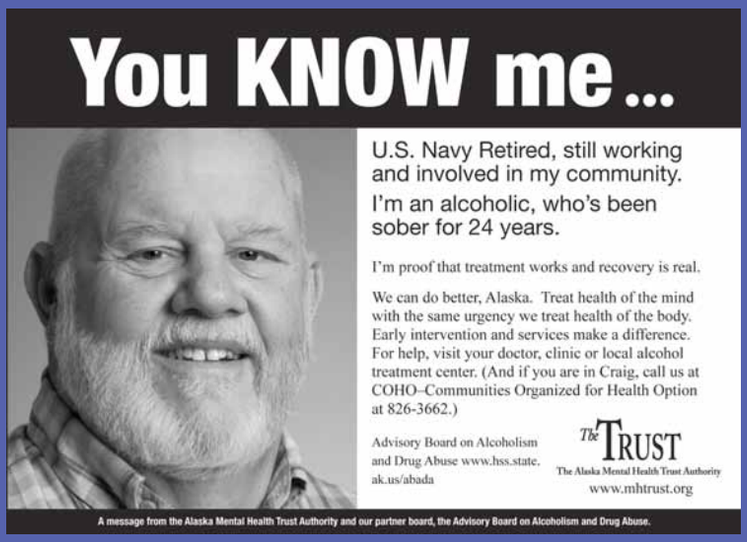
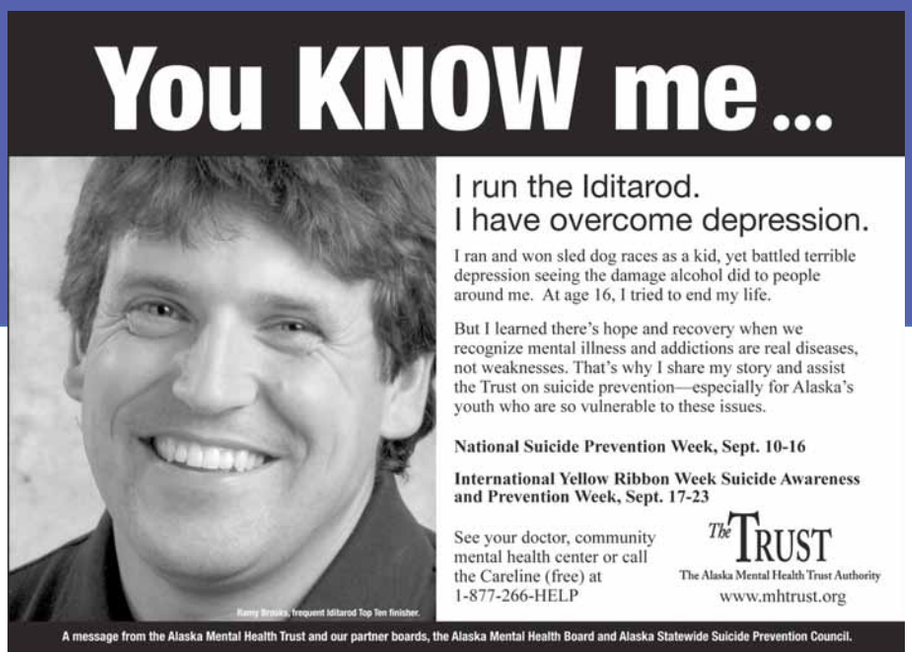
Annual Report

State Fiscal Year 2006





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

But did you know... The Advisory Board on Alcoholism and Drug Abuse and The Alaska Mental Health Board

Plan
Coordinate
Educate
Advise
Evaluate
and Advocate

With the goal of achieving quality Behavioral Health for all Alaskans so that they may lead healthy and productive lives

Introduction

Alaskans are a healthy people. Blessed with abundant natural resources, strong community ties, and a rich cultural heritage, the majority of Alaskans lead full satisfying lives. They tend to be independent, self-reliant citizens who think for themselves. The Alaska system of mental health care and substance abuse treatment has helped to strengthen the ability of Alaskans to flourish in their communities.

Yet, not all Alaskans enjoy this sense of health and well being. Some of the reasons that citizens are left out of this sense of security and prosperity are:

- Community isolation without a full range of necessary services;
- Limited ability to obtain services, because of financial limitations;
- Genetic predisposition to mental illness or substance dependence,
- Early trauma that leads to later problems;
- Lack of opportunity to learn how to take personal responsibility for their own full range of health behaviors.

