

Introduction

The State of Alaska Bring the Kids Home Initiative works to enhance or establish an array of services statewide to ensure that Alaskan youth experiencing severe emotional disturbance have appropriate treatment options within their communities or close to their families and to minimize out-of-state placement in residential psychiatric treatment facilities.

The State of Alaska Division of Behavioral Health convened a series of regional meetings with local service providers to collect their input on the system currently serving youth in the State. A series of summits was held during 2007 in Fairbanks, Juneau, Bethel, Kenai, and Kodiak. Based on the success of the 2007 summits, the Division is hosting a second series of summits throughout 2008 in Kotzebue, Valdez, Mat-Su, Anchorage, Dillingham, and Nome. This report summarizes the input and outcomes of the Valdez Summit.

The Valdez Summit was held in Valdez on April 17th and 18th. Twenty-six (26) participants were in attendance. This included attendees from many communities in the Prince William Sound and Copper Valley regions including Cordova, Tok, Copper Center, Chistochina, Kenny Lake, Seward, Kenai and Valdez. The tribes and organizations represented include Providence Behavioral Health System, Sound Alternatives, Tok Area Counseling Center; Copper River Native Association, Connecting Ties Incorporated, Mount Sanford Tribal Consortium, Alzheimer's Resource Agency, Schools for City of Cordova, Cordova Family Resource Center, Native Village of Eyak, Qutekcak Native Tribe, Chugachmiut, Valdez High School and Valdez Women's Shelter. See Appendix A for meeting notes and a list of summit attendees.

Meeting Format

The program began with short talks that were given by community service providers. These "Community Voices" described how organizations in their region are working locally to provide services to youth and families. Short summaries of the Community Voice discussions are provided below.

Following the Community Voices segment, Anne Gibson, a Utilization Review Specialist with Behavioral Health provided a general overview on the State's efforts to improve services and supports for youth and families in-state.

During the afternoon and the following morning, meeting participants broke into small groups and engaged in focused discussion of regional characteristics on the following general topics:

- Strengths + resources
- Barriers + weaknesses
- Solutions
- Priority actions
- Technical Assistance needs

Groups took detailed notes of their discussion. As the small group segment of the Summit was completed, attendees reported their results to the larger group. Major themes and a list of priority actions per group were identified. For a detailed listing of the questions participants focused on during the discussion phase of this meeting, please see Appendix B.

After priority actions were identified, a short panel discussion was convened. The panel included Bill Herman (Alaska Mental Health Trust Authority), Viki Wells (Behavioral Health), Anne Gibson (Behavioral Health), Beth McLaughlin (Rural Technical Assistance Provider, Agnew::Beck Consulting). The purpose of the panel was to discuss the issues raised during the Summit, how follow-up will be provided, and ways that resources can be accessed.

Following is a summary of presentations and of group responses recorded during the small group break out session. As previously mentioned, a detailed list of group responses is included as Appendix A.

Community Voices

Bill Purdy: Copper River Native Association

“The break-down we are seeing in our region is the disconnect between quality education services and quality residential facilities. The facilities are there, but some of the services needed to support the youth are not, so we send youth out of state. We are also working to try to cultivate relationships with law enforcement, schools, and other providers. I would like to discuss tools for setting up multi-disciplinary teams to discuss issues confidentially to best decide what resources are needed and to help us have free dialogue for preventative work.”

Kimberly Elias: Providence Valdez Medical Center

“We provide 24-hour crisis outreach services for the community. We are on-call with police, schools and Valdez Victims of Violence. We also provide group counseling for youth and adults. We offer a social responsibility Brain-Wise curriculum. We provide rehabilitation services for kids with SED and adults. We have a psychiatrist who travels in from Kodiak once a month to do prescriptions. There are some gaps in our services – one would be for level one treatment and high-level residential for folks with substance abuse issues. The hospital does provide detoxification services. We also don’t do much as far as respite services – lack capacity but have heard from people in the community that this would be helpful, particularly for folks with psychiatric illness. We try to focus on working with the whole family through our parenting programs, and we are considering starting a Celebrating Families program, structured after the Strengthening Families program – focusing on families with chemical-dependence problems. This program would offer help for children of alcoholics and also provide safe places for kids to go when there is trouble happening at home. It would be nice to have a local psychiatrist in Valdez. We are fortunate in that we do have a local psychologist. There are also some limitations as far as identification and treatment with FASD. Transportation has been a big difficulty for some of the lower-income people who are without personal vehicles – there is no bus service in Valdez, but sometimes we do have a relationship with a local taxi service. We do have a lot of dedicated professionals in the community who have to be jacks-of-all-trades and learn to do things that aren’t necessarily in our areas of specialty.”

Kris Johnson, Cordova Sound Alternatives

“Cordova Sound Alternatives works with youth with SED, SMI adults, mental health, and is also a community medical center. We have a group called “Lunch Bunch” and have an open session with the kids in the school over lunch hour. It started with four kids and has grown to nineteen. It’s been a stepping stone of trust to get into the schools. We have provider meetings in Cordova but I am excited to reach out to the schools and also the surrounding villages. My son is 19, about to be 20. When he was diagnosed, I put it out in the paper and asked for help and 14 people offered to help. So, we are a close community with people willing to help each other.”

