STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

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Community Town Hall Visit Grant
Report on September 30-October 2nd Outreach to Unalaska/Dutch HarborHarbor

Project Overview

The Alaska Mental Health Trust Authority (AMHTA) provided funding for the Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA) to conduct a series of town hall style outreach events in rural communities around Alaska. The objective of these visits is to obtain feedback about how behavioral health services are serving the community, what needs exist and whether there are gaps in services, as well as to find out what is going well in these communities.

Rebecca Busch, AMHB/ABADA Planner, is coordinating this project.

The Team

This visit was staffed by the following:

Eric Holland, Board Member ABADA
Bob Coghill, Board Member ABADA
Melissa Stone, Director, Division of Behavioral Health (DBH)
Rebecca Busch, AMHB/ABADA Planner

Unalaska/ Dutch Harbor

Unalaska was chosen as the last of five communities to be visited for this project. Unalaska is located (Northeast end of Unalaskan Island) on the Aleutian chain. Unalaska/ Dutch Harbor is a hub for the Aleutian Chain area and is a central commerce center for Southwest Alaska. Being the number one fishing port in the nation based on value and volume of seafood and fish processed, it is no wonder that Unalaska and the international port of Dutch Harbor became known for Discovery Channel's reality TV show *The Deadliest Catch*.

Unalaska acquired its name from the Russian spelling of the original Aleut (Unangan) "Agunalaksh" meaning "close to the mainland" of the Alaska Peninsula. the first dock was built in1890 and it is believed a Dutch Harbor ship was the first ship to enter the harbor, influencing the current name of the port. Unalaska and Dutch Harbor became a major naval base in 1941 during World War II. After two attacks from the Japanese, an air strip was built to be able to evacuate native Aleut (Unangan) people from the entire Chain and then to be relocated to Southeast Alaska. Over 880 people were transported. The lack of care and discomfort of makeshift camps resulted in many deaths of elders and youth, which resulted in significant loss

of the culture. This also may account for the small representation of native populations in the area. (Unalaska Visitor's Center)

Unalaska/Dutch Harbor has an estimated population of 4,347 residents (2005 Census). The Unalaska census (which includes Dutch Harbor) does not reflect the fluctuations of processor workers coming in and out during particular processing seasons. Meeting attendees shared that the fluctuations reach as high as 12,000 people at one time, depending on the overlap of seasons. Illiuluk Family Health Services (IFHS) serves over 5000 unique individuals in the clinic each year. As of the census of 2000, there were 4,283 people, 834 households, and 476 families, residing in the city. The diverse population of the area was 44.20% White, 3.67% Black or African American, 7.70% Alaska Native or Native American, 30.63% Asian, 0.56% Pacific Islander, 9.32% from other races, and 3.92% from two or more races. 12.86% of the population in 2000 were Hispanics or Latinos of any race.

Unalaska/Dutch Harbor is served by few social services. The providers of the area include:

- Illiuluk Family Health Services (IFHS)
- Oonalaska Wellness Center (APIAI)
- Unalaskans Against Sexual Assault & Family Violence (USAFV)
- Public Safety
- Senior Center

Preparation

The planning for this visit was a bit challenging as there were difficulties scheduling flights. The original visit was planned for June. We found in attempting the trip in June the fish processing companies had purchased a significant amount of the seats on flights to Dutch Harbor leaving insufficient seats for the team. Processing companies bring in many of their staff in June for the red salmon, pink salmon, halibut, cod and rockfish seasons. In attempting to reschedule a trip in either July or August we found that many of the providers and key community members were out of town during the summer. We finally settled on late September. The week of the scheduled trip, we were informed there would be competing community meetings: a community strategic planning meeting and the wellness Gathering in St. Paul during the consumer meeting, and forums for upcoming campaigning city assembly seats. These were both scheduled after we established meeting times and locations.

Staff members from both Oonalaska Wellness Center and Illiuluk Family Health Services assisted in the preparation for the visit helping with everything from identifying key local informants, locations for meetings, spreading the word and hanging flyers. A big thank you to both agencies and their fabulous staff!

The Schedule of Events

The visit to Unalaska:

September 30th	Arrival 4:30 P.M. Consumer Meeting 5:30P.M. Public Library
October 1st	Hosted Lunch and Meeting with Providers at Oonalaska Wellness Center Community Town Hall Meeting 5:30P.M. Public Library
October 2nd	Tour of Illiuluk Family Health Services Departure 1P.M.