There are many reasons for these failures. While we have had great success with many mental health and substance abuse programs, there are still gaps in the availability of trained providers, money, and, sometimes, vision. The cost of this failure to have a fully functioning system has multiple impacts. It affects the lives of the people who suffer, those around them, and those who encounter them in their communities, and it increases the expense these problems create for the state, community, and individual citizens.

This report will focus on what the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board are doing and how they are thinking about these problems. It is appropriate to be concerned that program costs grow too quickly. The legislature and other gatekeepers watch closely to make sure that costs are appropriate and contained. Yet, too often, we look at how much programs cost, but fail to look at how much we save when we support programs to respond to the needs of Alaskans suffering from mental health and substance abuse issues.

Did you know: It has been shown over and over that an investment in behavioral health is one of the most cost effective services that can be offered to a state's citizens.[1] Whether it is:

- Offering a long term support program to divert chronically mentally ill clients from prison;
- Having early intervention available for someone dealing with social or emotional problems;
- Making sure that those who go through drug or alcohol detox can immediately enter a treatment program;
- Acknowledging that methadone programs are effective, and assuring that they are available; or
- Offering the chance for parents to learn how to work with their child so the child can remain in the home or community.

Quality programs save money and enhance lives.

This report will look at costs, benefits, ongoing needs, and innovative responses to those needs. This is an attempt to give an honest picture of the system. As in all systems, there are problems still to be resolved. Yet, overall, behavioral health in Alaska is a system that uses resources with both efficiency and competence. Just as most Alaskans flourish in our state, we can be proud of the programs that exist to help all to succeed. Now we need to make them work even better…

Thank you for your interest.

TREATMENT WORKS! RECOVERY HAPPENS!

There is a new wind blowing in the behavioral health community – an awareness that people can get better. One of the greatest achievements of the merging of substance abuse and mental health services was the merging of two different philosophies of growth and recovery. The Alcoholics Anonymous model and the broader substance abuse treatment philosophy have always emphasized how people can move beyond their addiction. Within the old model of mental illness, people sometimes saw that they had to manage their mental illness, with little hope of significant improvement.

Now we know – people can get better. They can play a large part in moving themselves towards recovery and then can turn around and help their peers achieve the same results. The consumer recovery movement is a growing part of behavioral health philosophy and service in the state of Alaska. ABADA and AMHB celebrate and support this hope-giving direction.

Did you know?

The costs of alcohol and other substance abuse in Alaska amount to about $614 million a year. Yet, funding for substance abuse programs has dropped over the last few years. As behavioral health programs become increasingly dependent on Medicaid, substance abuse treatment, which is rarely covered by Medicaid, suffers. This results in a terrible human toll of loss of productivity, domestic violence, child abuse, ill health, and law enforcement problems.[2]

An Alaskan Story

Marie is 53 years old and has worked most of her life. Now, with a recent divorce and her children living down south, she was laid off from her job because she wasn't fast enough in learning new technology. She just moved to Anchorage from Fairbanks to try to start a new life, but is becoming more and more depressed. She finds it hard to leave her small apartment; she panics at the thought of going through a job interview. She has tried to seek help in the behavioral health system but has no health insurance and has encountered long wait lists. (This is a composite of many people in Anchorage and around the state at this time wishing they could get services.) The legislature has cut general mental health grant funds, and Medicaid funding goes to those with severe mental illnesses or who threaten to hurt themselves or others. She doesn't fall in that category.

Did you know?

According to a one-day snapshot study conducted for the Department of Corrections in 1997, 37% of those in the DOC system experience a mental disorder. An additional 8% experience chronic alcoholism. Many children needing behavioral health treatment end up in the juvenile justice system. Over a one-day count of Alaska's juvenile justice population completed during 2002, 40% of youth served by the Division of Juvenile Justice had at least one diagnosis of a mental disorder. Within this group 42% had a co-occurring substance abuse disorder. We don't have data about how many had substance abuse disorders without MH diagnoses.[3]

Medicaid Adult Dental Services

The Medicaid program provides people with disabilities access to health care services. Funded through a partnership between the state and federal government, the program covers mandatory services such as in-patient hospital care, and services covered at the state's option such as prescription drugs or dental care for adults.