Lew Lowry, Tok Counseling Center

The Tok Counseling Center came into existence in 1979. It is primarily funded through DBH as an emergency service center, but is expected really (and needs to) provide the full spectrum of services. The Center serves about 11 population centers over 20,000 square miles. It has three staff members and a part-time psychiatrist. “We work with the providers in the villages who work for TCC. Our gaps are similar to other rural areas. Travel is difficult and expensive. One trip to Eagle is about a third of our entire annual travel budget, for example. Sometimes the troopers are kind enough to provide the transportation to the hospital. Right now we are trying to re-build the client load and the ties to our communities and schools.” About 40% of our clients have Medicaid and Denali Kid Care; we can’t charge Alaska Native clients because of restriction from our grant funding.

Strengths and Resources

As a way of beginning small group discussions, groups were asked to identify community strengths in regard to serving and supporting youth in their home community and region.

Groups responded that serving youth in a small community can be positive in that a child is “known” by residents and service providers and potentially better supported in a more connected environment. An additional benefit to providing service in a small community is the energy, cohesion and dedication of local providers. Youth and youth organizations such as student councils and youth support groups were also listed as local strengths.

Other strengths that were noted included school based programs that prepare students to move into the workforce such as the Work Keys program; teachers and schools; committed providers; transportation programs that provide improved access to programs and resources; visiting service providers who provide levels of care that are not regularly available in small communities churches; medical services and medical support programs; training for local providers; local trainers who can share their knowledge; technical resources such as video conferencing and telepsychology; local villages and tribal involvement; local culture and cultural activities such as culture and wellness camps, talking circles, connecting with elders and storytelling; regional planning efforts that lead to a regional identification of needs.

Barriers + Weaknesses

Groups were asked to identify community weaknesses or barriers that make supporting and serving youth locally difficult or challenging. There were many responses and they have been organized into general categories and summarized.

Connectivity

As with other regions, it was noted that lack of connectivity provides many challenges: there is a disconnection and lack of communication between organizations providing services and support to youth and families; a lack of connection between service providers and schools before and after youth are sent out for treatment; lack of understanding between providers on the spectrum of services that are available in their community and region; once a youth “drops out” of the school system, there are few other resources to connect them with the training or education needed to function effectively in a community system; and a lack of connectivity with funding that may be available through the state system.

Training

Groups reported needs for training in many areas:

- healthy parenting training
- training for school staff (teachers, administration, aides) such as behavioral intervention training
- training on how to work with youth in a residential settings
- therapeutic foster care
- use “train the trainers” opportunities to increase amount of training locally and expand local capacity to offer training

Workforce

The workforce serving youth and families suffers from low retention; difficulty with retaining qualified staff; and in many positions is unable to offer competitive salaries. Offering better salary and benefits would likely improve retention and attract a greater applicant pool to Alaskan jobs. Keeping a strong workforce in rural communities is especially difficult as costs of living in rural increase and salaries are not able to keep pace.

An additional threat to the health of the workforce is a lack of trust between service providers and other organizations serving youth. Support services that alleviates burnout and increase connectivity between providers are needed as are training opportunities and forums that are inclusive of all organizations serving youth to build consensus and teamwork.

Prevention

More funding and focus is on critical care, not prevention. If more resources could be dedicated to the prevention side of the spectrum (dealing with family violence, drug and alcohol abuse, parenting techniques, etc.) there might be a decrease in critical and emergency care.

Service gaps

Several groups mentioned that there is a gap in services available for youth between the ages of 18-21.

Additionally, it was noted that the infrastructure needed to “bring the kids home” and offer support is not sufficient:

- Need for parental support
- Poor planning infrastructure for sending youth out for treatment and for how to effectively phase them back into community
- Discharge plans often cannot be met due to a lack of local providers

Funding

Education is needed on funding opportunities currently available and how to access this funding.

Funding specifically for training was prioritized by several groups (see training section for a listing of training needs).

Priority actions and solutions

Groups were asked to develop solutions that could build upon the community's strengths and minimize weaknesses and barriers to success identified in the preliminary group discussion. Many solutions were suggested. Specific solutions are listed below under several broad themes.

Create coalitions at many levels

- Including inter-agency collaboration with all elements of community (i.e. "Youth Awareness Coalition")
- Effect change on a policy level with input from all stakeholders – parents, youth, families, providers, schools, local law enforcement. Coalitions that represent the entire community are an effective way to communicate with legislators and policy makers.
- Form partnerships of community organizations to catch kids who fall through the gaps; encourage collaboration between schools, parents and service providers.
- Establish multi-disciplinary teams to deal with client specific issues and include input from many community resources (e.g. OCS, police, parents, service providers).

Create a central clearinghouse for information, funding, and services

- E-mail network to announce events, funding opportunities
- Create a "Where to Turn" periodical that lists resources for supporting youth and families with description of services and contact information (and is regularly updated)
- Create a "lexicon" for abbreviations and commonly used terms in behavioral health professional realm
- Create a list of places to post/list behavioral health related job opportunities

Technology

- Explore new applications for polycom or telehealth technology such as connecting urban and rural treatment teams before and after youth are sent out of state for treatment. It was mentioned that ISA funding can pay for the connectivity described above when it is not billable to Medicaid.
- Explore using video conferencing to supplement training needs.

