

Pathways to Sobriety Project III Report On Services Provided

**Municipal Department of Health and Human Services
Human Services Division
Safety Links Program
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**Municipal Department of Health and Human Services
Human Services Division
Safety Links Program**

**Pathways to Sobriety III
Final Report**

September 2008

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I. Executive Findings

The Pathways to Sobriety Project provides a critical service to homeless chronic public inebriates, one of Anchorage’s most vulnerable populations. The term “chronic public inebriate” refers to persons who are homeless and alcohol-dependent, and who have histories of public inebriation. Chronic public inebriates are high frequency users of the city’s Emergency Alcohol Service System (EASS). The city’s EASS is a two-tiered system that includes: 1) the Community Service Patrol (CSP), which transports public inebriates, and 2) the Municipal Transfer Station (the city’s sobering center). In most cases, the CSP transports individuals to the Transfer Station, which provides shelter and a safe environment for public inebriates taken into protective custody. In some cases, public inebriates are transported to local hospitals.

The Pathways Project was developed to break the “revolving door” cycle of repeated usage of emergency services responding to the homeless chronic public inebriate population in Anchorage. The Municipality of Anchorage contracted with Anchorage Community Mental Health Services, Inc (ACMHS) to provide case management services for the Pathways to Sobriety Project. Case management is intended to integrate and link services for the target population including substance abuse and mental health treatment, social and income support, housing, legal assistance, veteran’s services, employment services, and other mainstream services such as transportation, health care, and food stamps. The case manager assesses the individual needs of each client and provides the appropriate referrals to substance abuse and mental health treatment services.

Funding by the Bureau of Justice has allowed the city to implement a project that has surpassed all expectations—and determined that one of the most effective tools in assisting the public inebriate is *case management services*. Case management provides intensive support to the individual struggling to achieve sobriety. This project’s success is reflected in the reduced number of Pathways client admissions to the city’s sobering center, as well as the high percentage of persons who secured permanent housing. It is also worthy to note that a high percentage of veterans, both men and women, successfully met their needs through the project.

It is important to highlight that Pathways’ success was contingent on available community services. Lack of system services, such as detoxification beds, and pre- and post- treatment beds hamper the successful outcome of individuals working to achieve sobriety. Case management services cannot be successful without each critical component in place under the continuum of care.

Below are significant findings of this project, which will shape future case management services. These findings can inform public policy regarding the system of service needed to effectively serve the homeless chronic public inebriate.

Municipal Emergency System

- Community Service Patrol transports increased dramatically from 10,382 to 14,239 between 1997 and 2007, for an overall increase of 37 percent.
- From 1997 to 2007, Transfer Station admissions increased from 17,278 to 20,481, an increase of 19 percent.
- The number of Transfer Station admissions for Pathways clients who were permanently housed through the project decreased by 72 percent following housing placements.
- Transfer Station demographics show a notable change in ethnicity over time, with a nine percent decrease in unduplicated Alaska Native/American Indian clients from 88 percent (1997-1999) to 81 percent (2004-2007). The percentage of unduplicated Caucasian clients admitted to the Transfer Station increased by 4 percent from 11 percent (1997 – 1999) to 15 percent (2004-2007).
- Alaska Native/American Indians continue to be disproportionately represented in the Transfer Station population at 81 percent while comprising only 7 percent of the Anchorage population.
- The chronic public inebriate population in Anchorage is aging; women comprise a slightly higher percentage than in prior years; Breath Alcohol Content levels (BrACs) are increasing and; homelessness is pervasive.

Pathways To Sobriety Project

A total of 253 clients were engaged in the Pathways to Sobriety Project between 2006 and 2008.

- 71 percent were male
 - 64 percent were Alaska Native/American Indian
 - 26 percent were Caucasian
 - 57 percent identified Alaska as their state of birth
 - 47 percent were single
 - 28 percent were veterans
- According to data collected for the Alaska Housing Finance Corporation, Inc., 71 out of 75 (95 percent) of those served from July 1, 2007 through June 30, 2008, were identified as Mental Health Trust beneficiaries.

- Pathways clients attempted detoxification treatment twice, on average. Of those individuals who attempted detoxification treatment, 81 percent completed treatment. On average, Pathways clients also attempted residential treatment twice. Of these, 37 percent completed treatment.
- Female veterans represented a slightly higher percentage of the Pathways population (16 percent) compared to the general population (14.1 percent).
- Since 2006, 58 clients (23 percent) have been placed in permanent housing.
- Since 2006, 43 clients (17 percent) have secured full-time employment.

Continuum of Services in Anchorage

- Over the years, there has been a significant loss of medical detoxification beds in Anchorage, from twenty in 1994 to eight in 2008.
- The final loss of eight detoxification beds in November/December 2007 most adversely affected chronic public inebriates who are non-beneficiaries of Alaska Native/American Indian services.
- In November/December 2007, four social detoxification beds were introduced into the continuum of care at Cook Inlet Tribal Council's Ernie Turner Center; however, case management professionals point to the continued need for medical detoxification beds to assist the chronic public inebriate population.
- Pretreatment is the next stepping stone following detoxification treatment, which significantly reduces the chance of relapse and return to the streets; however, there is a serious lack of pretreatment bed availability.
- Public funding has decreased dramatically over the years, and links in the continuum of care have become disconnected or withdrawn from the system.

II. Introduction

Purpose of the Pathways to Sobriety Project

The purpose of the Pathways to Sobriety Project III is to provide outreach and intensive case management services to willing individuals in the target population of chronic public inebriates who are high frequency users of the city's Emergency Alcohol Service System (EASS). The city's EASS is a two-tiered system that includes: 1) the Community Service Patrol (CSP), which transports public inebriates, and 2) the Municipal Transfer Station. In most cases, the CSP transports individuals to the Transfer Station, which provides shelter and a safe environment for public inebriates taken into protective custody. In some cases, public inebriates are transported to local hospitals.

The term "chronic public inebriate" refers to persons who are homeless and alcohol-dependent, and who have histories of public inebriation, frequent emergency room visits, arrests, or co-occurring substance use disorders and mental health disorders.¹ The majority of individuals in the targeted population are "chronically homeless", which means they are unaccompanied individuals with a substance use disorder, or co-occurring substance use and mental disorder, who have either been continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years.²

The public inebriate problem in Anchorage has been documented since the late 1970s. In 2004, the number of chronic public inebriates interfacing with the city's EASS increased significantly, requiring substantial emergency transportation and police intervention, and impacting the criminal justice system with various related misdemeanor charges. Chronic public inebriates are frequent users of the CSP and Transfer Station, as well as services provided by the Anchorage Police Department (APD), and Anchorage Fire Department (AFD).

Under Alaska Statute Title 47, the CSP can pick up inebriated persons from a public place and transport them to the Transfer Station. CSP and Transfer Station services are authorized under Protective Custody Holds (PCH) for individuals who are a danger to themselves or others as a result of drug or alcohol use. See Appendix A for more information regarding Title 47.

¹ 1. The Substance Abuse & Mental Health Services Administration, TI-08-013, Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless, CFDA No. 93.243, FY 2008

² 2 Notice of Funding Availability for the Collaborative Initiative to Help End Chronic Homelessness/Federal Register, Vol. 68, No 17/Monday, January 23, 2003, 4019. This definition is shared by the U.S. Department of Housing and Urban Development, the U.S. Department of Health and Human Services, and the U.S. Department of Veterans Affairs.

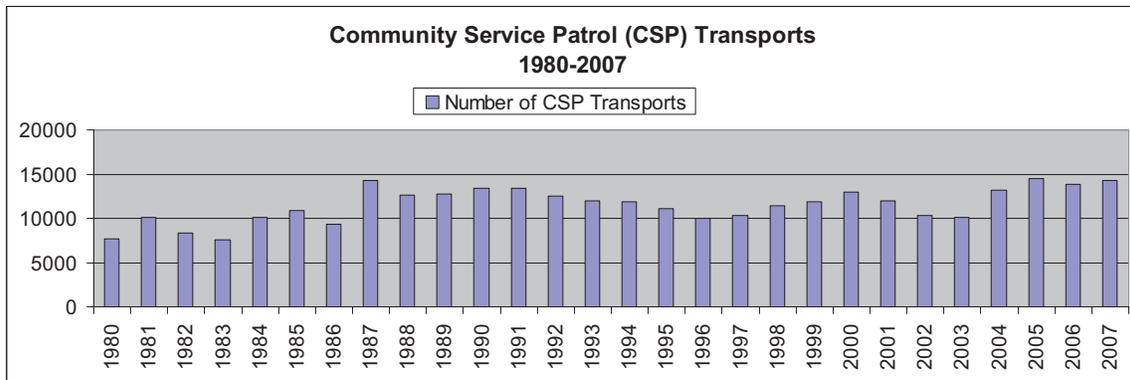
Alaska Statute 47.37.170 for PCH reads:

A person who appears to be incapacitated by alcohol or drugs in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol or drugs in a public place shall be taken to a state or municipal detention facility in the area if that appears necessary for the protection of the person's health or safety.