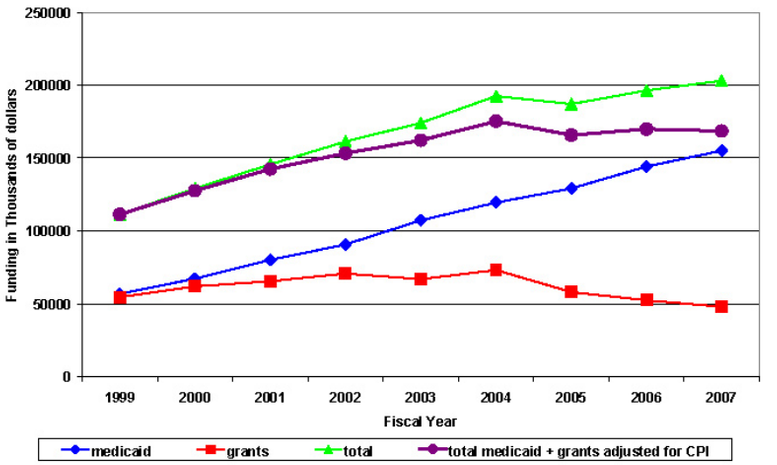
For many years, the disability community had been petitioning the Legislature to add adult dental care to the list of optional services covered by Medicaid. During the 2006 legislative session, the issue rose to the top of our advocacy priority list, and a major campaign to secure adult dental services was set in motion. Action coordinated between AMHB and ABADA as well as the Trust and other beneficiary boards included meetings and calls with legislators, public testimony at legislative hearings and even a march on the capitol! Through our concerted efforts we were able to convince key legislators that making people wait until dental pain drove them to the emergency room was expensive and inhumane. HB 105, which added Medicaid adult dental services to Alaska's optional services, passed both the House and Senate unanimously. Dental services will be available beginning in April of 2007.

The success of the adult dental campaign clearly shows that when we all work together, we can be successful in influencing the legislature to do the right thing for our beneficiaries. Our success has given us energy and optimism as we approach the 2007 legislative session.

An Alaskan story

At age 24 Mac was a good student and friend until he was about 16. Then, he began to have problems getting along with other people. He struggled in school and increasingly alienated those around him. His family was supportive, but didn't understand what was wrong. As he became more secretive and withdrawn, they realized that there was something more than normal adolescence happening. They contacted their behavioral health center and got Mac to see a counselor, who diagnosed him as experiencing the onset of schizophrenia, paranoid type. Mac saw a psychiatrist who prescribed medication, which made a big difference, and had a case manager who he checked in with on a regular basis. There are still times when life feels hard for him, and he worries about the effects of taking medication, but he has enrolled in community college this fall and is working a part time job. The system worked quickly and effectively for him. (This is a composite of people around the state who have been helped by the system.)

Funding for Behavioral Health Programs[4]



This chart represents Legislative funding, actual funding may vary based on Departmental reallocation of resources.[4]

How much does it cost?

You may not hear this too often, but behavioral health services are a bargain! For every dollar spent on behavioral health services, many dollars are saved in lost productivity and demands on other public institutions. In inflation adjusted dollars, the state's contribution to behavioral health services declined in state fiscal year 2007. For this year, the legislature appropriated $85.4 million in state funding for behavioral health services. This included grants, state Medicaid match, administration, and monies for running Alaska Psychiatric Institute, the state hospital.

There are a wide variety of cost effective interventions - from using brief therapy to manage life crises, to the use of medication to lessen depression, to inpatient treatment for someone suffering from chronic alcoholism, to provision of supportive housing to someone with mental illness. More and more we know that appropriate intervention not only changes the way the individual interacts in his or her world, it actually changes the structure and function of the brain. This is a long term investment that makes both fiscal and social sense.

Who needs these services?

Alaska is embarking on a number of epidemiological studies that will help us further define populations in need of behavioral health services. However, we can now use a combination of data collected in the state and studies conducted in the US in general to help us understand areas of need.

What about alcohol abuse?

First, we can look at information collected in Alaska that shows us how people use alcohol:[5]

Binge drinking is a real concern. Over 25% of high school youth reported that they had five or more drinks within a couple of hours in the 30 days prior to the survey.