Public Meetings

Around 10 community members attended the various meetings and/or connected with input outside of the meetings. The provider meeting was the most attended meeting, despite several staff members being out of town for various conferences and trainings. The attendance during the provider meeting speaks to the dedicated service providers in the area. There was a low turnout for the consumer meeting and the town hall meeting. This was attributed to the competing meetings, as well as to the issues of stigma in the community. Even so, the feedback we received was very informative and provided great insight for the needs of the area.

What we learned: Successes in the Community

While the community is small and has just a few provider agencies, it makes up for much of what is absent by the amount of collaboration shared by the agency staff and community members. In talking with providers, the deputy chief of police and members of the community it was very apparent the amount of collaboration between community leaders and the public. An interagency cooperative group of volunteering community members who work together to do community food and clothing drives to help provide basic needs, as well as being very focused working on suicide prevention in the community, was discussed frequently.

A resounding challenge in rural areas is the lack of services and workforce to offer needed services. While Unalaska has some of these challenges, the community has been very successful in establishing a workforce. Unalaska has two behavioral health providers: Illiuluk Family Health Services and the Oonalaska Wellness Center of the Aleutian Pribilof Islands Association, Inc. (APIAI). Both recognize the burden of one agency carrying all of the on-call responsibilities for crisis situations. IFHS and APIAI share on-call responsibilities for behavioral health crisis calls and jointly working with the local police team. This allows for the responsibility to be spread out and reduces burnout for staff.

APIAI has two behavioral health aides and two clinicians, and typically has mid-level staff at the clinics full-time. In St. Paul, they have one clinician and two behavioral health aides equating to fairly adequate coverage. IFHS has two clinicians, two case managers, and a psychiatrist visits seven times a year from Anchorage. It was mentioned more than once how integral the roles of behavioral health aides are in the continuum of behavioral health services, also because they are most often people who come from the area, behavioral health aides are more accustomed to the

culture and the expectations of community relationships and weather environment. They typically are more stable in the workforce than those who come from different areas who tend to have more turnover.

Workforce turnover is high but IFHS, APIAI, and the police department have been successful at implementing programs that provide incentives for staff to stay. IFHS is now getting national service awards: student loan reimbursement for various levels of staff. Other incentives include continuing education, creative rotations, and paying for housing for incoming staff for up to six months (as housing is quite expensive on the island). IFHS hosts a student program, so they have students who come and work as a part of their residency. They have hosted 14-17 medical practitioners in training *per year*, for the past 5 years, in addition to having occasional psychiatry rotations. They also offer their staff credit reimbursement through various programs.

Local agencies have worked together to increase access to services. IFHS has multiple services available who operate as a team. They have non-traditional services like acupuncture, as well as behavioral health, primary care, dental, physical therapy, and osteopathic manipulation. Treatment teams allow for holistic-whole person services. The benefit, for example is that the dentist may see oral hygiene effects from substance use or eating disorders and can co-staff issues with behavioral health staff. When a team staffs a case they have a view of the whole person.

APIAI has rented space, co-locating in IFHS building, to make it easier for clients to access services. Both agencies offer integrated behavioral health services in their health clinics. This is which helps to reduce the stigma in accessing services. Also, despite the difficulty with internet connection, both agencies have poly-conference equipment.

As an attempt to expand the services APIAI is able to offer in the community, they have recently hired a clinical supervisor and will be working to increase their Medicaid billing capabilities to include rehabilitative services.

There are many efforts for suicide prevention. Providers shared they have had behavioral health aides trained in ASIST and are now working to implement it in the community. ASIST is a two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers, as they are called after training, are taught to recognize the warning signs of suicide and to intervene with appropriate assistance.

Suicide prevention seems to be a collaborative effort among various agencies, community members and businesses that join as an interagency cooperative. This group is doing innovative outreach such as sending flyers to all processing companies to put in with their paycheck envelopes that outline the services available and signs to look for. Donna Henry from APIAI is working with youth in the community to do a natural helpers program, this is a peer-to-peer helping model that trains youth to offer support for one another. Participants gain knowledge of youth issues, practice effective helping skills, and become familiar with helping resources. Supported by adult sponsors, the youth meet regularly to offer support to one another and implement peer-to-peer prevention activities. Natural helpers define needs specific to their communities, plan and carry out service projects in both the school and in the community.