Focus on work force development.

- Explore partnerships with educational institutions – internships and educational opportunities in exchange for work experience; explore options for loan forgiveness in exchange for working in rural setting, work incentive programs
- Create a system to educate new hires prior to acceptance of jobs. This should include in-person interviews in the community if possible. Where this is not possible, consider creating a recruitment video showing new hires what life is like in the region where they will be working (Maniilaq has created a video like this)
- Explore incentives to encourage careers in behavioral health positions

- Salaries and benefits should be commensurate with cost of living increases. Where possible offer housing and supports (in rural communities there is often a lack of housing available)
- Relax barriers for and around background checks

Provide comprehensive training

- Training for therapeutic foster care
- Using “train the trainers” opportunities to increase amount of training locally and expand local capacity to offer training
- Create “in-service” for service providers – this model is a way for providers to receive training and education and also share resources between providers and network with other local organizations

Youth-oriented solutions

- Create a Youth Court to increase local connectivity/responsibility between youth and increase accountability and provide positive pressure for kids transitioning into community.
- Peer navigators – youth that have been involved with the system are trained to guide others who are not as experienced (could be an extension of youth court)
- Help youth to access training and educational opportunities such as AVTEC; Job Corps; military readiness school; union apprenticeship programs

Local Accountability: taking responsibility

It was noted that is important for providers to evaluate their own performance and be working to improve the services that they provide to the community. This can be done by:

- Tracking productivity (e.g. “How much did you do?”, “How well did you do it?”, and “Is anyone better off?”)
- Setting standards
- Surveying clients
- Strategic planning
- Working towards a goal
- Creating “Scorecards” – CSR’s – intake vs. discharge as a metric
- Have incentives/rewards/payoffs
- Staff evaluations
- Set aside money for training
- Measures like direct and in-direct billing

Priority Actions

Each of the three groups were asked to prioritize 5 action steps that could be taken as part of the Bring the Kids Home initiative to address the barriers and implement some of the solutions suggested. Of the priority actions listed, those that were mentioned with greatest frequency were:

- Workforce development -- recruitment and retention; salaries commensurate with cost of living increases; housing and supports; youth recruiting; incentives to encourage people to go into behavioral health related careers
- Increased agency collaboration and coalition building on many levels
 - Central clearinghouse created for information on resources
 - Email network to announce events/opportunities
- Training for on all levels for those working with youth
 - Parents
 - Staff
 - Mentors
 - Employers
 - Foster care providers

The full list of priority solutions is listed in Appendix C.

Conclusions & Next Steps

At the Summit's conclusion, a facilitated panel discussion took place. The panel consisted of Anne Gibson (Behavioral Health), Vicki Wells (Behavioral Health), Bill Herman (The Trust); and Beth McLaughlin (Agnew::Beck and technical service provider for The Trust). The purpose of the panel was to answer questions, make suggestions for follow up and next steps.

Follow-Up & Next Steps

1. Follow-up teleconference action-planning – summit participants agreed to convene a follow-up teleconference to act on priorities identified during the Valdez Summit. Beth McLaughlin, rural technical assistance contractor for the Trust will follow-up and coordinate this effort.
2. It was noted that advocacy is highly important and that it is necessary for providers, youth and families to reach out to those in policy making positions and make sure that they understand the needs of their constituents. Ideas for contacts include:
 - Senator Harris
 - Representative Hawker
 - Angela.Salerno@alaska.gov, 465-4765 (can give advice on how to advocate)
 - Google: “Alaska Mental Health Board”
 - Alaska Youth & Family Network: FranPurdy@ayfn.org, 770-4979
 - SEDA.org – training in advocacy
3. There will be a BTKH Stakeholders meeting convened by the Trust to assess what the initiative has accomplished and what its future goals should be. This meeting will take place on May 22. The initiative has now been underway for several years and it is time to set new priorities. Input from providers at this meeting will be highly important. For more information contact Bill Herman: william.herman@alaska.gov or 269-7262
4. Some funding is available from the Mental HealthTrust – www.mhtrust.org
 - Capital funding for equipment and facilities; program funding
5. Training funding is available from the State of Alaska. For more information on how to access funds contact:
 - Anne Gibson: anne_gibson@health.state.ak.us
 - Val Kenny: valerie_kenny@health.state.ak.us
6. Free technical assistance is available for rural organizations serving Trust beneficiaries. Contact Beth McLaughlin: beth@agnewbeck.com or 222-5424.