We are also seeing increasing problems with substance abuse. In 2006, for the first time, over 50% of drug

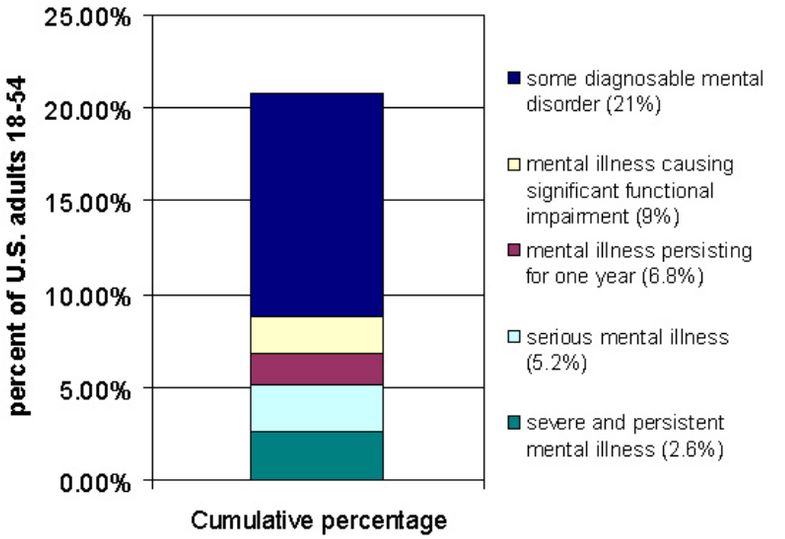
treatment programs in Alaska identified methamphetamine abuse as their highest concern.[6]

Did you know?

When we talk about mental illness, we are actually talking about a wide range of conditions. During a 1-year period, 22 to 23% of the U.S. adult population—or 44 million people—have diagnosable mental disorders, according to reliable, established criteria.[7] Applying those same percentage to Alaska would indicate that around 145,000 Alaskans experience a diagnosable disorder in any given year. This ranges from the person who has a couple of months in which they battle with moderate depression to the Alaskan who has struggled with psychosis for many years. When we look at the percentages of people who experience some impairment in their daily functioning because of mental illness, we realize that treating these conditions makes a big difference, not only in individual quality of life, but also in the functioning of the state and community.

We have further data to confirm these numbers in Alaska. In 2004, 9.4% of Alaskans surveyed said that they had 14 or more of the last 30 days in which their mental health was not good.[8]

Annual prevalence of mental disorders[7]



An Honest Assessment

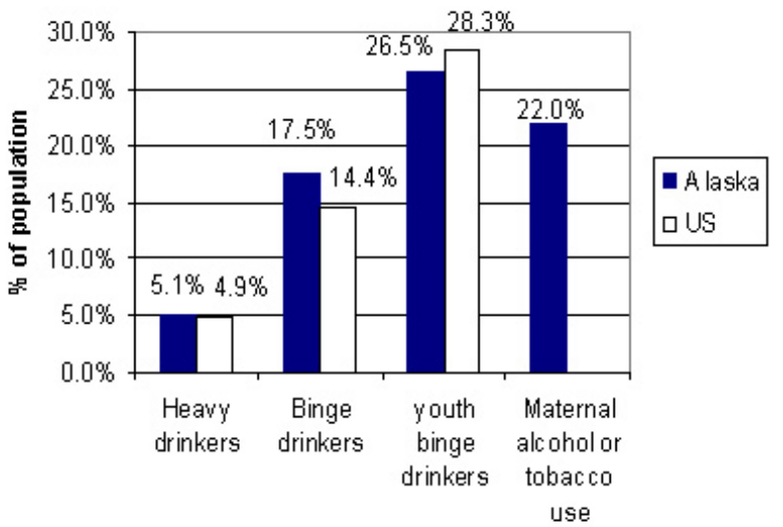
What works in the system? And what doesn't?

The Alaska behavioral health system has many faces. In some communities, services are provided by the Native health entity. In other communities, a state grant funded mental health center and substance abuse program co-exist side by side. Many people get services through a private provider, which may be a social worker, psychologist, or psychiatrist. In addition, much behavioral health care is provided by primary physicians. Sometimes, these practitioners offer the most up to date treatments. At other times, their expertise on physical health does not extend to behavioral health. Priests, pastors, and ministers also fill an important role in serving behavioral health needs in the community. Many of these services are excellent, providing the best evidence-based practices.

Sadly, much of our behavioral health care is delivered in parts of the system little prepared to serve these needs.

Many citizens suffer without any help. Waitlists are long in many communities.

