

9.b.(7) Health-related needs include immunizations, routine well-care appointments, and dental care.

3.R. **10. The program advocates for the placement of children/youth with their siblings, as appropriate.**

3.R. **11. When placement of children/youth with their siblings is not possible, the program advocates for and facilitates regular visits with their siblings, if appropriate.**

Intent Statements

The program facilitates ongoing connections with siblings. Safety is always a consideration, and visits are supervised as needed.

3.R. **12. The program assists birth/adoptive families to receive services that promote reunification, when appropriate.**

3.R. **13. If the program is responsible for reunification, it provides or arranges for supervised visits based on identified permanency goals.**

3.R. **14. The program has on-call availability of supervisory personnel to respond to urgent situations 24 hours a day, 7 days a week.**

3.R. **15. The services for each child/youth served are supervised by a qualified practitioner who:**

a. Provides clinical oversight.

b. Directs the treatment plan.

Intent Statements

See the Glossary for the definition of *qualified practitioner.*

3.R. **16. The program has a plan for access to qualified practitioners 24 hours a day, 7 days a week.**

Intent Statements

See the Glossary for the definition of *qualified practitioner.*

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation of training provided to personnel and foster care providers
- Comprehensive plan for recruitment, selection, and maintenance of specialized or treatment foster care providers, if applicable
- Written agreements that clearly define what the foster care providers can expect from the program and what is expected of the foster care providers
- Plans for monitoring each foster home placement
- Plan for access to qualified practitioners 24 hours a day, 7 days a week
- Individual program plans for the persons served
- Records of the persons served

CASII

Service Intensity Level Determination Grid

Dimension	Recovery Maintenance Health Management **Service Level 1**	Outpatient Services **Service Level 2**	Intensive Outpatient Services **Service Level 3**	Intensive Integrated Services Without 24-Hour Psychiatric Monitoring **Service Level 4**	Non-Secure, 24-Hour Services With Psychiatric Monitoring **Service Level 5**	Secure 24-Hour Services With Psychiatric Management **Service Level 6**
I. Risk of Harm Score	2 or less	2 or less	3 or less	3 or less	3 (4)	4 (5)
II. Functional Status Score	2 or less	2 or less	3 or less	3 or less	3 (4)*	4 (5)*
III. Co-Occurrence of Conditions Score	2 or less	2 or less	3 or less	3 or less	3 (4)*	4 (5)
IVA. Recovery Environment - Stress Score	Sum of IVA + IVB is 4 or less	Sum of IVA + IVB is 5 or less	Sum of IVA + IVB is 5 or less	3 or 4	4 or more	4 or more
IVB. Recovery Environment - Support Score				3 or less	4 or more	4 or more
V. Resiliency and/or Response to Services Score	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIA. Involvement in Services - Child or Adolescent Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIB. Involvement in Services - Parent/Primary Caregiver Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Score	**10 to 13**	**14 to 16**	**17 to 19**	**20 to 22**	**23 to 27**	**28 or more**

(◯) *Indicates that independent criteria require admission to this service intensity level regardless of composite score. *Independent criteria may be waived if the sum of the Recovery Environment sub-scale (IVA and IVB) scores = 2.*

***In the composite score, include only the higher of the two Involvement in Services sub-scale scores: either VIA or VIB.*