Community Service Patrol (CSP)

The CSP consists of two daily van shifts (noon - 4:00 AM), staffed by a driver and one Emergency Medical Technician I. During winter months, an additional van shift is added to accommodate the significant increase in admissions brought on by cold weather conditions. The vans operate in the downtown/midtown area and account for the majority of admissions to the Transfer Station. The chart below shows the number of transports between 1980 and 2007. Between 1980 and 2007, CSP transports increased by 86 percent.

Chart 1: CSP Transports, 1980-2007



Source: Anchorage Fire Department.

Table 1 shows the number of annual CSP transports from 1997 to 2007, with annual percentage change. CSP transports increased from 10,382 to 14,239 between 1997 and 2007, an overall increase of 37.2 percent. *The most recent and notable increase occurred between 2003 and 2004 at 29.8 percent.*

Table 1: CSP Transports, 1997-2007

Year	CSP Transports	Annual % Change
1997	10,382	
1998	11,426	+10.1%
1999	11,890	+4.1%
2000	12,937	+8.8%
2001	11,948	-7.6%
2002	10,357	-13.3%
2003	10,137	-2.1%
2004	13,156	+29.8%
2005	14,552	+10.6%
2006	13,833	-4.9%
2007	14,239	+2.9%

Source: Anchorage Fire Department.

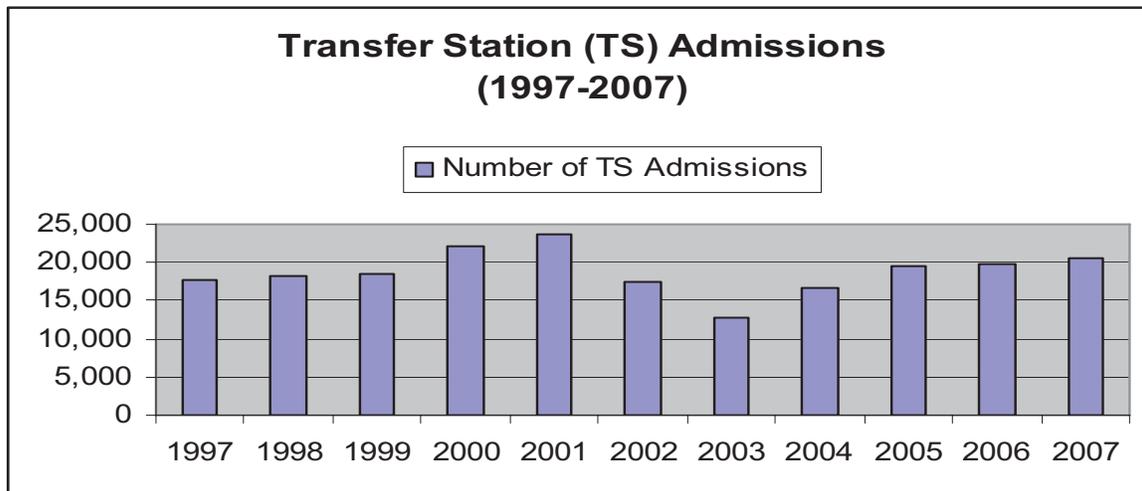


Transfer Station

It is important to note for historical purposes that the Transfer Station did not exist until the early 1990s. Anchorage's "Sleep-Off Center" was operated by the Salvation Army until July 1992, at which time the Municipality contracted services with Allvest Corporation.³ The Transfer Station provides shelter and a safe environment for public inebriates taken into protective custody, with a minimum of three staff on duty at all times, one of which is an Emergency Medical Technician I. To maintain a staff to client ratio of 10:1, this basic staffing allows for a maximum of 30 clients present at any one time. When client numbers exceed 30, additional staff is added. Clients are checked every 30 minutes to assess their physical condition throughout their stay at the Transfer Station. The Transfer Station is open 24 hours a day, 7 days a week, 365 days a year. Currently, under contract with the AFD, Purcell (NANA Corporation) provides CSP and Transfer Station services. The Transfer Station is located alongside Cook Inlet Pretrial, which is the state's jail. For clients who are combative or assaulting staff or other clients, APD will take clients from the Transfer Station to jail under a non-criminal charge for incarceration.

Chart 2 shows the number of annual Transfer Station admissions from 1997 to 2007. *From 1997 to 2007, Transfer Station admissions increased from 17,278 to 20,481, for an increase of 19 percent.*

Chart 2: Transfer Station Admissions, 1997-2007



Source: Anchorage Fire Department.

³ Municipal Department of Health and Human Services, Social Services Division, SAFE City Program, Municipal Emergency Alcohol Service System, Analysis of Data Collected Between 1992 – 1998

Table 2a shows the number of annual Transfer Station admissions from 1997 to 2007, with annual percentage change. According to a University of Alaska Anchorage (UAA) evaluation of the Pathways to Sobriety Project II, the significant percentage reduction in 2002 and 2003 is partially attributable to the case management services provided at the Transfer Station under Pathways to Sobriety Project II.⁴ Under Pathways II, the DHHS partnered with Cook Inlet Tribal Council to provide two case managers at the Transfer Station. According to the University study, the increase in Transfer Station admissions in 2004 may be the result of the Municipality's population increase.

Table 2a: Transfer Station Admissions, 1997-2007

Year	Transfer Station Admissions	Annual % Change
1997	17,278	
1998	18,357	+6.2%
1999	18,533	+1.0%
2000	22,060	+19.0%
2001	23,653	+7.2%
2002	17,548	-25.8%
2003	12,643	-28.0%
2004	16,776	+11.8%
2005	19,469	+16.1%
2006	19,687	+1.1%
2007	20,481	+4.0%

Source: Anchorage Fire Department.



⁴ Behavioral Health Research & Services, Evaluation of the Pathways to Sobriety Project, Pathways to Sobriety Data Report: July 1, 2004 to June 30, 2005, BHRS Pathways Related Technical Report No. 4

Table 2b shows that Anchorage’s population increased by nine percent between 2000 and 2007. Based on the UAA study’s assumption, increases in the Anchorage population may have contributed to increases in Transfer Station admissions over the years.

Table 2b: Anchorage Annual Population Increases

Year	Anchorage Population	Annual % Change
2000	260,283	
2001	264,840	+1.8%
2002	267,810	+1.1%
2003	273,024	+1.9%
2004	277,810	+1.8%
2005	278,294	+1.7%
2006	283,244	+1.8%
2007	283,823	+0.2%

Source: Alaska Department of Labor and Workforce Development.

Population

Table 3 shows a comparison of demographics between the Anchorage population and the Transfer Station population between 2004 and 2007.⁵ With respect to gender, there is a much greater percentage (75 percent) of males at the Transfer Station than represented in Anchorage’s population (50.6 percent). The Alaska Native/American Indian population is vastly disproportionately represented (81 percent) compared to the general population (7.3 percent). The mean age is ten years older at the Transfer Station than the general population.

Table 3: Comparison between the Anchorage Population and the Transfer Station Population, 2004-2007

	Anchorage Population	Transfer Station Population 2004 thru 2007
Gender		
Male	50.6%	75%
Female	49.4%	25%
Ethnicity		
AK Native/A.I.	7.3%	81%
White	72.2%	15%
Hispanic	5.7%	1%
Asian	5.5%	0.5%
Black	5.8%	2%
Average Age	32	42

Source: U.S. Census Bureau and Anchorage Fire Department.

⁵ U.S. Census Bureau, accessed website September 15, 2008

Table 4 shows the number of annual Transfer Station admissions between 2004 and 2007 for clients who were placed in permanent housing in 2006 and 2007. Transfer Station admissions decreased significantly for both groups in 2007. Transfer Station admissions for clients housed in 2006 decreased by 80 percent between 2006 and 2007 and 82 percent between 2004 and 2007. Clients housed in 2007 show steady annual increases in Transfer Station admissions from 2004 to 2006, and a sharp decrease in 2007 (68 percent). *Both groups together show a decrease of 72 percent between 2006 and 2007.*

Table 4: Transfer Station Admissions by Permanently Housed Pathways Clients, 2004-2007

	2004	2005	Annual % Change	2006	Annual % Change	2007	Annual % Change
Housed in 2006	192	226	+17.7%	175	-65.9%	35	-80.0%
Housed in 2007	203	282	+38.9%	420	+48.9%	134	-68.1%
Total	395	508	+28.6%	595	+17.1%	169	-71.6%

Source: Anchorage Fire Department and DHHS ServicePoint.