Alcohol abuse distribution[5]



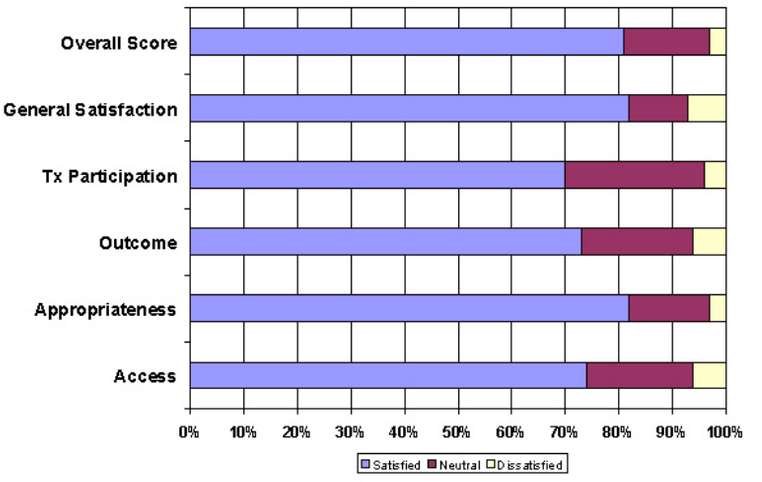
Programs are generally funded through Medicaid with a small grant supplement. This has changed markedly over the last decade as the state has come to depend more and more on Medicaid funding.

In addition, the cuts in funding at the administrative level have led to failure to do genuine quality assurance. Because of the dedication of the providers coupled with the oversight of local entities, and the good support of those who administer the programs at the state level, many programs are excellent. Yet, the ability to assess quality is lacking in the current system. In addition, due to the complexity of the undertaking and, again, a lack of people able to manage it, the system lacks a functional management information system.

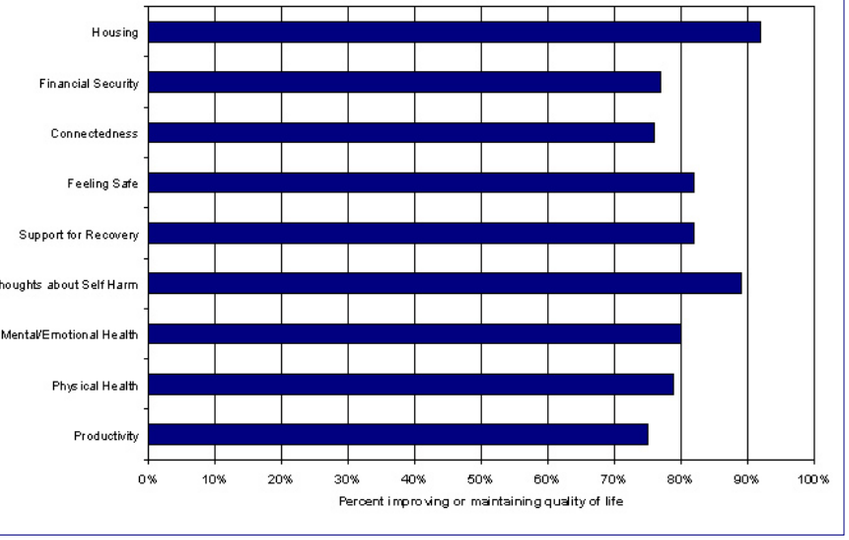
Again, many things are working. Most people who received services were positive about their experiences:[9]

Clients also reported that they had gotten better:[10]

FY06 Adult Behavioral Health Consumer Survey Results[9]



FY06 Adult positive outcomes in life domains[10]



Where to go from here

The goal of the Boards is to define a system that retains what is working now while addressing the gaps that exist. It is clear that Alaska now has the fiscal ability to respond to most of the behavioral health problems of its citizens, but money is not enough. We must support the quality aspects of the current system while we develop a long-range vision of how to provide sustainable, effective behavioral health care to all Alaskans. A brief assessment of the system and where to go follows.

ABADA and AMHB – working together

ABADA and **AMHB** have mirrored the broader system transformation, merging services for mental health and alcohol and drug abuse into behavioral health services. The two Boards still exist to represent the unique needs of their beneficiaries. At a retreat in Spring, 2006 they formalized their collaboration. They now work closely together and share the same staff. This lets them be even more effective in assuring good behavioral health to those they represent.

What works

- The dedication of providers.
- Wisdom and stories from our elders and traditional leaders.
- The support of good administrators.
- Clients get better and express satisfaction with the help they have gotten.
- We have greatly reduced the size of our state psychiatric institution.
- We are doing a better job providing services to the most vulnerable, using federal and state Medicaid dollars to extend these services.
- We are beginning to bring and keep the kids home.