Child and Adolescent Service Intensity Instrument (CASII) Review

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension I. Risk of Harm

1. Low Risk of Harm	2. Some Risk of Harm	3. Significant Risk of Harm	4. Serious Risk of Harm (Requires Care at Level 5)	5. Extreme Risk of Harm (Requires Care at Level 6)
A. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation	A. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention, and no significant distress	A. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child and family to contract for safety and carry out a safety plan. Child expresses some aversion to carrying out such behavior.	A. Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child has expressed ambivalence about carrying out the safety plan and/or family's ability to carry out the safety plan is compromised.	A. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior: 1) without expressed ambivalence or significant barriers to not doing so, or 2) with a history of serious past attempts that are not of a chronic, impulsive or consistent nature, or in presence of command hallucinations or delusions that threaten to override usual impulse control
B. No indication or report of physically or sexually aggressive impulses	B. Mild suicidal ideation with no intent or conscious plan and with no past history	B. No active suicidal/homicidal ideation, but extreme distress and/or history of suicidal/ homicidal behavior	B. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction, repetitive fire-setting or violence toward animals)	B. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (eg fire setting with intent of serious property destruction or harm to others or self, planned and/or group violence) with history, plan, or intent, and no insight and judgment (forceful and violent repetitive sexual acts against others.
C. Developmentally appropriate ability to maintain physical safety and/or use environment for safety	C. Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others	C. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (ie status offenses, impulsive acts while intoxicated, self-mutilation, running away with voluntary return, fire-setting, violence toward animals, affiliation with dangerous peer group)	C. Indication of consistent deficits in ability to care for self and/or use environment for safety	C. Relentlessly engaging in acutely self-endangering behaviors
D. Low risk for victimization, abuse, or neglect	D. Substance use without significant endangerment of self or others	D. Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors	D. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child or family to restrict use	D. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.
E. Other	E. Infrequent, brief lapses in the ability to care for self and/or use environment for safety	E. Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways	E. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety	E. Other
	F. Some risk for victimization, abuse, or neglect	F. Serious or extreme risk for victimization, abuse, or neglect	F. Other	
	G. Other	G. Other		

CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension II. Functional Status

1. Minimal Functional Impairment	2. Mild Functional Impairment	3. Moderate Functional Impairment	4. Serious Functional Impairment (Requires Care at Level 5)	5. Severe Functional Impairment (Requires Care at Level 6)
A. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/ hygiene/ control of bodily functions. B. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative sleep, eating, energy, and self-care. C. Other	A. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationship with peers, adults, and/or family (eg defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems) or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention. B. Sporadic episodes during which some aspects of sleep, eating, energy, and self-care are compromised. C. Demonstrates significant improvement in function following a period of deterioration D. Other	A. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression. B. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis. C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level. D. School behavior has deteriorated to the point that in-school suspension has occurred and the child or youth is at risk for placement in an alternative school or expulsion due to their disruptive behavior. E. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in constructive activities, and ability to maintain responsibilities. F. Recent gains and/or stabilization in functioning have been achieved while participating in services in a structured, protected, and or/ enriched setting. G. Other	A. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors. B. Significant withdrawal and avoidance of almost all social interaction. C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level. D. Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning. E. Inability to perform adequately even in a specialized school setting due to disrupted or aggressive behaviors. School attendance may be sporadic. The child has multiple academic failures. F. Other	A. Extreme deterioration in interactions with peers, adults and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors. B. Complete withdrawal from all social interactions. C. Complete neglect of and inability to attend to self-care/hygiene/ control of biological functions with associated impairment in physical status. D. Extreme disruption in physical functions causing serious comprise of health and well-being. E. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level. F. Other

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Dimension III. Co-Occurrence of Conditions: Medical, Substance Use, Developmental, and Psychiatric

1. No Co-Occurrence	2. Minor Co-Occurrence	3. Significant Co-Occurrence	4. Major Co-Occurrence (Requires Care at Level 5)	5. Severe Co-Occurrence (Requires Care at Level 6)
A. No medical, substance abuse, developmental disability, or psychiatric disturbances apart from presenting problem. B. Past medical, substance use, developmental, or psychiatric conditions stable and pose no threat to child's or adolescent's current functioning or presenting problem. C. Other	A. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and or compensation. B. Self-limited medical problems are present that are not immediately threatening or debilitating and have no impact on the presenting problem and are not affected by it. C. Occasional, self-limited episodes of substance use are present that show no escalation, no indication of adverse effect on function or presenting problem. D. Transient, occasional, stress-related psychiatric symptoms are present that have no impact on presenting problem. E. Other	A. Developmental disability is present that may/does adversely affect the presenting problem, or require significant alteration of services for the presenting problem or co-occurring condition. B. Medical conditions are present requiring significant medical monitoring C. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem. D. Substance abuse is present, with significant adverse effect on functioning and the presenting problem. E. Recent substance use that has a significant impact on presenting problem and that has been arrested stopped due to use of a highly structured/protected setting or through external means. F. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem. G. Other	A. Medical conditions present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring. B. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder. C. Uncontrolled substance use that poses a serious threat to health if unabated and impedes recovery from presenting problem. D. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder. E. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem. F. Other	A. Significant medical condition poorly controlled and/or potentially life threatening in absence of close medical management B. Medical condition acutely or chronically worsens or is worsened by the presenting problem. C. Substance dependence present, with inability to control use, intense withdrawal symptoms, & extreme negative impact on the presenting disorder. D. Developmental disorder that seriously complicates, or is seriously compromised by, the presenting disorder. E. Acute or severe psychiatric symptoms that seriously impair functioning, and/or prevent voluntary participation in treatment for presenting problem, or prevent recovery. F. Other