Appendix A

List of Summit Attendees & Notes

Bring the Kids Home Summit Attendees

Valdez, Alaska

17-April-08

	First	Last	Association/Interest
1	Ann	Gibson	Division of Behavioral Health Providence Behavioral Health System
2	Kandice	Connor	Providence Behavioral Health System
3	Kimberly	Elias	Providence Behavioral Health System
4	Jeff	Finch	Cordova, Sound Alternatives
5	Lew	Lowry	Tok Area Counseling Center Tok Counseling Center, AmeriCorps volunteer, former licensed foster care home
6	Christine	Grangaard	Copper River Native Association
7	Bill	Purdy	Glenallen/Copper River Native Association, therapist Valdez-based service provider w/ Connecting Ties Inc., grandparent of consumer
8	Connie	Rogers	Mount Sanford Tribal Consortium, ICWA Worker Alzheimer's Resource Agency, Kenny Lake Behavioral Health Services, DBH
9	Eva	Dunning	DBH, Project Assistant Superintendent of Schools, City of Cordova, Board of Directors for Superintendents Association for Alaska, CIRC Board School Board Member, Cordova Family Resource Board
10	Cecil	Sanford	Cordova, parent, Providence Behavioral Health
11	Gay	Wellman	Native Village of Eyak, Special Events Coordinator – Sobriety Celebration, Case Manager for Substance Abuse & DV
12	Vicki	Wells	Governor's Council for Special Education, Chair for Special Education Advisory Panel, Sound Alternatives
13	Laura	Sanbie	
14	Jim	Nygaard	
15	Peter	Hoepfler	
16	Patty	Masters	
17	Belen	Cook	
18	Kris	Johnston	

19	Bill	Herman	Alaska Mental Health Trust Authority
20	Wayne	Binns	SESA
21	Connie	Pavlov	Seward, Qutekcak Native Tribe, Youth Development
22	Nick	Pavlov	Chugachmiut, Substance Abuse Counselor
23	Gary	Pauly	Chugachmiut, Positive Relationship Pathways Program
24	Mona	Riddle	Valdez High School Advocates for Victims of Violence, Valdez Women's Shelter, Youth Coordinator
25	Sarah	Gilmore	
26	Beth	McLaughlin	Agnew::Beck Consulting
27	Ellen	Nelson	Agnew::Beck Consulting

Meeting Notes

Community Voices

Bill Purdy: Copper River Native Association

We recently had a situation in our area where we just learned that we might have been able to keep a youth in the state that we sent out to Utah. The break-down we are seeing in our region is the disconnect between quality education services and quality residential facilities. The facilities are there, but some of the services needed to support the youth are not, so we send youth out of state so they can get the services they need while in residential treatment. We are also working to try to cultivate relationships with law enforcement, schools, other providers. Would like to discuss a tool for multi-disciplinary teams to discuss issues confidentially to best discuss what resources are needed. Help us able to have free dialogue for preventative work.

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We provide 24-hour crisis outreach services for the community. We are on-call with police, schools and Valdez Victims of Violence. Fortunately not too often, but we do get some of these calls in the middle of the night. We also provide group counseling for youth and adults. We offer a social responsibility Brain-Wise curriculum. We provide rehabilitation services for SED kids and adults. We have a psychiatrist who travels in from Kodiak once a month to do prescriptions. There are some gaps in our services – one would be for level one treatment and high-level residential for folks with substance abuse facilities. The hospital does provide detoxification services. We also don't do much as far as respite services – lack capacity but have heard from people in the community that this would be help, particularly for folks with psychiatric illness. We try to focus on working with the whole family through our parenting programs, and we are considering starting a Celebrating Families program, structured after the Strengthening Families program – focusing on families with chemical-dependence problems. This program would offer help for children of alcoholics and also provide safe places for kids

to go when there is trouble happening at home. It would be nice to have local psychiatrist in Valdez. We are fortunate in that we do have a local psychologist. There are also some limitations as far as identification and treatment with FASD. Transportation has been a big difficulty for some of the lower-income people who are without personal vehicles – there is no bus service in Valdez, but sometimes we do have a relationship with a local taxi service. We do have a lot of dedicated professionals in the community who have to be jacks-of-all-trades and learn to do things that aren't necessarily in our areas of specialty.

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Anne Gibson, Utilization Review Specialist, State of Alaska Division of Behavioral Health

Four UR Specialists hired about 4 years ago, and divided the state into 4 regions: Fairbanks and north, Kenai, Kodiak & Dillingham; Anchorage and Southcentral; MSB and SE Alaska. If we have questions we can help you with, we are here to help you. Major initiative is to keep the kids at home, and to help the transition of kids who are returning in-state. Any children in state custody who are being considered for out of state care are reviewed by our team.

We also each have responsibility for the different acute care facilities: Providence, Northstar, API. Anytime these facilities are considering sending kids out of state, we review the case.

When children are returning, we try to see where they can be placed in-state, or keep some children from leaving the state. At the beginning of this year, we had about 292 kids in out-of-state care. Used to be more than 400 kids at any one time for the last

several years; in 2000 there were more like 600 children out-of-state. So, we are starting to succeed.