What needs work

- Provision of services to a range of Alaskans regardless of funding source.
- Finding ways to keep severely disabled clients from cycling through API and the correctional system.
- Making the management information system work.
- Putting an effective quality assurance system into place.
- Continuing to develop an effective, well trained behavioral health workforce.
- Making sure that programs work together to produce a continuous system of care without significant gaps.

What to do?

- Increase funding for non-Medicaid eligible clients and for essential services that Medicaid does not cover.
- Continue to develop training programs, loan forgiveness programs, and recruitment and retention options for behavioral health workers.
- Analyze what is needed to make the AKAIMS management information system functional and take action to make it work.
- Reinstate a quality assurance program that uses AKAIMS, site visits, and consumer and community feedback to identify programs that work and to offer technical assistance when something is not working.
- Continue to identify best evidence-based practices and offer training and support to use these within cultural and community limits.

The role of ABADA and AMHB

In the future the Boards will continue to:

Plan

in concert with other stakeholders to create an effective, comprehensive, continuous system of behavioral health that serves all Alaskans.

Coordinate

From our place between consumers and providers, the Boards have a unique chance to see needs and responses and speak out about how the system can work most effectively. We will continue to be a part of most decision making bodies that shape behavioral policy and practice.

Educate

Teach all Alaskans about the importance of behavioral health and the possibility that Treatment Works, Recovery Happens.

Advise

In our role as the Governor's advisory boards, we will continue to help guide policy development and program planning.

Evaluate

Only with good data can programs improve their own functioning. Only with good data can decision makers appropriately allocate resources. The Boards will demand that data be available for these functions and dedicate their staff to using that data in effective planning and decision making.

Advocate

At the beginning of this report, we talked about the self reliance of Alaskans. But Alaskans also help each other. The Boards will use their unified voice and help amplify the voice of all behavioral health consumers to assure that necessary programs are sufficiently funded, administered, evaluated, and sustained.

The Advisory Board on Alcoholism and Drug Abuse 2006

Mission

In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.

Members

Lonnie Walters, Chair
Consumer member, Craig
Eric Holland, Chair Elect
Provider member, Dillingham
Lucy Hudson, Recorder/Treasurer
Public member, Juneau
James Duncan,
Public member, Soldotna
Marvin Deacon
Consumer member, Grayling
Owen Eben
Consumer member, Anchorage
Verner Stillner, MD
Physician, Juneau
Fred Glenn
Consumer member, Kenai
Art Hansen, DDS
Consumer member, Craig
Judith Lethin
Public member/Dual appointee, Fairbanks
Theodora "Teddy" Williams
Provider member, Wrangell
Cristy Willer,
DBH Ex-officio member
Sarah Williams,
DOC, Unofficial representative

Statutory Authority:

AS 44.29.140 states the duties of the Advisory Board on Alcoholism and Drug Abuse:

(a) The board shall

(1) act in an advisory capacity to the legislature, the governor, and state agencies in the following matters:
(A) special problems affecting mental health that alcoholism or drug abuse may present;
(B) educational research and public informational activities in respect to the problems presented by alcoholism or drug abuse;
(C) social problems that affect rehabilitation of alcoholics and drug abusers;
(D) legal processes that affect the treatment and rehabilitation of alcoholics and drug abusers;
(E) development of programs of prevention, treatment, and rehabilitation for alcoholics and drug abusers; and
(F) evaluation of effectiveness of alcoholism and drug abuse programs in the state;
(2) provide to the Alaska Mental Health Trust Authority for its review and consideration recommendations concerning the integrated comprehensive mental health program for the people who are described in AS 47.30.056 (b)(3), and concerning the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031 .
(b) The board is the planning and coordinating body for purposes of federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment services.
(c) The board shall prepare and maintain a comprehensive plan of services
(1) for the prevention and treatment of alcohol, drug, and other substance abuse; and
(2) for persons described in AS 47.30.056 (b)(3).

The Alaska Mental Health Board
2006

Mission

The Board is the state planning and coordinating agency and the advocate for mental health consumers and mental health beneficiaries of the Alaska Mental Health Trust, including Medicaid-eligible consumers and beneficiaries, for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the Board is to assist the state in ensuring an integrated Comprehensive Mental Health Program.