Overview of the Pathways to Sobriety Project

The goal of the Pathways to Sobriety Project is to decrease the repeated usage of the Emergency Alcohol Service System (EASS) by chronic public inebriates through activities and strategies that address addiction and mental health issues. The capability of the emergency care system to keep pace with the increasing number of individuals with severe treatment needs is unfeasible and economically unviable. It is widely understood in the professional field that the chronic public inebriate is beset with a myriad of physical and mental health issues requiring comprehensive medical care and attention. The Pathways to Sobriety Project is intended to address these needs through an integrated, multi-strategy framework. This approach reaches out through several agencies, because a combination of services is needed to address addiction and mental health disorders.⁶ An essential component includes placement in long-term housing and wraparound services to reduce substance abuse and maintain stable housing. The success of the project is contingent on inter-agency collaboration and coordination to meet the needs of the chronic public inebriate.⁷

Strategies within this project include:

- bridging chronic inebriates into detoxification and treatment programs
- providing referrals for medical care, employment, and mental health services
- linking the target population to transitional and permanent housing
- coordinating with therapeutic courts, including, drug, alcohol, and mental health courts
- providing referrals for veteran's services
- accessing financial support for individuals, such as Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI)
- partnering with community agencies that provide job training

Irrespective of the strategy, it is critical to offer intensive, individualized case management at the site of emergency protective services in order to bridge persons to each needed service. The Pathways to Sobriety Project provides intensive outreach and individualized, culturally appropriate case management services at the Transfer Station.

Pathways clients must navigate through a myriad of services to receive substance abuse treatment, mental health care, and find stable housing. In most cases, Pathways clients are identified and engaged in the project after being discharged from the Transfer Station. The case manager provides information on the project and begins coordinating with willing individuals to help them enter treatment.

⁶ Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature, Prepared for Translating Research into practice Subcommittee National HCH Council & HCH Clinician Network Research Committee, by Suzanne Zerger, National Health Care for the Homeless Council, June 2002.

⁷ Schumacher JE, et al. "Effective treatment of homeless substance abusers: The role of contingency management." In Higgins 1999.

For chronic public inebriates, the first step to alcohol treatment is medical clearance, which must be carried out at one of the Anchorage hospitals. Medical clearance is required prior to detoxification treatment. Following the successful completion of detoxification treatment, clients are placed in pretreatment beds (when available), while awaiting residential treatment. Clients who successfully complete residential treatment begin an outpatient program or an aftercare program for continued support. Further case management services are provided at this time to place clients in stable housing and provide referrals to employment services.

Project Goals

Beyond the strategies outlined, the Pathways to Sobriety Project also worked toward achieving the following goals: (1) establishing a *systems change agent* to institute changes at a policy-level and enhance the coordination of services; (2) provide *case management services* to triage and assess persons at the Transfer Station; and (3) provide *core emergency services* for public inebriates by providing outreach and first aid care in a secure shelter.

Goal 1:

Grant monies were used to fund a *systems change coordinator*, housed in DHHS from October 25, 2004 through December 31, 2007. DHHS continues to fund this position with department operating dollars. The goal was to institute a system change that would improve the coordination of detoxification and treatment services, law enforcement, therapeutic courts, and housing services for homeless veterans and all persons who access the Municipality's Emergency Alcohol Service System.

Goal 2:

Project funding provided *case management services* at the Transfer Station, the city's sobering center. The goal of case management was to provide access to alcohol and drug abuse detoxification and treatment. Case management services also linked persons to employment services, veteran's services, and temporary, transitional, and permanent housing. Case management services were provided by Anchorage Community Mental Health Services, Inc (ACMHS) through a contract with DHHS.

Goal 3:

Project monies supported *core emergency services* which were provided by CSP and Transfer Station services under contract. CSP transported inebriated persons from public places to a secure shelter known as the Transfer Station. At the Transfer Station, core emergency services included first aid and referral for medical clearance by a state certified Emergency Medical Technician I. DHHS administered the contract from 1980 until April 2006, when it was transitioned to the Anchorage Fire Department (AFD).

Core emergency services under this project were initially provided by the Anchorage Downtown Partnership, Inc.; however, the Municipality placed the service out for bid and Purcell Ltd. of NANA Corporation was awarded the contract on April 3rd, 2007.

The body of this report will highlight the results and impacts of the Pathways to Sobriety Project with respect to the goals outlined above.

Demographics of Public Inebriates in Anchorage

In addition to understanding the Emergency Alcohol Service System which is in place to assist the chronic public inebriate population, it is equally important to gain an understanding of the population's characteristics.

The majority of chronic public inebriates who frequent the Transfer Station are homeless, and dually-diagnosed with alcohol and/or drug abuse issues and co-occurring mental health disorders. Substance abuse and dependence is associated with behaviors that place a person in a physically hazardous situation, often leading to criminal offenses, and social and interpersonal problems.⁸ Common co-occurring mental health disorders include: depression, bipolar disorder, post traumatic stress syndrome, schizophrenia, dementia, psychosis, and acute anxiety disorders. Research from across the country indicates that 20-30 percent of homeless individuals have either a substance abuse or co-occurring mental health disorder.⁹ Consistent with national findings, data collected on Anchorage's homeless population (1,023) for a point-in-time survey, reflect that 32 percent were identified as either severely mentally ill and/or chronic substance abusers.¹⁰

Core Group

Multiple studies by DHHS indicate that a very small number of people, between 150 to 200 individuals, comprise the core group of chronic public inebriates that seriously impact the community's emergency resources. In 1999, 1,985 individuals accounted for 18,533 visits to the Transfer Station that year. Although 50 percent were admitted only one to two times, 145 individuals alone visited 40 to 75 plus times per year. These 145 individuals comprise the core group who represent only seven percent of all Transfer Station users, but consume an estimated 40 percent of all emergency alcohol services.

In 2007, 3,308 individuals accounted for 20,481 visits to the Transfer Station. Fifty-nine percent (59 percent) of all clients were admitted only one time. At the other end of the frequency spectrum, 200 individuals (six percent) accounted for 56 percent of all visits in 2007.

⁸ Definitions and Terms Relating to Co-Occurring Disorders, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Center for Substance Abuse Treatment, www.samhsa.gov, accessed September 2008.

⁹ Milby, JB, Schumacher JE, et al. "Sufficient conditions for effective treatment of substance abusing homeless persons." *Drug and Alcohol Dependence* 43(1-2); 39-47, 1996

¹⁰ Anchorage Homeless Count, January 2008, Point In Time Survey conducted by the Municipal Department of Health and Human Services, Homeless Management Information System (Safety Links Program) in partnership with Alaska Housing Finance Corporation, Inc.

Table 5 shows the frequency of Transfer Station use by 2,383 clients from October 27, 2003 through December 31, 2004. Eight percent of all clients (approximately 200 clients) account for 60 percent of all admissions and consume an estimated 40 percent of all emergency alcohol services.

Table 5: Frequency of Transfer Station Use, 2003-2004 (N=2383)

Individual's Frequency of Use (Intakes)		# of Clients	% of all Clients	# Intakes	% of all Intakes
	1 intake only	1,207	51%	1,207	8%
	2-4	601	25%	1,565	10%
	5-10	252	11%	1,781	11%
	11-18	122	5%	1,712	11%
Top 200 Users	19-60	151	6%	5,101	32%
	Top 50 Users				
	60+	50	2%	4,460	28%
Totals		2,383	100%	15,826	100%

Source: Anchorage Fire Department.

Table 6 shows the average annual BrAC levels at admission for top Transfer Station users from 2005 to 2008. BrAC levels range from 0.233 to 0.251 for top users.

Table 6: Average BrAC Levels for Top Transfer Station Users, 2005-2008

Average BrAC Level	2005	2006	2007	2008*
Top 200 Users	0.237	0.233	0.244	0.233
Top 50 Users	0.246	0.234	0.251	0.238

Source: Anchorage Fire Department.

* January through June, 2008

Chronic Public Inebriate Changes: Comparison for 1989, 1999, and 2007

Based on data collected over the last several years, changes in the chronic public inebriate population include: a higher percentage of women; a higher percentage of older age groups; and higher Breath Alcohol Content (BrAC) levels compared to prior years. Homelessness for this group is still pervasive. Additionally, there is evidence of increasing mental health disorders as documented in Transfer Station files identifying prescription medication for dementia, psychosis, and depression.

Age Groups

A comparison of data collected in 1978¹¹ and 1989¹² show changes in the ages of Anchorage’s public inebriate population. According to the data in Table 7, the public inebriate population is aging. *While the largest percentage of public inebriates were aged 25 – 44 in 1978 and 1989, the highest percentages in 1999 and 2007 were aged 35 – 54 years.*

Table 7: Anchorage Public Inebriate Age Group Comparisons, 1978, 1989, 1999, and 2007

Age Group	1978	1989	1999	2007
18 –24	11.3%	11.2%	6.1%	11.4%
25 – 34	32.3%	36.3%	18.8%	18.0%
35 – 44	28.7%	27.9%	39.8%	25.3%
45-54	14.5%	24.7%	24.8%	31.6%
55 – 64	6.1%	*	7.6%	5.3%
65 +	1.8%	*	2.8%	2.0%

Source: DHHS (age group data for 1999) and the Anchorage Fire Department (age group data for 2007).