The city of Unalaska provides a great deal of monetary support for behavioral health services. The city funds grants to non-profits like IFHS for mental health services, as well as, to USAV for domestic violence programs. It generates revenue through various taxes, many of the taxes are very fruitful; ie commercial fisheries tax and the fresh fish tax.

IFHS funds behavioral health support in the schools two days a week, as well as a school nurse through patient revenues and federal grant money. Unalaska has a preschool run by the school, kids who are screened to have delays at age three go to the preschool and head start; there is a pre k- 4th and a 5-12th. Much of the support for these programs comes from local taxes. Infant learning is done through itinerate programs. In 2002, the local child care center closed due to lack of funding, certification and inconsistent demand. The local schools typically have a 10:1 ratio students/teacher.

Unalaska has one of the highest percentages of English is the second language (ESL) youth in their schools, with two ESL teachers. There are 14 different languages in the schools and about 24 in the community. On average 55% of incoming students English is their second language. This is attributed to the number of people coming to the community to work in the fishing industry and or to be with family who has relocated to do so. Graduating classes are around 23-29 students.

A recent community success in health promotion is a ban on smoking in all enclosed establishments passed in May, 2009 (implementation required by August, 2009). In preparation for this ban, IFHS offered smoking cessation classes attended by community members. This is an inter-agency collaboration and utilizes the integration of acupuncture cessation treatments.

With the extreme environmental factors, and the intensity and dangerous nature of the work involved in fishing, crabbing and harvesting seafood, it is no surprise the popular reality tv show *The Deadliest Catch* has put Dutch Harbor and Unalaska on the map. There are often physical injuries, and accidents as well as mental health and substance abuse crises. The Red Cross has responded to compounded mental health crisis situations witnessed, such as when someone completed a suicide by jumping off a boat (an entire crew witnessed), sunken boats, and large casualties. They offer debriefing, staff assistance and support to local provider staff. IFHS also has trained staff for compound complex behavioral health trauma, working with Red Cross in these instances.

Unalaska is an extremely diverse community. There are about 24 different languages spoken in the community. Only 7-8% of the population is Native, and 45-50% is Caucasian. Many people come from all over the world to work in Unalaska/Dutch Harbor. The canneries offer room and board for around $5/day. Residents and managers of companies are paid well and their housing is covered.

During our visit we had the opportunity to hear some about the community of St. Paul. APIAI serves the St. Paul community. Jan Idlebeck, who does itinerate trips out from Anchorage to both Unalaska and St. Paul and other communities on the Chain, was able to call in to a couple of the meetings we held. In discussing successes in St. Paul Jan shared there was an annual

wellness gathering in St. Paul. She offered that this was a success as it promoted health and wellness and encouraged connection to those in the community who may not otherwise engage due to issues of stigma. Many are involved in the gathering, including the Native Justice Center, and a local native judge. Teachers are supportive and encourage kids to attend.

Jan also shared that St. Paul has a new integrated clinic. She noted this was successful in providing services and reducing the stigma in going to the clinic. Stigma in St. Paul seems to be a great barrier in accessing services. Both APIAI and IFHS in Unalaska have integrated models where behavioral health services are offered in the clinic. APIAI has recently added another building for more space which now houses the behavioral health offices yet services continue to be offered in the main clinic and at IFHS in their behavioral health offices within that clinic.

What We Learned: Needs Work

Jan attributed causes of difficulty accessing services in St. Paul as reluctance and fear. There is a need for outreach and she discussed calling services less intimidating terms, which may not immediately scare off someone. Melissa Stone shared her feeling that using the prevention and early intervention framework may diminish some of the stigma attached and raise the willingness to seek services. Jan notices many who do not come in into clinic, do approach clinicians and staff in community locations (ie. grocery, post office) to discuss needs and issues/referral. This is very difficult as there is no way to bill for this. It speaks to the reluctance of coming into the clinic for services as is the system currently.