Members

Bill Evans, Chair
Attorney, Anchorage
Andrea Schmook, Vice Chair
Consumer member, Anchorage
Valerie Naquin, Secretary
Consumer member, Eagle River
Suzanne Price, Treasurer
Provider member, Fairbanks
Barry Creighton, At Large
Consumer member, Kasiloff
Arthur Hansen, DDS
Public member, Fairbanks
Brenda Moore
Public member, Anchorage
Stan Steadman
Public member, Kenai
Eva Leveque
Consumer/Provider member, Dillingham
Doug Smith, MD
Provider member, Juneau
Debi Keith
Consumer, Anchorage

Ex-officio:
Cristy Willer, DBH director
Colleen Patrick-Riley, DOC
Dwayne Peeples, HCS Director
Tammy Sandoval, OCS
Sharon Schumacher, EED
Steve McComb, Acting DJJ Director
Jane Macintosh, DVR Program coordinator
Kris Duncan, AHFC rep.

Statutory Authority:

AS 47.30.666 states that the AMHB is the state planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program. At least one half of the members of the Alaska Mental Health Board must be people with a mental disorder or members of their family.

On behalf of persons with mental disorders, the Board shall:

(1) prepare and maintain a comprehensive plan of treatment and rehabilitation services;
(2) propose an annual implementation plan consistent with the comprehensive plan and with due regard for the findings from evaluation of existing programs;
(3) provide a public forum for the discussion of issues related to the mental health services for which the board has planning and coordinating responsibility;
(4) advocate the needs of persons with mental disorders before the governor, executive agencies, the legislature, and the public;
(5) advise the legislature, the governor, the Alaska Mental Health Trust Authority, and other state agencies in matters affecting persons with mental disorders, including, but not limited to,
(A) development of necessary services for diagnosis, treatment, and rehabilitation;
(B) evaluation of the effectiveness of programs in the state for diagnosis, treatment, and rehabilitation;
(C) legal processes that affect screening, diagnosis, treatment, and rehabilitation;
(6) provide to the Alaska Mental Health Trust Authority for its review and consideration recommendations concerning the integrated comprehensive mental health program for those persons who are described in AS 47.30.056 (b)(1) and the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031 ; and
(7) submit periodic reports regarding its planning, evaluation, advocacy, and other activities.

The role of the Boards is to
Plan

Helping to plan for coordinated, comprehensive behavioral health care, the Boards participate in a variety of efforts including:

- Developing the Mental Health Block Grant
- Developing the Substance Abuse Prevention and Treatment Block Grant
- Monitoring and revising the Comprehensive Integrated Mental Health Plan
- Preparing budget recommendations for the Trust Request for Recommendations budget planning project
- Working with all partners to develop a behavioral health agenda for the Legislature
- Developing a joint plan for the AMHB and ABADA to guide their involvement in the behavioral health system

The role of the Boards is to
Advocate

The Boards advocate for the resources needed to adequately fund mental health and substance abuse prevention and treatment services in Alaska. To ensure that quality programs and services are available to all who need them, AMHB and ABADA, along with the Trust and partner Boards, provide strong and consistent legislative and administrative advocacy. Our activities include legislative monitoring and reporting, grassroots organizing among our stakeholder groups, legislative strategy development and stakeholder mobilization to influence legislative action on the budget and on policies that affect our beneficiaries. In 2005, the boards hired an "Advocacy Coordinator" charged with guiding the advocacy efforts of AMHB, ABADA and our partner agencies.

The 2006 legislative session provided a variety of challenges. Budget makers chose not to allocate funds to expand or create new programs or to "backfill" expiring federal funds. Additionally, lawmakers were alarmed with what they saw as "uncontrollable" growth in Medicaid spending, and demanded assurances from the Department of Health and Social Services that everything possible was being done to find efficiencies and control costs. Even in this climate, our advocacy efforts resulted in a number of real successes for consumers of mental health and substance abuse services.

The role of the Boards is to
Coordinate

The day to day tasks of the Boards and their staff focus on cooperative work with a variety of stakeholders. This opportunity to bring together different voices and perspectives greatly increases the power of what we as Boards can do. We bring not only our joint expertise to these venues; we also use our involvement to make sure that the voices of consumers are heard. Examples of cooperative tasks include:

- OISPP – Outcomes identification and Systems Performance Project - working with the Trust, the Division of Behavioral Health, and other stakeholders in developing a way to use data to assess the effectiveness of state funded programs
- Mental Health Trust Authority Focus Area workgroups – these are developing programs in a number of areas including:
  - Bring the Kids Home, and keep them home
  - Housing for beneficiaries
  - Beneficiary justice
  - Trust beneficiary projects
  - Workforce development
- Shared development of and participation in numerous educational programs and conferences including:
  - Public Health Summit
  - Rural Behavioral Health Summit
  - Peer provider conference
  - NAMI Leadership Conference
  - Aging and Disability Summit
  - Behavioral Health Community Planning Project
  - Department of Corrections Community Entry of Offenders with Co-occurring Disorders committee (APIC model)
  - Epidemiological Outcomes Workgroup (with Public Health & DBH)
  - National Association of State Mental Health Planning and Advisory Boards
  - Annual School on Addictions
  - Full Lives Conference