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Dimension IV.A. Environmental Stress

1. Absent Environmental Stress	2. Mild Environmental Stress	3. Moderate Environmental Stress	4. Serious Environmental Stress	5. Severe Environmental Stress
A. Absence of significant or enduring difficulties in environment and life circumstances are stable. B. Absence of recent transitions or losses of consequence C. Material needs met without significant cause for concern that they may diminish in the near future with no threats to safety or health. D. Living environment is conducive to normative growth, development, and recovery. E. Role expectations normative and congruent with child's age, capacities and/or developmental level. F. Other	A. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher. B. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, illness or death of distant extended family member that has a mild effect on child and family. C. Transient but significant illness or injury (pneumonia, broken bone). D. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, etc. E. Expectations for performance at home or school create discomfort. F. Potential for exposure to substance use exists. G. Other	A. Disruption of family/social milieu B. Interpersonal or material loss that has significant impact child and family. C. Serious prolonged illness or injury, unremitting pain, other disabling condition. D. Danger or threat in neighborhood or community, or sustained harassment by peers or others. E. Exposure to substance abuse and its effects. F. Role expectations that exceed child's or adolescent's capacity, given his/her age, status and developmental level. G. Other	A. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment. B. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence or immersion in alien and hostile culture. C. Inability to meet needs for physical and/or material well-being. D. Exposure to endangering criminal activities in family/community. E. Difficulty avoiding substance use and its effects. F. Other	A. Traumatic or enduring and highly disturbing circumstances, such as: 1) Violence, sexual abuse or illegal activity in the home or community 2) The child or adolescent is witness to or a victim of natural disaster 3) The sudden or unexpected death of a loved one 4) Unexpected or unwanted pregnancy B. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal status. C. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such. D. Severe pain, injury or disability or imminent threat of death due to severe illness or injury. E. Other

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Dimension IV.B. Environmental Support

1. Optimal Environmental Support	2. Adequate Environmental Support	3. Limited Environmental Support	4. Minimal Environmental Support	5. No Environmental Support
A. Family and ordinary community resources are adequate to address child's developmental and material needs. B. Continuity of active, engaged care takers, with a warm, caring relationship with at least one care taker. C. Other	A. Continuity of family members/care takers is only occasionally disrupted, and/or relationships with family members/care takers are only occasionally inconsistent. B. Family/care takers willing and able to participate in treatment if requested and have capacity to effect needed changes. C. Special needs addressed through successful involvement in systems of care D. Community resources are sufficient to address child=s developmental and material needs. E. Other	A. Family has limited ability to respond appropriately to child or adolescent's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems. B. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network. C. Family or primary care takers demonstrate only partial ability to make necessary changes during treatment. D. Other	A. Family or primary care taker is seriously limited in ability to provide for the child or adolescent's developmental, material, and emotional needs. B. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet. C. Family and other care takers display limited ability to participate in treatment and/or service plan D. Other	A. Family and/or other care takers are completely unable to meet the child or adolescent's developmental, material, and/or emotional needs. B. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations and mentoring from unrelated adults. C. Lack of liaison and cooperation between child/youth-serving agencies. D. Inability of family or other primary care takers to make changes or participate in services E. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent and/or threatening others. F. Other