*Data not represented in cells was not available for this comparison.

Gender Differences

In, Kelso’s 1978 Anchorage study, 80 percent of public inebriates were male, aged 25 to 34, and 70 percent were Alaska Native. Table 8 shows some of the discussed demographic changes of Anchorage’s public inebriate population that reflect a *higher percentage of women over the years (32 percent in 2007 compared to 20 percent in 1978), and a higher percentage of individuals between the ages of 35 and 54 (57 percent in 2007 compared to 44 percent in 1978).*¹³

Table 8: Anchorage Public Inebriate Demographics, 1978, 1999, 2007

Demographics	1978	1999	2007
AK Native/American Indian	70%	88%	82%
Males	80%	71%	68%
Females	20%	29%	32%
Aged 25 – 34	32%	19%	18%
Aged 35 – 44	29%	34%	25%
Aged 45 – 54	15%	25%	32%

¹¹ Kelso, Dennis (1978). “A Descriptive Analysis of the Downtown Anchorage Skid Row Population. New York: Haworth Press

¹² Segal, Bernard, (1991). *Homeless and drinking: A study of a street population.* Haworth Press, NY

¹³ Data collected from the DHHS ServicePoint data bank and Anchorage Fire Department databases.

Comparison of BrAC Levels

Based on earlier studies conducted in Anchorage, it appears that the average BrAC level of public inebriates has increased.¹⁴ In 1989, the highest percentage of BrAC levels documented at admission were between .156 -.255, while in 1999 a significant percentage (19 percent) were at .300 and higher. Table 9 shows a comparison of BrAC levels at admission from 1989 to 2007. All individuals screened for BrAC levels were admitted to the city’s Emergency Alcohol Service System. *The data shows that the percentage of individuals with BrAC levels between .256 - .300 increased by 21.5 percent between 1989 and 2007. Additionally, while there were no individuals with BrAC levels of .300 or higher in 1989, 15.5 percent of individuals had BrAC levels of .300 or higher in 2007.*

Table 9: BrAC Levels, 1989, 1999, 2007

BrAC Levels	1989*	1999**	2007***
.001 - .055	7.7%	0	0.2%
.056 - .099	4.5%	.1%	0.5%
.100- .155	18.5%	6.7%	8.0%
.156 - .200	37.4%	19.7%	20.6%
.201 - .255	31.3%	32.0%	33.2%
.256 - .300	.6%	22.7%	22.1%
.300 - +		18.8%	15.5%

* The 1989 study assessed 206 individuals.

** The 1999 assessment included 18,526 admissions.

*** The 2007 assessment included 20,216 admissions.

Homelessness, Location and Beverage of Choice

Since 1997, there have been increasing reports of homelessness by chronic public inebriates frequenting the Transfer Station. The downtown area remains the primary location where most public inebriates are picked up and transported to the Transfer Station. According to surveys conducted in 1997 and again in 2008, the beverage of choice is vodka¹⁵.

¹⁴ Segal, Bernard, (1990). *Addictive Disorders in Arctic Climates*. Haworth Press, NY and

Segal, Bernard, (1991). *Homeless and drinking: A study of a street population*. Haworth Press, NY

¹⁵ Municipal Department of Health and Human Services, Human Services Division, Safety Links Program conducted a client survey in 1997 and 2008.

III. Methodology for Pathways to Sobriety Project III

The Anchorage Fire Department contracts with Purcell, of NANA Corporation, to provide CSP and Transfer Station services. CSP and Transfer Station staff uses designated forms to collect baseline information on all persons who are sheltered at the Transfer Station or transported by CSP. Baseline information includes; name, Breath Alcohol Content at admission and discharge, ethnicity, gender, origin of birth, location of pick-up, and type of discharge. Discharge types can include third party release, medical transport to a hospital, or arrest under a non-criminal action by the APD and transported to the jail. AFD's database is also useful for identifying new candidates for outreach under the Project and is also used to determine the impact of the Pathways Project by assessing trends and admissions of Pathways clients.

The DHHS stores Pathways client information in a database system called *ServicePoint*. This system maintains Pathways client demographic data, as well as data on services accessed, referrals, and completion rates of detoxification, pretreatment, residential, outpatient and after care services. Project staff tracks the status of clients, including program completions and housing placements (temporary, transitional and permanent). *ServicePoint* allows project staff to evaluate the existing menu of services and treatment options available, identify any gaps in service and potential interventions. Both ACMHS and DHHS entered data into *ServicePoint* to track services provided by Pathways III. Only project staff is authorized to access client data. Client data is presented in aggregate form in this report to protect the identification of individual clients.

The following indicators were tracked through data entry using *ServicePoint*:

- Number of substance abuse assessments
- Number of detoxification attempts
- Number of completed detoxification attempts
- Number of alcohol treatment attempts
- Number of completed alcohol treatment attempts
- Number of mental health assessments
- Number and type of documented mental illnesses
- Number of mental health services provided
- Number of medical health services provided
- Number of clients in Mental Health Court
- Number of clients in Drug/Alcohol Court
- Number of clients incarcerated
- Number of veterans engaged
- Number placed in transitional and temporary housing
- Number placed in permanent housing
- Number of mainstream services provided including job training

IV. Implementation

Case Management Services

The Municipality of Anchorage contracted with ACMHS, Inc. on March 15, 2005 to provide outreach for case management services for the Pathways to Sobriety Project. Outreach is conducted at the Transfer Station, as well as on the streets and in the homeless camps throughout the city. Case management is intended to integrate and link services for the target population including substance abuse and mental health treatment, social and income support, housing, legal assistance, veteran's services, employment services, and other mainstream services such as transportation, health care, and food stamps. The case manager assesses the individual needs of each client and provides the appropriate referrals to substance abuse and mental health treatment services. Detoxification is the first necessary step to recovery. The case manager provides information on treatment options and assists willing individuals to enter detoxification treatment. Case management services are provided at all stages of recovery. Further assistance is provided following the completion of substance abuse treatment to assist clients in finding permanent housing and employment.

Case management provides access to a number of services that include the following:

- Referral and linkage to veteran's services.
- Access to detoxification services.
- Coordination with Therapeutic Court (drug, alcohol, mental health).
- Access to substance abuse treatment programs.
- Case management services for up to 24 months.
- Assistance with housing to maintain stability and self-sufficiency.
- Referral to employment services.

Additionally, the case manager tracks client demographics (including age, gender, veteran status, race, marital status, and ethnicity), status of clients during project duration, as well as data on services accessed, referrals, number of clients served and completion rates of detoxification, pretreatment, residential, outpatient and after care services. All data is entered into *ServicePoint*, allowing DHHS to record detailed client profiles, assess treatment outcomes, and define demographics of the chronic public inebriate population, including veteran status.

Using data extracted from *ServicePoint*, demographic information is summarized in Table 10 for the 253 individuals served by Pathways since 2006. Males account for 71 percent of Pathways clients; females account for 29 percent. The mean age of female Pathways clients is 44 years and for male clients, 48 years. The majority of Pathways clients are Alaska Native (64 percent). Caucasian clients make up the second largest ethnic group of Pathways clients (26 percent). Over half of all Pathways clients were born in Alaska (57 percent). Just over a quarter of all Pathways clients are veterans (28 percent). Further details are included in the table below.

Table 10: Demographics of Pathways Clients, 2006-2008

	Females	Percentage	Males	Percentage	Total	Percentage
Number	73	29%	180	71%	253	100%
Mean Age	44		48			
Race						
AK Native	50	68%	112	62%	162	64%
White	18	25%	48	27%	66	26%
Black	0	0%	9	5%	9	4%
Pacific Is	0	0%	3	2%	3	1%
Other	3	4%	2	1%	5	2%
Unknown	2	3%	6	3%	8	3%
State of Birth						
Alaska	46	63%	99	55%	145	57%
Other	19	26%	59	33%	78	31%
Unknown	8	11%	22	12%	30	12%
Born in Anchorage	6	8%	15	8%	21	8%
Marital Status						
Married	5	7%	10	6%	15	6%
Single	32	44%	86	48%	118	47%
Divorced	15	21%	36	20%	51	20%
Widowed	4	5%	4	2%	8	3%
Separated	8	11%	17	9%	25	10%
Unknown	9	12%	27	15%	36	14%
Veteran Status						
Yes	11	15%	61	34%	72	28%
Permanent Housing	21	29%	37	21%	58	23%

Source: DHHS *ServicePoint*.

Substance Abuse Treatment

Case management services provided by Pathways are intended to integrate and link substance abuse treatment services for the target population. The first step in alcohol treatment for chronic alcoholics is detoxification treatment, which normally lasts five days. Entering residential alcohol treatment as soon as possible following detoxification is important in order to decrease the possibility of relapse.