Those serving behavioral health needs of Alaskans stretch across many systems. The Boards are increasingly playing a role in helping to pull the various players together. As you can see from the lists of Board members, the Boards include representatives from many parts of the system to help them serve the broad mandate of assuring behavioral health for all Alaskans.

The role of the Boards is to
Educate

You may have seen the ads in the movie theater, the newspaper, or on TV or you may have heard them on the radio. They all focus on the message…You KNOW me.

With this phrase, the Boards have entered into a public education campaign in partnership with the Alaska Mental Health Trust Authority. The goals of the campaign are to:

- Reduce stigma around issues dealing with alcoholism, substance, abuse and mental illness.
- Encourage people with these problems to seek help, knowing that they can get better.

In addition, the Boards use their public voice to let lawmakers and other state officials know that it is a good investment to work for recovery of our beneficiaries.

The role of the Boards is to
Evaluate

Through the Outcomes Identification and Systems Performance Project (OISPP), the Boards are working with the Division of Behavioral Health to identify data that will tell us how the system is working. The Boards are also actively assisting in the development of an effective information management system to provide that data.

The role of the Boards is to
Advise

Board involvement in planning councils, policy decision-making meetings, and preparation for the governor's budget submission are all part of fulfilling our statutory role of advising the legislature, the governor, the Alaska Mental Health Trust, and other state agencies.

Notes

1. It has been estimated that direct and indirect costs of substance abuse and mental illness exceeded $313 billion in the United States in 1990. American Psychiatric Association, Opening Windows into the Future: Psychiatric Research in the 21st Century, Washington D.C.:APA, 1997

2. Advisory Board on Alcoholism and Drug Abuse, Alaska Department of health and Social Services. 2001 Economic Costs of Alcohol and other Drug Abuse in Alaska, 2005 update. McDowell Group, Juneau, 2005

3. Mental Health Needs Assessment of the Individuals in the Custody of the Alaska Department of Corrections; Phil Smith & Associates, Juneau, 1997

4. http://www.legfin.state.ak.us/Download/History.php

5. Behavioral Risk Factor Surveillance System, Center for Disease Control, 2005

http://www.cdc.gov/brfss/technical_infodata/surveydata.htm ; the Youth Risk Behavior Survey 2003

http://www.cdc.gov/HealthyYouth/yrbs/pdf/trends/2005_YRBS_Alcohol_Use.pdf ;

Blabey, Margaret, and Gessner, Bradford Findings of the Alaska Maternal-Infant Mortality Review 1992-2001, 2006, Centers for Disease Control, http://www.epi.hss.state.ak.us/bulletins/docs/rr2006_03.pdf

6. National Drug Threat Assessment 2006, January 2006

7. U.S. Department of Health and Human Services, Epidemiology of Mental Illness, 1999 http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html

8. Centers for Disease Control, Health Related Quality of Life Survey, 2005 http://apps.nccd.cdc.gov/HRQOL/TrendV.asp?State=3&Category=1&Measure=7

9. State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Behavioral Health Consumer Survey, 2006

10. State of Alaska, Department of Health and Social Services, Division of Behavioral Health. The Client Status Review of Life Domains, Findings for FY2006, 2006.

The Advisory Board on Alcoholism and Drug Abuse

The Alaska Mental Health Board

Sarah Palin, Governor
State of Alaska

Karleen K. Jackson, Commissioner
Dept. of Health and Social Services

541 N. Franklin, Suite 200
Juneau, AK 99801

Toll Free (888)464-8920
In Juneau 465-8920

e-mail: Lance_Brown@health.state.ak.us
http://www.hss.state.ak.us/abada/
http://hss.state.ak.us/amhb

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Our Staff

- Kathy Craft, MA, LPC, Interim Executive Director
- Lance Brown, Administrative Assistant
- Angela Salerno, MSW, Advocacy Coordinator
- Carol Greenough, PhD, H&SS Planner II
- Mariah Coe, PhD, H&SS Planner II
- Connie Olson, MS Research Analyst III