In addition to reluctance in accessing services due to stigma, we also heard from community members outside of the meetings. They have very strong concerns for their own confidentiality in receiving services. While the clinics are large employers in a small community, there are significant concerns about who has access to their records and how their confidentiality is respected. Community members contacted us directly about the issue to further distance themselves from the public eye on the issue. One person shared examples of breached confidentiality. This in turn creates distrust for the services provided and discourages continuation of treatment. Issues around confidentiality are complex in a small community, as many wear several hats socially and professionally.

We heard anecdotal observations by locals that many people come to Dutch Harbor, expecting their history and their issues won't follow them. Many reported the idea that working non-stop will diminish a person's problems (ie. diabetes, substance abuse and mental health). Of course the reality is that many find these to be exacerbated. Often the requirements of the work are more than they can do and they aren't able to stay, or able to get the support they need there and find they cannot stay. The providers talked about the mythical geographical cure.

Unalaska/ Dutch Harbor is unique in that people come there to work. They often choose work over services. There is a huge stigma against needing mental health services, in that it suggests having mental health concerns makes a person unfit to do the work required. Anecdotal examples were shared of workers on fishing crews not taking their medications in fear of the judgment or not being allowed, then suffering repercussions.

Providers also commented that those with needs for behavioral health services, particularly higher levels of services, end up leaving the community. There is an underlying community perception that if you need high levels of services, then you need to go somewhere else. The community characterizes itself due to the extreme isolation, lack of acute services and the expectation that people not only work, but work hard.

Much like we found in Homer, also a community dependant on fishing industry, there is a higher tolerance for substance abuse than there is for mental illness. The stigma weighs much heavier on people with mental health concerns, but substance abuse is somehow expected and tolerated as normal.

As is the case around the state, Unalaska/ Dutch Harbor has unmet workforce needs. While Unalaska has great staff, it is also often that same behavioral health staff who are the volunteers in the community acting in many more capacities. They hold fundraisers and organize food and clothing drives and often become overextended. There is frequent turnover. Many come from outside the area and it is a dramatically different lifestyle due to the environment and the isolation. Staff are frequently new, putting pressure on others who have been in their position longer to constantly be training those who are new. Positions are harder to sustain, and it is difficult to recruit quality staff. It takes a lot of incentives to lure workforce to such a remote, extreme place, despite how beautiful it is.

Nevertheless, local agencies have had a lot of success by offering continuing education, residency rotation placements, opportunities to leave the community for training, loan reimbursement and repayment. Many positions and services are offered intinerately simply due to the lack of economy of scale required to sustain some provider positions. Itinerate positions include but are not limited to psychiatrist, infant learning programs, Office of Childrens Services social worker, and others. Behavioral health aides are local residents typically, clinicians are not. In general those accustomed with the way of life seem to have less frustration and tend to stay longer.

Sonia Handforth-Kome, executive director of IFHS shared how the Division of Behavioral Health (DBH) grants, in the past, did not align with the focus of the clinic. It was the decision of the clinic not to pursue state funding due to the direction it required and the parameters around providing services. The IFHS mission for prevention was not the focus of DBH grants when they made this decision. She mentioned how it is hard to imagine a non-intervention model: "What does prevention look like? It takes talking to those who are well and identify what makes them well and how to stay well. There is no funding for that." Luckily there have been many transformations in the directions of state grant funds. This provides an opportunity to communicate with providers around the state how various state funds have shifted focus, and the need to better highlight these changes.

IFHS is hoping to expand their facility. They have plans to build up to hospital code, but not become a hospital, as they would lose much of the funding they are eligible for now as a non-profit clinic. They did a renovation in 2005 ($779K), which was funded through support from the City of Unalaska, Murdock Foundation, Rasmussen Foundation, Denali Commission fund and local donations.

Some of this renovation support is going to the development of the infrastructure and transfer over to electronic record keeping. It was noted that at this point the state does not have all the templates required for data entry of rendered services, so some, but not all, will be up and operating by November 17.

It was shared how little IFHS is able to bill Medicaid, mostly due to eligibility. Much of the clientele the clinic sees is not income eligible or does not have citizenship. Typically about 4-6% of services are Medicaid billable. Most clients, around 67%, are uninsured.

Legislative supports for behavioral health and capital projects have benefited the community. On the other hand, primary care has not been a legislative focus. Sonia Handforth-Kome, director of IFHS, highlighted how often it is primary care that generates more revenue and then can aid in offering behavioral health services, demonstrating the importance of prevention and early intervention.