Questions and Comments:

- *Need not just facilities, but real training for the providers in the facilities.* State has money through the state budget to provide technical assistance for training. The local service providers have a hard time budgeting for adequate amounts of training. There is one scheduled for this summer – Dr. Emery. Being sponsored by Serenity House. Going to test the outcome of the training to see how effective it is going to be.
- *Are you using local trainers as well? Alaska has some very good people.* Some local people who are training is FASD waiver training and Carl Dennis.
- *Schools have a great need for training, they are starting to get the infrastructure bit have a need for pretty intensive training to be working with individuals with pretty extensive needs. Want to have cross-training; almost an academy with a lot of follow-up would be very helpful. Also, want to common types of training so that people aren't just going into their own little pockets.* UAA offers residential services training on how to work with kids in residential settings.
- *Real need to have teams of trainers to come into communities to stay for a good block of time – not just a weekend or a week, and not just in Anchorage or Juneau or Fairbanks, but to be in the communities helping. Don't spend the money on just big conferences in Anchorage. Also need opportunities for people who do go to Anchorage or other places for training to come back into the communities and have them return and give a "mini-training" to the local providers.* Yes, we have heard that before. We're open to that. People who will come in and learn really what we're dealing with and train to our situations, not the big cities.

Break Out Sessions

Group 1

STRENGTHS

- Senior year – attempt to place kids in apprentice jobs, but there are gaps prior to getting them to this point
- Pilot project: Work Keys, now in statute – start in sixth grade rather than waiting until 12th grade
- Option: UAP micro-enterprise program
- Small communities: everybody knows the students, student is familiar with community, it is a safe place for the child
- Incentive ideas for success – 1st entry be via school or different approach
- Passion for what we do
- Part of the plan – collaboration with other communities
- Bring back what we learn from other trainings
- Regional identification of needs

WEAKNESSES

- Parent needs/School District/School Board – there is a disconnect in the ability to work together
- Parent training, communication styles, funding for training
- Bridges between cultural entities
- Gaps and barriers to programs, services, clients
- Connection with kids coming back
- Connection beforehand with service providers and school
- Kids the drop out do not get access to services unless they are picked up by police or are identified because of other problems
- No diagnosis made or families don't want diagnosis made
- Barriers with the school, behavioral health agencies:
 - Schools don't really serve the vocational needs of drop-outs
 - NCLB teach to testers – students are not really education-bound; certificate of attendance ? qualified education, not vocational education qualified
- Staff turnover, low retention of qualified staff
- DVR v. microenterprise – extend definition of “employment” for rural settings
- Gaps in 18-21-year-old age group in Medicaid, social services, DVR, eligibility; if identified, cases of sexual assault have no eligibility
- ICAP process – it is difficult to report the negative
- Lack of adequate training for educational aides, behavior intervention, parent training v. views, opinions of others – viewed as bullies, lots of behavior problems

SOLUTIONS, RESOURCES & LEADS

- In-service for service providers – way to share resources with schools from providers
- Process for parents/IEP team/or educational program to talk and share ideas; then be able to talk the same language about the program
- Lexicons – teach individuals about abbreviation glossary for common language
- Lead contact – ½ to full day discussion on SVS out there: where they are, pots of funds, what is or not available
- Lead educational agencies – loan forgiveness, work incentive program
- More awareness, training, and publicity
- Compensation for providing any services has been level funded for 12 years minimum
- Incentive for communities that do it right/successful for a bonus with no strings.
- Hard to compete with the Lower 48 when not paying for well-built package or retirement to come to a higher cost area.

Short Term

- Poly-Com, Tele Med
- Could be cheaper to bring into community than outreach to other communities
- After care from residential placement
 - For continuum care
 - Educational piece

- Coalitions between agencies
 - For lobbying additional funding
 - Wrap around SVS – continuum of care; open dialogue
- Notification of return from residential placement (1 month prior minimum)
- Coordination of kid count; or be able to count kids even if out of community partial year
- Foster care – provide training, respite, funding; possible rate increase
 - *ISA – possible funding for 24 hr. care for respite
 - (Very few producers and they burn out)
- *SAGA Program – teens to build housing for low income families
 - Expand: have them train or be trainers of trainers
 - Grant opportunities?
 - Union apprenticeship programs; awareness
 - Plug drop-outs into program for GED's into:
 - AVTEC, Job Corps/union apprenticeship program, SAGA program, military readiness school
 - Relax barriers for and around back ground checks

TOP 5 PRIORITY SOLUTIONS

1. Central clearinghouse for information, funding, services - possible person connected to it
2. Work force development, incentives, work keys link, recruiter
3. Training (parent, staff mentors, employers, etc...) & agency collaboration including schools
4. Cost of living increases – housing & supports, safe housing
5. More concrete after care programs – continuum of care

Group 2

STRENGTHS

- Everyone looking for the same result
- Services are available
- People
- Community Spirit

WEAKNESSES

- Turf issues
- Changing community focus
- Negative connotation of to mental health
- General communication
- Accountability, responsibility
- Involve community
- Inconsistent providers
 - Underpaid and overworked
 - Unappreciated
 - Training (?)
- Trust – with police, counselors
- Support for supporters

- Mid-economic needs not eligible
- Threat of closing sites
- Lack of State funding or lack of knowledge of State funding
- No expansion of funding or flexibility based on need
- Utilization of resources
- Critical care, not prevention
- Lots of resources for services kids in grade school, junior high, but not high school
- Kids graduating can't read, write, do basic math
- Difficulty of youth breaking out of cliques
- Too many meetings with the same people