Because there are waitlists for residential treatment, Pathways clients are placed in pretreatment beds (when available) while awaiting residential treatment. Residential/inpatient substance abuse treatment is crucial for the target population. Chronic alcoholics require a structured environment with intensive treatment and close supervision in order to succeed. Outpatient treatment is only appropriate for this population in order to provide continued support following the completion of residential treatment. Outpatient treatment is not appropriate as the primary source of alcohol treatment for chronic alcoholics; this would only be appropriate for individuals with substance abuse problems that can effectively be resolved in a less structured program.

Chronic public inebriates who successfully complete residential treatment often take part in an outpatient program or an aftercare program for continued support. Aftercare programs support clients in their ongoing recovery following treatment. Aftercare provides support and maintains connections with the agency but generally the client is functioning independently at this time using the skills learned in treatment to maintain sobriety. Further case management services are provided to clients following substance abuse treatment to assist them with finding stable housing and sustained income. Sustained income can include Supplemental Security Income, Social Security Disability Insurance, and/or securing employment.

Clients of Pathways are referred to a number of alcohol treatment programs in Anchorage, depending on the availability of beds. The only detoxification treatment service currently available in Anchorage is offered by the Cook Inlet Tribal Council (CITC) at the Ernie Turner Center. During Pathways III, detoxification services were provided by the Salvation Army Clitheroe Center (until August of 2007, when the detoxification unit closed down) and the Ernie Turner Center. Pretreatment was provided by Nugen's Ranch and the Henry House. Residential/Inpatient treatment was provided by Nugen's Ranch, the Genesis House, Akeela, Inc., the Ernie Turner Center, the Salvation Army Clitheroe Center, and the Salvation Army Adult Rehabilitation Program. In some cases, clients were transported to communities outside of Anchorage to receive residential treatment. Descriptions of the substance abuse treatment services provided at each facility in Anchorage are provided below. See Appendix B for a list of local treatment facilities and contact information.

Nugen's Ranch

Nugen's Ranch is a large treatment facility on an eight-acre site that became the first **long-term treatment program** in Alaska to receive national accreditation in 1993 through the Commission on Accreditation of Rehabilitation Facilities (CARF). Nugen's Ranch is funded through State of Alaska grant money, private donations, thrift store and produce sales at the facility, and sliding scale client fees which are determined by the client's income.

Nugen's Ranch provides a long-term residential substance abuse treatment program. The program provides 25 beds and the length of stay varies from 6 months to 2 years. Each client receives a personalized assessment from a counselor before beginning treatment. The client and the counselor develop a treatment plan together that outlines problem areas and the necessary steps to address them. During treatment, clients take part in regular individual and group therapy sessions. The treatment program at Nugen's Ranch is based on the AA Twelve Step philosophy. Staff members at Nugen's Ranch lead educational programs and provide guidance on issues such as money management and nutrition.

Following treatment, each client works with a counselor to develop an “aftercare” plan before returning to his or her home. This plan allows for continuing support of clients after they leave Nugen's Ranch. The plan includes referrals to available community agencies, as needed.

Genesis House

The Genesis House provides a mix of **mental health and substance abuse services** to individuals with co-occurring mental and substance abuse disorders. The Mission Statement of Genesis Recovery Services, Inc., is to target adult men, women, and families needing behavioral health services. Services are provided for those experiencing substance abuse disorders, mental health disorders, dual diagnosis, lack of safe housing and family dysfunction.

The Genesis House provides a 20-bed residential treatment program including long-term treatment (more than 30 days) and short-term treatment (30 days or less), as well as outpatient treatment, and partial hospitalization/day treatment. Genesis Recovery Services provide 24-hour monitored care, transitional living, family treatment and/or assessment and referral to assist the achievement and maintenance of sobriety. After being evaluated by a staff professional, clients receive the support of counselors, nurses and other experienced professionals. Together they provide group and individual support.

In addition to treatment services, Genesis House provides a safe and sober transitional living environment for individuals who are committed to a lifestyle of sobriety located in close proximity to the treatment facility. Genesis provides monitoring by staff to insure that the safety and alcohol/drug free environment is maintained. Individuals have the option of renting single apartments or sharing apartments with private bedrooms with

other individuals dedicated to remaining substance free. Thirteen apartments are provided at the Genesis House.

Akeela, Inc.

Akeela, Inc. is a non-profit organization offering a comprehensive array of services for the **prevention and treatment of substance and alcohol abuse** in Anchorage and other communities throughout the state. Akeela was founded in 1974 and serves the community by striving to "enhance the ability of citizens and their families to succeed in life." All rehabilitation program components are licensed by the Alaska Division of Behavioral Health and accredited by the Commission on Accreditation of Rehabilitative Facilities.

Akeela provides a long-term, 20-bed residential treatment program. This program has operated in Anchorage for nearly 30 years and is funded by the Alaska Division of Behavioral Health. Akeela's residential program serves a co-ed population of men and women who have a primary diagnosis of substance abuse, and a broad spectrum of special need populations including pregnant and post partum drug-addicted women, substance abusers with HIV/AIDS and Hepatitis C, mentally ill substance abusers, criminal justice populations, the homeless, the physically handicapped, and veterans.

Akeela, Inc. also provides drug and alcohol free transitional housing, including buildings with fourteen apartments for clients who need housing when they leave treatment.

Cook Inlet Tribal Council - Ernie Turner Center

Residential services are composed of four distinct treatment units located at CITC's Ernie Turner Center. Additionally, two outpatient programs are offered.

Wisdom Place is an 8-bed residential unit serving Alaska Native Elders. Adults must be age 55 and older and assessed to need this level of support in order to be eligible.

Recovery Journey is an 8-bed, 60 to 90 day co-ed residential program that is specifically designed to treat adults over the age of 18 and under the age of 55 who have been assessed to receive this level of care. The Recovery Journey program accommodates up to six patients with co-occurring disorders (mental health and substance abuse).

Transitions is a 6-bed co-ed unit designed for homeless individuals who have extensive involvement with Community Patrol Services as determined by the number of pick-ups in the last 30 days. Services are provided for up to 6 months.

Emergency Care/Detox Unit is a 12-bed adult unit. Six of the medically monitored beds are reserved for those who are eligible for Indian Health Services benefits. Six additional beds are available for non-beneficiaries. Two of these six beds are medically-monitored beds and four are clinically-managed beds (also called social detoxification beds). See Appendix C for more information concerning social detoxification.

Co Ed Adult Outpatient Unit serves adult men and women who experience substance abuse or addiction and have been assessed and recommended to Level I or II Treatment and Continuing Care. Outpatient (OP) care includes group and individual counseling, mental health counseling, case management and other activities aimed at encouraging sobriety and recovery. Clients remain in treatment for 3-6 months, which includes Continuing Care.

Continuing Care Services are provided for those adults who have just completed outpatient treatment. Continuing Care is individualized and can include a weekly group, one-on-one counseling, and some case management prior to graduation. Continuing Care allows the client to maintain connections with the agency; however, the client is expected to be functioning independently using the skills learned in treatment to remain in recovery.

Salvation Army Clitheroe Center

The Salvation Army Clitheroe Center is a **comprehensive substance abuse and dual diagnosis treatment program** providing treatment services to adults who are addicted to alcohol and other drugs. Residential programs are provided for individuals with substance abuse disorders and co-occurring mental health disorders. The Clitheroe Center also provides family services. Outpatient services provide counseling and support for those who have completed inpatient treatment or for those who are not in need of inpatient treatment. Clitheroe staff also work within the corrections system to provide substance abuse counseling for inmates in Anchorage area correctional facilities.

The Salvation Army Clitheroe Center is licensed and funded, in part, through grants from the State Department of Health & Social Services Division of Behavioral Health. The program is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The Clitheroe Center's programs are described below.

Intermediate Care Unit (ICU) is a 6-bed residential treatment program designed for people who want to stop using but are unable to do so in their present environment.

Long Term Care Unit (LTC) provides a 6-bed longer term residential treatment for chronically addicted and more severely impaired substance abusers. The program serves individuals for whom short-term residential treatment has proven to be ineffective.

Dual Diagnosis Program (DD) offers a 12-bed residential program and an outpatient program for individuals suffering from serious mental illness and substance abuse. Treatment focuses on a broad range of problems common to this population.

Reflections Program is a 16-bed program that provides individual, family and group counseling, case management, referral, vocational services and parenting skills training for women. In addition to chemical dependency and relapse prevention, other issues such as physical and sexual abuse, relationships, self-esteem, women's health issues and sexuality are addressed.

Outpatient Program (OP) is designed for people with substance abuse problems that can effectively be resolved without residential treatment. The intensity and design of the outpatient program is individualized for each client.

Aftercare/Continuing Care Program (CC) supports clients in their ongoing recovery following treatment. All Clitheroe Center clients completing primary treatment are referred into the Aftercare Program.