Pamela Keller, APIAI physician assistant, discussed how behavioral health situations are often not acute enough for transport. She frequently refers patients who have chronic opiate, alcohol, drug addictions to behavioral health and substance abuse services for those may require outpatient or inpatient services but because the service is not available in Unalaska/ Dutch Harbor, they aren't willing to leave the community to receive services. We also heard that once someone does make the decision to leave to attend detox and/or treatment returning to the community is very difficult and could benefit from increased community support.

A common situation is a worker from a processing company is brought to the clinic, the actual situation is a sleep deprivation psychosis from working so many days w/o sufficient sleep, working on the boats or in the canneries. This situation doesn't typically require transport, they sleep at the clinic for supervision.

While it may be a perceived unmet need that the community does not have a pharmacy it is actually a system that promotes better monitoring of prescription medications. Each clinic has their own dispensary, which is different from a pharmacy in that you cannot bring in a prescription to be filled. A patient has to see a provider from the clinic to receive medication. Neither dispensary carries Oxycontin. It was discussed how the lack of security through the airport is well known. While there is a significant amount of this drug brought to the community, it is not dispensed by local providers, cutting down on its prevalence.

What We Learned: Unmet Needs

Lack of Services

As mentioned earlier, the community's ability to coordinate and collaborate addresses many gaps in services, but some of these gaps are significant. In Unalaska and Dutch Harbor there is no infrastructure for social services. The interagency community cooperative pools resources and volunteers to organize efforts to collect food and clothing for those in need. The biggest problem

is there is no storage for it all to be stored. While there is no shortage of cold storage, there is not a location for dry storage.

In Unalaska/Dutch Harbor there is not an agency that determines eligibility for TANF, child care, or other benefits. Food stamps can be applied for online. On the other hand, APIAI does have an ICWA worker, vocational rehabilitation, and case management support for their clients.

The Office of Children's Services had had a locally stationed social worker until recently. It was shared that the position was vacated largely due to the lack of support for the position and "unresolved issues." Since then the work is completed by itinerate workers. Providers felt this to be a very negative decision. It was their opinion that there is enough work that in fact two positions would be busy. Those attending the meetings thought OCS needs at least one in St. Paul, and one in St. George as well.

The region has very little available for FASD specific services. Melissa Stone discussed the FASD Waiver program and how this could benefit the area. There is not currently a diagnostic clinic in the region. For someone to be screened by a diagnostic team, they have to go out of the area to receive the service (travel for which is extremely expensive). Like most rural areas in the state, even once a person is diagnosed it doesn't always mean there are specific services to help. Many people have cognitive difficulties from traumatic brain injury or FASD, and many of these same people have mental health and substance abuse issues. There aren't sufficient services to locally attend to their needs. An example was shared of three generations in a family presenting with FASD, and on the verge of homelessness with many significant service needs.

There are no developmental disability waiver services provided in Unalaska or Dutch Harbor. APIAI offers some services to help with daily living at home for elders. While there is a senior center, there are no long-term care residential providers in Unalaska/Dutch Harbor. The concept of aging in place would require more program development and community-based services. The average age of locals was thought to be just over 45. APIAI is in the process of purchasing an assistive living center in Anchorage for a designated place to go for long term care but it would be in Anchorage, it will also be available to tribal members living in Anchorage.

Expectant mothers are able to stay in the community up to a certain point in their pregnancy. Though IFHC is a large clinic and provides many emergency services it is difficult to adequately staff a full OB GYN unit prepared for complicated births.

The need for a homeless shelter was discussed. Situations where canneries fire or lay off employees result in people being stranded without housing. When a person decides they are not able to continue doing the work and elect to leave, some companies will not pay their airfare home nor will they house them until they leave. The USAV shelter when possible does accept men in their shelter if there is not a family or women currently housed.

As noted during all the other community visits, accessing acute care from rural Alaska is a significant problem. There is no acute care in Unalaska, nor is there an appropriate location to securely care for someone until they could be transported out for a behavioral health crisis.

Matt Betzen, Deputy Police Chief, and his team recognize that jail is not the appropriate place for someone experiencing a mental health crisis. He described it as, "far from ideal but who else has the facility to be secure? No one." The jail can only hold someone if they are being held under ex parte Title 47. Sometimes a person cannot be transported for 3-5 days, all the while experiencing a psychotic break.