SOLUTIONS, RESOURCES & LEADS

TOP 5 PRIORITY SOLUTIONS

1. Coalitions at many levels
2. Prevention – community based services
3. Workforce development with resources (\$)
4. Consistency & follow through. Incentives/Motivation.
5. Accountability/Evaluation

Group 3

STRENGTHS

- Good youth, work well with others
- Teachers
- Community – cohesive, made up of people with commitment to the community
- Long-term providers, and many of them
- Native Villages
- Medical Care
- Seven people from Cordova are present at this Summit (demonstrated commitment)
- Student Councils
- Transportation Program (The Ride) in Cordova
- Diabetes Programs (Eyak)
- Restarting youth group
- Psychologist visit to Cordova for training and practice
- Churches – ministerial support and ability to use facility
- Food Banks
- Thrift Store
- FASD Trainer
- Alzheimer's Resources – training and indoor workers
- Providers Meetings
- Schools
- Emergency Planning Meetings
- Video Conferencing
- Transportation program – In Works, Copper Center
- Trained Staff

- Tribal Involvement
- Substance Abuse Counseling
- Fatherhood Initiative Involvement
- Seward – many providers
- Strong Tribal Councils
- Develop Talking Circles
- Developing Relationship-Building Panels
- Elders-In-Training/Storytelling
- Strong Village Entities
- Kinship Relationships
- Extended Family
- Models for Sobriety
- The incredible work and treatment of care by participants at the Summit
- Self-Help and Support Groups
- Hudson Lake Healing Camp
- Participation in RHS Programs

WEAKNESSES

- Healthy Families to Model
- Treatment of other drug abuse and it's consequences (we should not forget)
- Lack of purposeful cooperation between agencies
- Better and more communication between agencies
- More youth services – current OCS works supervised by someone hundreds of miles away
- More State support for Family Pres. Efforts
- More Elder support
- Traditionalist v. Revisionists
- Racism
- Need more specialty providers
- Housing
- Cost of living
- Lifestyle changes in Native communities
- Hiring Native providers
- Prejudice, resentment and anger
- Competition for money
- Poor infrastructure to actually bring the kids home
 - Little parent support
 - Poor planning
 - Discharges can't be met due to no provider
- Disconnect between City professionals and rural living – top-heavy, push back
- Worker burnout
- High turnover
- How to compensate new hires to work in a rural setting

SOLUTIONS, RESOURCES & LEADS

- Art therapy programs for sobriety

- Know that it is sometimes OK to take a child out of the home, out of the situation, if it is harmful – need to show them a different way of life, expose them to a fresh situation that is healthier for them. In this case, maybe *don't* want to bring the kids home. Sometimes we do more damage putting them back in their homes. “My culture, my village, my family, everything is here. I have it with me. And some people can live in the culture and village and never really are a part of it.” *Everybody's* got to be ready for the kid to come home.
- Deal with the family issue before the kids come back
- Teach that you can make the choice to change the pattern, to keep the abuse from your house

TOP 5 PRIORITY SOLUTIONS

1. Training for foster care
2. Successful recruitment & retention
3. Youth court
4. E-mail network to announce events
5. MDT Development

Presentations from the State Division of Behavioral Health and The Trust

FASD Waiver Program

Focus is “modeling, mentoring and monitoring.” Grant will allow payment by Medicaid for services that hadn't been allowed before – such as consultation with occupational therapist or work with the families. This first year, will only have 8, and over a 5-year period, will have 88. Agencies that want to become eligible to provide services should attend training on the program. There is one coming up in Anchorage with Kelly Donnelly and Michelle Lyons-Brown.

Individual Service Agreements (ISAs)

A lot of diversion is happening because of the ISA funding – it's working. Sign up by entering into a Memorandum of Agreement with the State for providing individualized services for children who are severely emotionally disturbed and imminent for going out of the home.

This program covers youth up until they are 22 years old, helping to cover the transitional stage from 18 through 21. This can cover things like respite services, family skill development, group psychotherapy, individual skill development, transportation, parenting classes. You request the services for a 90-day period, and can bill every 30 days. There is no cap on it. It is intended to be a fast turnaround, and very simple paperwork. We also pay \$25 for your time spent on billing. We encourage people to think creatively in how to use these dollars. For instance, we bought a bicycle for a child who was depressed and suicidal because of domestic violence in the house – gave the child a sense of independence, a way to escape and also to commute to work and school. Also have paid for a mattress for a child who was sleeping in strips of foam on the floor. You have to request the money and it has to be in the treatment. Equine therapy could work, family membership in to the Alaska Club, music, martial arts or art classes, peer mentoring. Not intended to cover medicine, really. This money is intended to pay for gaps in services that Medicaid or the 5% set-aside dollars won't cover. You are only limited in your imagination.

Alaska Mental Health Trust Authority

For starters, everyone here counts as rural, so you all qualify for technical assistance. Call Beth at Agnew::Beck.

May 22, the BTKH Stakeholders are going to meet and we are going through a mid-course visioning process. We have gotten 2-3 years into this, we've had some impact, but we need to fine tune and find out what the priorities are, what's working, what's not working. I am dealing with a lot of policy stuff, and it is important for me and others to hear from people and providers like you.