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Dimension V. Resilience and/or Response to Services

1. Full Resiliency	2. Significant Resiliency	3. Moderate/Equivocal Resiliency	4. Poor Resiliency	5. Negligible Resiliency
A. Child/youth has demonstrated significant and consistent capacity to maintain development in the face of normal challenges. B. Prior experience indicates that efforts in most types of services have been helpful in controlling the presenting problem in a relatively short period of time. C. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent services. D. Able to transition successfully and accept changes in routine without support; optimal flexibility E. Other	A. Child/youth have demonstrated average ability to deal with stressors and maintain developmental progress. B. Previous experience with services has been successful in controlling symptoms but more lengthy intervention is required. C. Significant ability to manage recovery demonstrated for extended periods, but has required structured setting or ongoing care and/or peer support. D. Recovery has been managed for short periods of time with limited support or structure. E. Able to transition successfully and accept changes in routine with minimal support F. Other	A. Child/youth has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development. B. Previous experiences with services at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms. C. Recovery has been maintained for moderate periods, but only with strong professional/peer support or in structured settings. D. Developmental pressures and life changes have created temporary stress. E. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support. F. Other	A. Child/youth has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level. B. Previous services have not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated interventions. C. Attempts to maintain whatever gains that can be attained with intensive services have limited success, even for limited time periods or in structured settings. D. Developmental pressures and life changes have created episodes of turmoil or sustained distress. E. Transitions with changes in routine are difficult even with a high degree of support. F. Other	A. Child/youth has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level. B. Past response to services has been quite minimal, even when treated at high levels of service intensity for extended periods of time. C. Symptoms are persistent and functional ability shows no significant improvement despite receiving services. D. Developmental pressures and life changes have created sustained turmoil and/or developmental regression. E. Unable to transition or accept changes in routine successfully despite intensive support. F. Other

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Dimension VI.A. Child or Adolescent Involvement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
A. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers. B. Able to define problem(s) as developmentally appropriate and accepts others' definition of the problem(s), and consequences. C. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem. D. Cooperates and actively participates in services. E. Other	A. Able to develop a trusting, positive relationship with clinicians and other care providers. B. Unable to define the problem as developmentally appropriate, but accepts others definition of the problem and its consequences. C. Accepts limited age-appropriate responsibility for behavior. D. Passively cooperates in services. E. Other	A. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers. B. Acknowledges existence of problem, but has trouble accepting limited age-appropriate responsibility for development, perpetuation, or consequences of the problem. C. Minimizes or rationalizes problem behaviors and consequences. D. Unable to accept others definition of the problem and its consequences. E. Frequently misses or is late for appointments and/or does not follow the service plan. F. Other	A. A difficult and unproductive relationship with clinician and other care providers. B. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem. C. Frequently disrupts assessment and services. D. Other	A. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness. B. Unaware of problem or its consequences. C. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment. D. Other

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Dimension VI.B. Parent/Primary Caregiver Involvement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
A. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers. B. Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting problem. C. Sensitive and aware of their child or adolescent's problems and how they can contribute to their child's recovery. D. Active and enthusiastic participation in services assessment and services. E. Other	A. Develops positive therapeutic relationship with clinicians and other primary care takers. B. Explores the problem and accept others definition of the problem. C. Works collaboratively with clinicians and other care takers in development of service plan. D. Cooperates with service plan, with behavior change and good follow-through on interventions. E. Other	A. Inconsistent and/or avoidant relationship with clinicians and other care providers. B. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem. C. Unable to collaborate in development of service plan. D. Unable to participate consistently in service plan, with inconsistent follow-through. E. Other	A. A difficult and unproductive relationship with clinician and other care providers. B. Unable to reach shared definition of the development, perpetuation, or consequences of problem. C. Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members. D. Engages in behaviors that are inconsistent with the service plan. E. Other	A. No awareness of problem. B. Not physically available. C. Refuses to accept child or adolescents, or other family members' need to change. D. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment. E. Other