Public safety and behavioral issues are often a mutual problem; when the problem is not criminal but requires public safety staff, funding is not accounted for. For example when someone becomes intoxicated to the point they cannot care for themselves and need safe supervision. Billing for situations where an individual has not committed a criminal act but is at personal risk of harm or others are at risk of harm is non-existent. The question he returned to is who in the community has the responsibility to deal with these situations? As public safety is the last resort, it is natural that the clinic has the responsibility, but they don't have the facility to be a secure location.

Matt shared that it is hard to access mental health and substance abuse services once someone has crossed the line and become a public safety concern. But once the jail places someone and they develop a medical issue the cost of these situations falls on the city, (i.e. a person with diabetes that is intoxicated and disorderly exhibits medical complications can end up costing up to $4,000 plus transport for care). They have about $8,000 that the jail earmarks for medical issues with mental health and substance abuse situations per year. Beyond that covering staffing for these situations begins to pull funding from other budget areas like training.

With these issues in mind, we heard from providers there is a need for a place where they could securely deal with these overlap crisis. A place where on-call services would respond as there is not enough need for full-time staff. It would not be jail, it would need medical staff, the clinic isn't equipped to be secure or suitable for seclusion, and of course would require trained behavioral health staff on an on-call basis as well. This space could be used for issues around detox needs as well as mental health crisis, and secure holds while awaiting transport. The clinics by default end up watching after people as they sober up, while it is not a sleep off center it is the most medically appropriate place in the community. This could look like a sleep off plus safe room with on-call services. Because the size of the community would not require a full-time DES/DET facility it may be a consideration for clinic expansions to include a unit that could serve this multi-role purpose. This service would particularly benefit this community as transportation issues can seriously delay prompt transport.

What We Learned: Issues of Policy

Anonymity in small, rural communities is quite difficult. Ensuring confidentiality for anyone who seeks behavioral health services is a must. Developing and practicing methods that can make someone feel comfortable encourages trust in rural providers. In many communities there are one or maybe two providers and if someone is unable to have trust in the only agency that might deter from receiving treatment at all.

The system in which someone in need of behavioral health services visits a clinic to access services is not always effective. As mentioned earlier, there are often community members who

are not comfortable coming into a clinic but do connect with clinicians in the community. As we move to offer more truly community-based services, it will be important this is supported in rural and bush communities. It also allows a consumer to be supported in the community.

Many evidence based practice models may not necessarily work in rural Alaska. Many that do work may not look the same as they do in urban and hub communities. It is important that funders recognize this and have the flexibility to accommodate different models by funding project and program based parameters that function to address community needs.

Medicaid billing is a complicated system. There is significant need for technical assistance to agencies in rural Alaska. Agencies that have been successful in implementing Medicaid billing systems could be a great resource. DBH offers technical assistance, but this could be augmented if agencies who are successful in organizing and implementing billing for services could be compensated for mentoring another agency that seeks to improve its own system.

It is clear from the five community visits that there is a need to improve secure transportation of people from rural communities to receive acute care. Small communities don't always have the needed staff, facility and resources to accommodate crisis programs. Whether or not there is a consistent need for a facility, it is important that, when adequate services are not available locally, a quick, secure, respectful system can transport someone to appropriate treatment.

Follow-Up

Thank you notes and emails have been sent to all community agencies who participated, those who attended the community meetings and provided contact information. Team members (or their staff) have begun to contact participants to follow up on specific questions, funding resources or contacts including:

- Medicaid billing technical assistance and training for documentation;
- Billing contacts for behavioral health services for youth;
- Workforce incentive efforts;
- How agency staff and administration can become involved with organizations like ABHA (Alaska Behavioral Health Association) or AAPA (Alaska Addictions Professionals Association, which used to be known as Substance Abuse Directors Association); and
- FASD waiver resources and contacts.

The Alaska Mental Health Trust, the Boards, and the Division of Behavioral Health are all very invested in working with the community to address the continuum of care for substance abuse and mental health concerns. During the community visit, there was a shared message between the visiting team and community members that developing solutions for the needs within the community must be driven by the community itself. We look forward to supporting the community in the development of their solutions.