In Anchorage, the effort started by collaborating kid-by-kid to look for solutions and figure out ways to keep kids in-state.

Focus areas of The Trust are related to areas you are probably frustrated about. They are:

- Workforce Development, a new focus area. Trying to find out what's happening training-wise and broaden it to reach more people. What's needed for retention of staffing? Also doing recruitment, starting at the high school levels. Work force development is challenging and expensive.
- Housing. Created a housing trust this year, working with the legislature. Health begins with a warm place to sleep and a safe place to be.
- Disability Justice. A lot of our constituents are in the criminal justice system.
- Transportation. Usually get about \$300-500K for transportation help. This year we hit the jackpot and received \$800,000 of General Fund money. It's a good year to ask for a vehicle. Good for agencies to be collaborating on the use of the vehicle.

Impact Asmute – working with Chugachmiut and SEARHC. When physical health providers encounter people with behavioral disorders, depression or other problems, we are training them to identify and also refer people to services. Where this has been tried in the past, it has been very successful in other states.

Report to the legislature and feedback. Generally, legislators are wondering “Why do we never turn a corner, why aren't things getting better?” To them, it seems like they are pouring money down a black hole. We need to show that when we fund some services, they have an effect. We need to have data and go back to them with follow-up information and share it with us and your local legislator. Much better to go to their office or bring them to your place when they are not in session, when they have time to listen to you? Why does prevention seem to be a bottomless pit? They want to see a better feedback loop on information – not two years back, but 6 months back.

Measuring outcomes is very important.

For 600,000 people, we have about 300 kids in residential treatment out of state.

Compared to the state of Arizona, for example, for 200,000 people, they have 5 kids in residential treatment. The way they work it, they get a general pot of money, and they do more services with fewer dollars because they have a lot of counselors who do home visits and more lower-level care. They have more home and community-based

programs. Maybe there are too many reinforcements to send a kid away and not enough money to keep them in the region – it costs more to keep them in the region. 60 new beds at Northstar, 150 new beds coming into Fairbanks, Southcentral Foundation is building 40 new beds at Eklutna focused on Alaska Native youth, new beds with Volunteers of America, 40-50 new beds in Maniliiq, Juneau has 14 new beds and 14 new apartments for kids moving out of residential and into life within the community. So now we have a lot of beds, but we need to focus more on lower-levels of treatment. In spite of this need, the legislative budget cut \$250,000 out of this kind of treatment. We do have the legal ability to not approve moving kids out of state, but we've preferred to just ratchet down slowly. Also, working more with the schools to have them help with a kid's transition back into their community and home. Put \$350,000 into Parent and Youth Peer Navigation – kids talking with kids about recovery. Finally, the FASD Waiver that was just approved and we are trying out from a huge federal grant.

Priority Solutions Discussion

Group 1

1. Central clearinghouse for information, funding, services - possible person connected to it
2. Work force development, incentives, work keys link, recruiter
3. Training (parent, staff mentors, employers, etc...) & agency collaboration including schools
4. Cost of living increases – housing & supports, safe housing
5. More concrete after care programs – continuum of care

Additionally: Booklet “Where to turn”- a resource that expands on this resource
Technology – new applications for polycom or telehealth – connecting urban and rural treatment teams.

ISA money to pay for connectivity described above when not billable to Medicaid.

Partnerships: catching kids who fall through the gaps; collaboration between schools and service providers for “life skills planning.”

IEP teams (with parent involvement)

Microenterprise – staff training or de-escalation for those interested in moving into the workforce

Training – video conferencing to supplement training needs

Using “train the trainers” opportunities to increase amount of training locally

AKPIR – Alaska Parent Resource Information

Group 2

1. Coalitions at Many Levels (i.e. “Youth Awareness Coalition”)

Effect change on a policy level – program changes

2. Prevention & Intervention

Community based services thru the efforts of local coalitions:

(i.e. Kids summer camps: organizing donations, activities, equipment, curriculum development, money for programs. Began as provincial grant; now self-sustaining thru local effort.)

Other programs: “ropes”, trails – free to local youth, National Guard as partner to coalition effort.

3. Workforce Development

Attracting more qualified employees to BH positions.

Youth recruiting

Incentives to encourage careers

4. Consistency & Follow Through

and

5. Local Accountability: Taking responsibility for programs

We need support and money, but we need to hold ourselves accountable and make sure we are getting done what needs to be done.

How?

- Track productivity (e.g. “How much did you do?”, “How well did you do it?”, and “Is anyone better off?”)
- Set standards

- Surveys to clients
- Strategic planning
- Working towards a goal
- “Scorecard” – CSR’s – intake vs. discharge as a metric
- Have incentives/rewards/payoffs
- Staff evaluations
- Set aside money for training
- Measures like direct and indirect billing

Resources – local youth

(Note: The Alaska Mental Health Trust Authority offers small projects funding up to \$10,000 for direct benefits to beneficiaries – www.mhtrust.org – June 1 deadline.)