Treatment Outcomes

Table 11 shows the total number of substance abuse treatment services provided to Pathways clients by treatment type, the total number of completions by treatment type, as well as the number of individuals attempting and completing each treatment type since 2006. Individual clients may attempt and complete more than one treatment type and/or cycle through more than one time; therefore duplicate clients are included in the table below. For example, 120 individuals attempted detoxification treatment 223 times. Therefore, Pathways clients attempted detoxification treatment twice, on average. Of those individuals who attempted detoxification treatment, 81 percent completed treatment. On average, Pathways clients also attempted residential treatment twice. Of these, 37 percent completed treatment.

Of the total number of treatment attempts by Pathways clients across all treatment types (485), half were completed (244), a completion rate of 50 percent. Seven in ten detoxification treatment attempts (70 percent) were completed, compared to completion rates of 36 percent for residential/inpatient treatment and 28 percent for outpatient treatment.

Table 11: Treatment Attempts and Completions, 2006-2008

Type of Treatment	Individual Attempts	Total # of Attempts	Individual Completions	Total # of Completions	% of Completions	% of Individuals Completing Treatment
Detoxification	120	223	97	157	70%	81%
Residential/Inpatient Treatment	124	198	46	71	36%	37%
Outpatient Treatment	8	18	5	5	28%	63%
Naltrexone Treatment	3	4	0	0	0%	0%
After Care	33	42	11	11	26%	33%
Total	*	485	*	244	50%	*

Source: DHHS *ServicePoint*.

* There are duplicate clients between treatment types.

The case manager maintains records of all treatment outcomes, including successful and unsuccessful attempts which are entered into *ServicePoint*. Reasons for failure to complete treatment are provided in Table 12. In the case of pretreatment, residential treatment and aftercare, “walking out” of treatment was the most common reason for failed treatment attempts. Being placed on a waitlist was the most common reason for failure to complete detoxification. Fourteen percent of all detoxification attempts failed because clients were placed on a waitlist. Over the years, there has been a substantial decrease in the number of detoxification beds available in Anchorage. This shortage of beds has resulted in waitlists for detoxification treatment.

Table 12: Reasons for Failed Treatment Attempts, 2006-2008

	Detoxification N=223 Attempts		Pretreatment N=159 Attempts		Residential Treatment N=196 Attempts		Outpatient Treatment N=18 Attempts		After Care N=42 Attempts	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Walked Out	22	10%	38	24%	55	28%	2	11%	9	21%
Expelled	2	1%	19	12%	8	4%	2	11%	5	12%
Wait List	31	14%	8	5%	20	10%	0	0%	1	2%
Other	9	4%	4	2%	24	12%	5	28%	12	29%
Unknown Outcome	2	1%	8	5%	20	10%	4	22%	4	10%

Source: DHHS *ServicePoint*.

Note: Categories under “Other” include the following: referred, transferred, no show/refused, medical discharge, safe stay, and banned.

Mental Health Services

The majority of Transfer Station users are considered dually-diagnosed with alcohol and/or drug abuse issues and co-occurring mental health disorders. Common co-occurring mental health disorders include: depression, bipolar disorder, post traumatic stress syndrome, schizophrenia, dementia, psychosis and acute anxiety disorders. The Pathways to Sobriety Project provides assessment of individuals' mental health status and referral to mental health treatment. Table 13 shows the number of mental health treatment services provided to Pathways clients. It should be noted that individual clients may be referred to more than one treatment type and/or more than one time, therefore duplicate clients are included in the table below. In addition to the treatment service provided below, Pathways also provided 72 transports to mental health appointments.

The most consistent and accurate data collection and reporting on mental illness took place during the past year. From July 2007 to June 2008, 71 out of 75 Pathways clients served during this timeframe were diagnosed with a mental illness, accounting for 95 percent of all clients served in the last year.

Table 13: Mental Health Treatment Services Provided, 2006-2008

Mental Health Treatment Services	Total # of Mental Health Treatment Services Provided to Pathways Clients
Individual Counseling	28
Mental Health Case Management	26
Outpatient Evaluation	5
Psychiatric Hospitalization	2
Day Treatment Program	1
Total	62

Source: DHHS *ServicePoint*.

Services Provided to Veterans

According to the U.S. Census, the Municipality of Anchorage has a total of 198,770 residents who are 18 years of age and older, of which 15 percent (30,073) are veterans. Of this veteran population, males account for 85.9 percent or a total of 25,833 and females account for 14.1 percent or a total of 4,240. Table 14 shows the total number of veterans served through Pathways. Based on gender, there is a slightly smaller percentage (-0.9 percent) of male veterans served by Pathways and a slightly higher percentage of female veterans (+0.9 percent) served compared to those represented in Anchorage's population. Females account for 15 percent of all veterans served by Pathways and males account for 85 percent. A total of 72 veterans have been served through Pathways since 2006.

Table 14: Comparison of Veterans in the Anchorage Population vs. Pathways Client Population, 2006-2008 (N=72)

	Anchorage Veterans	Anchorage Percentage	Pathways Veterans	Pathways Percentage	Percentage Difference
Male	25,833	85.9%	61	85%	-0.9%
Female	4,240	14.1%	11	15%	+0.9%
Total	30,073	100%	72	100%	

Source: DHHS ServicePoint.

All veterans served by Pathways have received at least one of the following mainstream services: case management, transportation, substance abuse treatment, veteran's services, primary health care, housing/rental assistance, food stamps, mental health service, and job training. It should be noted that individual clients may receive more than one mainstream service and/or more than one time; therefore, duplicate clients are included in the table below. The total number of unduplicated clients in the table below is 72.

Table 15: Mainstream Services Provided to Veterans, 2006-2008 (N=72)

Mainstream Services	Total # of Mainstream Services Provided to Veteran Clients
Case Management	163
Transportation	108
Substance Abuse Treatment	99
Veteran's Services	47
Primary Health Care	36
Housing/Rental Assistance	19
Food Stamps	12
Mental Health Service	8
Job Training	3

Source: DHHS ServicePoint.

All veterans served by Pathways received one or more types of substance abuse treatment. Table 16 shows the total number of substance abuse treatment services provided to veteran clients by treatment type, the total number of completions by treatment type, as well as the number of individuals attempting and completing each treatment type since 2006. Individual clients may attempt and complete more than one treatment type and/or cycle through more than one time; therefore, duplicate clients are included in the table below. For example, 30 veterans attempted detoxification 59 times. Therefore, veteran clients attempted detoxification treatment twice, on average. Of those individuals who attempted detoxification treatment, 73 percent completed treatment.

Of the total number of treatment attempts by veteran clients (136), approximately two in five of those treatment attempts were completed (57), a completion rate of 42 percent. Nearly three in five detoxification treatment attempts (59 percent) were completed. Less than one third of all residential/inpatient treatment attempts were completed (29 percent).

Table 16: Treatment Outcomes for Veterans, 2006-2008 (N=72)

Substance Abuse Treatment Type	Individual Attempts	Total # of Treatment Attempts	Individual Completions	Total # of Completed Treatments	Percentage of Completions	% of Individuals Completing Treatment
Detoxification	30	59	22	35	59%	73%
Residential/Inpatient	37	58	16	17	29%	43%
After Care	9	9	4	4	44%	44%
Outpatient	4	4	1	1	25%	25%
Naltrexone Treatment	2	3	0	0	0%	0%
AA/NA	2	3	0	0	0%	0%
Total	*	136	*	57	42%	*

Source: DHHS *ServicePoint*.

* There are duplicate clients between treatment types.

One third of all veteran clients in the Pathways program have received substance abuse treatment through the Veterans Administration (VA) Domiciliary or Veterans Administration Outpatient Services. It should be noted that many veterans do attend continued recovery services including PTSD classes and relapse groups at the VA Domiciliary twice per week. However, these classes are not considered to be “after care” services. This accounts for the low number of veteran clients attempting aftercare treatment attempts, as outlined in Table 16 above.

Table 17: VA Treatment Outcomes, 2006-2008

VA Substance Abuse Services	Total # of Treatment Attempts	Total # of Completed Treatments
VA Domiciliary	26	10
VA Outpatient Services	6	3
Total	32	13

Source: DHHS *ServicePoint*.

Client Case Status

The case manager maintains records of all contacts, assessments, treatment, referrals, housing placements and other services, which are entered into *ServicePoint*.

Table 18 shows the project status in terms of number of closed/inactive and active client cases and reason for leaving the program. Nearly one in four clients (23 percent) is permanently housed. One in five clients (18 percent) either relapsed or refused service.

Table 18: Project Status, 2006-2008 (N=253)

Project Status	Number	Percentage
Active	84	33%
Closed/Inactive	169	67%
Reason for leaving		
Completed Pathways, Permanently Housed	58	23%
No Contact	31	12%
Relapsed	30	12%
Refused Service	16	6%
Deceased	13	5%
Unknown Reason	8	3%
Incarcerated	8	3%
Moved away from Anchorage	5	2%

Source: DHHS *ServicePoint*.