Group 3

1. Training for foster care: safe places for kids locally
 - Elders/Committee leaders as part of support system
2. Recruitment/retention – Ways to alleviate high turnover, decrease burnout, and attract and keep good employees.
 - Educate new hires before acceptance of jobs
 - Important: check hires in an in-person interview (Funding for this?)
 - Job Fair
 - Recruitment video for area – Maniilaq has already produced; it shows good results
 - Resources – where to announce job opportunities for Alaska jobs; how to properly advertise?
 - Cordova – Housing for incoming new hires is often hard to find
 - Valdez – Strong communication system between service providers and volunteers
3. Youth Court
 - Increase local connectivity/responsibility between youth. Increase accountability and provide positive pressure for kids transitioning into community.
 - Peer navigators – Youth that have been involve with the system to guide others who are not as experienced (as extension of youth court).
 - ASAA Funding – for classes for extra curricular activities to orient youth to consequences for negative social behaviors. Also with follow up if substance abuse takes place.
4. Email to announce events; increase connectivity and knowledge about local events.
 - Keep efforts manageable; start small and work up
5. MDT Program
 - Multi-Disciplinary Team establishment – dealing with client specific issues including many community resources (e.g. OCS, police, parents, service providers).
 - “Getting everyone in room to discuss child’s welfare.”
 - Local justice system – waives HIDA boundaries to communicating about client

- Bristol Bay – FRC model – Agreements thru MOU's
- Scammon Bay – Tribal Court intervening in family issues

Follow-Up & Consequences

6. Follow-up teleconference Action-Planning
 - Valdez Providers Coalition
 - Copper Center
7. Advocacy
 - Sen. Harris
 - Rep. Hawker
 - Angela.Salerno@alaska.gov, 465-4765
 - Google: "Alaska Mental Health Board"
 - Alaska Youth & Family Network: FranPurdy@ayfn.org, 770-4979
 - "Meeting the Challenge"
 - SEDA.org – training in advocacy
8. BTKH Stakeholders Work Session – May 22
9. Some funding available from the Trust – www.mhtrust.org
 - Capital funding for equipment and facilities; program funding
10. Training funding from state – partnerships are good
 - Anne Gibson
 - Val Kenny
 - Also: request from TNR through quarterly reports – use logic model
11. Funding spreadsheet.

Appendix B

Small Group Break-Out Session Agenda Discussion Questions

1. Housekeeping 10:45-11:00

- Elect one record-keeper and one spokesperson from your group.
- Make sure everyone understands the ground rules for discussion.
- The aim of these discussions is to put all the ideas out on the table on ways to increase home and community-based services or otherwise support the Bring the Kids Home Initiative, and to find ways to effectively implement actions that will accomplish this goal.

2. Small Group Discussion: Identify Strengths + Weaknesses 11:00-12:00

- What strengths does your community have that will help Bring the Kids Home, and keep them home, rather than sending them for treatment outside of their home communities or the state?
- What is being done well? What makes us ready to Bring the Kids Home?
- Also, what are weaknesses in your community that make Bringing the Kids Home difficult?
- What are priority issues that need to be addressed?

3. Small Group Discussion: Community Opportunities + Solutions 1:30-2:30

- You have identified a variety of important community strengths and weaknesses.
- What are some solutions (ideas and actions) that will build upon those strengths and minimize those weaknesses?
- What kind of opportunities exist or could exist that would Bring the Kids Home?
- Think of these solutions in both the short-term (within the next 6 months) and long-term (6 or more months).

4. Small Group Discussion: Resources + Leads 2:30-3:00

- Identify existing resources that could be drawn upon in implementing the solutions you've identified.
- Brainstorm how to use these resources to create solutions.
- Identify specific people or organizations in your community that could lead each effort.
- Which ones can be done right now by your communities without additional funding or resources?
- Which ones will require more funding and/or additional resources?
- What kind of technical assistance would help you in your efforts?

5. Summarize: Record your list of Priorities 3:30-4:00

- After solutions are listed by the group, identify which ones the group feels are most important to implement.
- Which solutions are the "highest priority?" Which ones need the most urgent attention?
- Choose up to 5 top priorities and use them to fill out the priority action table.
- If it helps, create a "short-term" table of what can be done within the community within the next six months.

Then create a "long-term" table for solutions that will need additional time, resources and/or funding.

- You will use these tables to report back to the full group.

Appendix C

List of Priority Solutions

Group 1

TOP 5 PRIORITY SOLUTIONS

1. Central clearinghouse for information, funding, services - possible person connected to it
2. Work force development, incentives, work keys link, recruiter
3. Training (parent, staff mentors, employers, etc...) & agency collaboration including schools
4. Cost of living increases – housing & supports, safe housing
5. More concrete after care programs – continuum of care

Group 2

TOP 5 PRIORITY SOLUTIONS

1. Coalitions at many levels
2. Prevention – community based services
3. Workforce development with resources (\$)
4. Consistency & follow through. Incentives/Motivation.
5. Accountability/Evaluation

Group 3

TOP 5 PRIORITY SOLUTIONS

1. Training for foster care
2. Successful recruitment & retention
3. Youth court
4. E-mail network to announce events
5. MDT Development