Therapeutic Court

The Pathways case manager regularly works with the State of Alaska's Wellness Court, and Partners for Progress, to provide alternate sentencing for persons who have been admitted to needed treatment services. ACHMS Inc also administers its own Jail Diversion Program and Pathways clients for whom this is an appropriate venue are served in this program.

Since 2006, 25 clients have been involved in therapeutic court, including three in drug/alcohol court and 22 in mental health court.

Table 19: Therapeutic Court Involvement, 2006-2008

Total # in Therapeutic Court	
Total # Mental Health Court	22
Total # Drug/Alcohol Court	3
Total	25

Source: DHHS *ServicePoint*.

Housing Placements and Mainstream Services Provided

Table 20 shows the total number of housing placements, broken down by permanent, transitional and temporary housing. Since 2006, 58 clients have been placed in permanent housing, which accounts for 23 percent of all clients served since 2006. It should be noted that individual clients may be placed in more than one type of housing and/or more than one time, therefore duplicate clients are included under transitional and temporary housing placements in Table 21. Pretreatment and residential treatment placements are not included in this table; however, these placements also served as temporary housing for clients.

Table 20: Housing Placements, 2006-2008

Housing Type	Number of Placements
Permanent Housing	58
Transitional Housing	28
Temporary	19
Total	105

Source: DHHS ServicePoint.

The case manager works with clients to access housing, health care, job training, clothing, food, home furnishing and other mainstream services to gain self-sufficiency. A total of 43 Pathways clients (17 percent) secured full-time employment since 2006. Table 21 shows the number of mainstream services provided to Pathways clients. It should be noted that individual clients may receive more than one mainstream service and/or more than one time; therefore, duplicate clients are included in the table below.

Table 21: Mainstream Services Provided, 2006-2008

Mainstream Services	Total # of Mainstream Services Provided to Pathways Clients
Substance Abuse Treatment	643
Case Management	569
Transportation	407
Primary Health Care	174
Housing/Rental Assistance	67
Mental Health Service	62
Veteran's Services	57
Food Stamps	55
Job Training	52

Source: DHHS ServicePoint.

All available community resources are utilized to assist clients to attain the ultimate goal of clean, sober self-sufficiency in the community. The Pathways case manager has a great deal of experience in the community and has established relationships with other provider agencies. The implementation of the interagency cooperative components of the Service Point Homeless Management Information System has greatly enhanced the availability of resources to clients.

Assessments

A number of agencies participating in this project provide assessments which are necessary for entrance into treatment programs. A positive accomplishment toward this goal has been the increased willingness of the treatment programs to accept assessments performed by Pathways case managers. Since ACMHS Inc can perform these assessments for both alcohol and mental health issues, it has led to much smoother transitions for clients.

From mental health assessments carried out on 91 Pathways clients, the following types of mental health illnesses were diagnosed.

Table 22: Type of Mental Illness, 2006-2008 (N=91)

Type of Mental Illness	Total # of Mental Health Assessments
Depression	23
Bipolar Disorder	21
Posttraumatic Stress Disorder	13
Unknown Mental Illness	12
Anxiety/Panic Disorder	8
Schizophrenia	4
Schizoaffective Disorder	4
Personality Disorder	3
Dual Diagnosis	2
Dementia/Alzheimer's	1
Total	91

Source: DHHS ServicePoint.

Table 23 shows the number of substance abuse assessments that were completed and the status of pending assessments. Note that individual clients may be assessed more than once, therefore duplicate clients are included in the table below.

Table 23: Substance Abuse Assessments Provided, 2006-2008

Substance Abuse Assessment Status	Total # of Substance Abuse Assessments
Completed	549
Not Scheduled	44
Scheduled	40
Total	633

Source: DHHS ServicePoint.

V. Gaps in Alcohol Treatment Services

Detoxification Services

Over the past 14 years, there has been a substantial decrease in the number of detoxification beds available in Anchorage. According to a 1999 analysis of the Municipality's Emergency Alcohol Service System, there were three components: (1) the Community Service Patrol; (2) the Transfer Station (then located at 6th and C Street); and (3) the Detoxification Unit, located at Point Woronzof¹⁶. Starting in the mid 1990s, there began an abrupt reduction of detoxification services.

In July 1994, municipal and state funded detoxification beds were reduced from twenty to fifteen, of which eight of the beds were reserved specifically for CSP/Transfer Station clients. In March 1996, the CSP/Transfer Station reserved beds were further reduced from eight to four. In October 1996, municipal and state funded beds were further reduced from fifteen to eight, with no beds exclusively reserved for CSP/Transfer Station clients. After 2000, the Municipality no longer provided financial support for detoxification services, and the Salvation Army began receiving monies directly from the State of Alaska. Due to lack of adequate funding, the Salvation Army Clitheroe Center (SACC) closed down its eight-bed detoxification unit on August 10th 2007. SACC remains Alaska's largest comprehensive substance abuse treatment facility, providing both long-term and short-term residential treatment programs and outpatient services.

Presently, there is a significant shortage of detoxification and pretreatment beds in Anchorage. Alcoholism has long been recognized as the state's number one behavioral health problem. Alcohol abuse and dependence in the state is at 14 percent, twice the national average. Those individuals seeking detoxification services are often placed on waitlists. Many addicts lose motivation to enter treatment if they are not admitted immediately. Currently, Cook Inlet Tribal Council's (CITC) Ernie Turner Center is the only treatment facility in the state of Alaska that offers detoxification services. In November 2007, the state contracted services with CITC to expand its detoxification services from six beds for Alaska Native/American Indian beneficiaries, to 12 beds. The additional six beds funded by the state provide four social and two medical detoxification beds. Medically monitored beds provide a high level of medical care and supervision. "Social detoxification" is provided in a residential nonmedical setting for individuals whose alcohol withdrawal symptoms do not require medical monitoring. See Appendix C for more information on social detoxification. Below is a more comprehensive outline of available services and the impact on the Pathways to Sobriety Project.

¹⁶ Municipal Department of Health and Human Services, Social Services Division, SAFE City Program, Municipal Emergency Alcohol Service System, Analysis of Data Collected Between 1992 – 1998

Salvation Army Clitheroe Detoxification Unit

To understand the impacts of the loss of detoxification services provided by Salvation Army, it is important to analyze client usage. The majority of SACC's detoxification patients were low income and few had insurance benefits. The total number of annual admissions and demographics of clients served by SACC in the detoxification unit between FY2002 and FY2007 are included in Table 24. Between FY2002 and 2007, the majority of clients were male, Caucasian, and between the ages of 30 and 49 (with the highest percentage of clients between the ages of 40-49). Alaska Native clients make up the second largest ethnic group of clients served.

Table 24: Demographics of SACC Detox Patients, FY 2002 - FY 2007

	FY02	FY03	FY04	FY05	FY06	FY07
Total Admissions	960	922	928	713	911	876
Gender						
Male	72%	68%	67%	67%	62%	60%
Female	28%	32%	33%	33%	38%	40%
Age						
Under 20	<1%	1%	1%	1%	3%	1%
20-29	8%	14%	12%	17%	19%	23%
30-39	34%	31%	34%	30%	30%	29%
40-49	39%	39%	38%	35%	31%	32%
50-59	16%	15%	14%	15%	16%	13%
60-69	2%	1%	1%	1%	<1%	2%
70+	0%	0%	0%	<1%	<1%	0%
Ethnicity						
Caucasian	59%	53%	62%	61%	61%	60%
Black	7%	7%	7%	8%	5%	5%
American Indian	4%	2%	4%	2%	1%	3%
AK Native	27%	34%	23%	25%	24%	25%
Hispanic	<1%	1%	2%	<1%	4%	3%
Asian	<1%	<1%	<1%	>1%	1%	2%
Other	2%	2%	1%	3%	4%	2%

Source: Salvation Army Clitheroe Center.

Because the majority of SACC’s detoxification patients were low income without insurance benefits, the program was heavily dependent upon adequate state grant funding. SACC’s detoxification unit received no increases in state grant funding from 1993 through 2004 despite increases in operating costs. In FY 2005, the program received a \$259,400 cut from the State of Alaska, Division of Behavioral Health. This reduction was reversed temporarily through a one-year earmark from SAMHSA (federal grant) that ended in FY 2006. SACC researched many options for continued funding through no avail.

This unit required medical expertise because of the severely ill individuals served and the risks associated with alcohol/drug withdrawal. SACC was not able to compete with local hospitals and medical clinics for a very limited pool of nurses. SACC could not recruit and retain employees in this extremely competitive market without additional funding from the State of Alaska that allows competitive wages. As a result, in FY 2007 the bed capacity was decreased and the unit was eventually closed. See Table 25 for an overview of the loss of detoxification beds from 2004 to 2008.

Table 25: Detoxification Beds Available in Anchorage, 2004-2008

	2004	2005	2006	2007 (Jan – Aug)	2008
Salvation Army Clitheroe Center	8	8	8	8	0
CITC Ernie Turner Center (non-beneficiaries only)	6	6	6	6	6
Total Detox Beds	14	14	14	14	6*

Source: Salvation Army Clitheroe Center and CITC Ernie Turner Center.

Note: CITC currently provides a total of 12 beds, six of which are available only for beneficiaries, and an additional six available for non-beneficiaries (four are social detoxification beds and two are medically-monitored beds).

* Including four social detoxification beds.

CITC Ernie Turner Center

The importance of the partnership between the State of Alaska, Municipality of Anchorage, and CITC cannot be stressed enough. CITC partnered with the Municipality over six years ago to implement Pathways to Sobriety I and II. CITC’s establishment of six detoxification beds to serve the chronic public inebriate is commendable, and much needed to serve this vulnerable population.

The State of Alaska turned to CITC to begin a new effort to replace the loss of SACC services. The State of Alaska awarded a grant to CITC’s Ernie Turner Center (ETC) to expand its detoxification services. ETC began with six detoxification beds and has increased the number of beds to 12. Six of the medically monitored beds are covered by a grant from Indian Health Services (IHS) and reserved for those who are eligible for IHS benefits. The other six beds are available to all non-beneficiaries. These six beds are funded by an annual \$750,000 state grant, with remaining costs covered by CITC and Southcentral Foundation.

Two of these six beds are medically-monitored beds, which provide a high level of care and supervision; four are clinically-managed beds (also called social detoxification beds), which offer services for individuals whose alcohol withdrawal symptoms need 24-hour care but do not rise to the higher level of medical monitoring.

The Ernie Turner Center (ETC) detoxification unit currently employs four full-time nurses and three on-call nurses, as well as two case managers. Two nurses work each shift. Generally, detoxification services last four to five days for each patient. The majority of detoxification patients served at the ETC are homeless (68-70 percent) and dually diagnosed with a mental illness. The majority of the patients at the ETC detoxification unit also have medical conditions such as HIV, hepatitis, heart conditions and diabetes. Additionally, many of the patients are victims of domestic violence.

There has been an increase in patients seeking detoxification services from opiates, including heroin, and legal prescription pain killers. Opiate withdrawal, while extremely uncomfortable, is generally not considered fatal. Alcohol withdrawal can be fatal; therefore, the decision was made to prioritize patients with the most dangerous withdrawal symptoms in ETC's limited bed space. In order to ensure that funds are not spent on the same person repeatedly, a wait time between possible admissions was implemented that allows patients to return every 60 days. This was lengthened to 90 days for patients who leave without completing detoxification. As a result, accessibility to new patients has increased. The completion rate for those discharged in the last quarter averaged 78 percent. This is much higher than the national average of 55 percent, as reported through the Treatment Episode Data Set for Medical Detoxification (2003 rates), by the U.S. Department of Health and Human Services.

The increase in the availability of bed space due to state funding allows ETC to serve the Alaska Native/American Indian population at almost double the previous capacity. Those entering into the "open" state beds are approximately 74 percent Alaska Native/American Indian (per last 2008 quarterly submission). However, clinically-managed beds are not appropriate for Pathways clients because this population requires a higher level of care and supervision. This leaves only two medically-monitored detoxification beds available for non-beneficiaries. Therefore, the number of medically-monitored beds available to Pathways clients who are non-beneficiaries has decreased from eight (at the SACC) to two beds at ETC since 2007.

According to data collected for the Pathways to Sobriety Project and project staff, the loss of beds has hampered efforts to bridge some clients to detoxification treatment. According to Transfer Station data (2004-2007), 15 percent of Transfer Station users are Caucasian or a non-beneficiary, as is 26 percent of the Pathways to Sobriety clientele. For the Pathways Project, the loss of medical detoxification beds reduces the opportunities to assist the project's non-beneficiary clients.

Table 26 outlines the current total of eight medical detoxification beds and four social detoxification beds.

Table 26: Medical and Social Detoxification Beds in Anchorage, 2008

Available Detoxification Beds	2008
Salvation Army Clitheroe Detox Center	0
CITC Ernie Turner Center Medical Detox Beds Beneficiaries Only	6
CITC Ernie Turner Center Medical Detox Beds Non-Beneficiaries	2
CITC Ernie Turner Center Social Detox Beds Non-Beneficiaries & Beneficiaries	4
Total Medical Detox Beds	8
Total Social Detox Beds	4
Total Detoxification Beds	12

Source: Salvation Army Clitheroe Center and CITC Ernie Turner Center.

CITC Ernie Turner Wait List

Currently, there is a waitlist for detoxification beds at the Ernie Turner Center (ETC). Every 24 hours, 15 to 20 individuals requesting detoxification services are turned away. Patients who withdraw from substances typically self-medicate by using more of the substance to which they are addicted. Therefore, waitlists often result in patients losing their motivation for treatment, especially when they are using heavily. The ETC requires individuals to call back every day to maintain their place on the waitlist. If they fail to call in after 24 hours, their name will be moved to the bottom of the list. If they fail to call back after 48 hours, their name is removed from the waitlist. Individuals can wait anywhere from two to 20 days for a detoxification bed. In one case, a client called in for 16 consecutive days before he was admitted into detoxification. Those with IHS benefits are more likely to get admitted within a five day period because there are more beds available to them. On average, those without IHS benefits will wait seven to 10 days, while those with IHS benefits will wait two to five days.

Secure Detoxification

The loss of detoxification beds in Anchorage over the past several years has put a strain on city paramedics and police. Many detoxification patients are chronic public inebriates, who are picked up from the streets and parks of Anchorage by the police, CSP and city paramedics. The Municipality of Anchorage is currently working with the State to develop a secure detoxification treatment center in Anchorage to serve chronic public inebriates at Point Woronzof.

The State of Alaska, Department of Health and Social Services, recently awarded \$1,157,000 for both a capital component and an operational component.

The capital component would complete facility modifications that will allow a “secure detoxification” unit to be opened at the former location of Salvation Army’s Clitheroe Detoxification Center. Secure modifications include fencing the facility. These modifications will allow for as many as 10 secure detoxification beds to be brought on-line and provide a much needed service for those individuals who are extremely treatment resistant, severely at risk, and can be treated only through the use of AS Title 47/Involuntary Commitment, as defined in the Alaska State Statute 47.37.190 below.

(a) A spouse or guardian, a relative, the certifying physician, physician assistant, advanced nurse practitioner, or the administrator in charge of an approved public treatment facility may petition the court for a 30-day involuntary commitment order. The petition must allege that the person is an alcoholic or drug abuser who (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol or drugs. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician, physician assistant, or advanced nurse practitioner who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition. The certificate must set out the physician's, physician assistant's, or advanced nurse practitioner's findings of the examination in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on

(1) the petitioner;

(2) the person whose commitment is sought or the person's guardian, if any;

(3) the attorney representing the person whose commitment is sought;

(4) the administrator in charge of the approved public or private treatment facility in which the committed person has been committed for emergency care; and

(5) any other person the court considers appropriate.

(c) A person who is the subject of a petition filed under this section does not have the right to a jury.

According to Alaska State Statute 47.37.207, when a person committed under Alaska State Statute 47.37.190 is absent from a treatment facility without authorization, the administrator, or that person's designee, may contact peace officers who shall take the person into custody and return the respondent to the treatment facility.

This new secure detoxification service will provide involuntary substance abuse treatment for people who are incapacitated by their addiction and are a danger to themselves and/or others. The ten beds would be available for involuntary commitment cases from the well documented population of persons with addictions or co-occurring substance abuse and mental health disorders who, in a best case scenario, chronically recycle through the city's limited non-secure treatment services, emergency rooms, and sleep-off facility. This unit would assist severely at-risk Alaskans who may lack the ability to make reasonable choices for their health and well-being and provide that critical and often difficult "first step" toward ending the cycle of drug and alcohol addiction. Proposals have been approved from RSA Engineering and LCMF Engineering to do the design work for the modifications to the facility. At this time, the Municipality has not chosen a contractor to provide the secure detoxification service.

Pretreatment

For those Pathways clients who successfully complete detoxification, often there are no pretreatment beds available for them while they await residential substance abuse treatment. In cases where patients have nowhere to go following detoxification, they inevitably return to the street and relapse. Currently, the only pretreatment option for Pathways clients includes four pretreatment beds at Nugen's Ranch, made possible through a contract between ACMHS Inc and Nugen's Ranch. Without this contract, there would be no designated pretreatment beds in Anchorage. Some Pathways clients have also been placed in the Henry House following detoxification while waiting to enter treatment. However, the Henry House is not designated for pretreatment and this option only makes sense for clients who are relatively self-sufficient and do not need medical attention or close supervision, which make up a very small percentage of Pathways clients. The Henry House is not a treatment center. It is a congregate living facility that provides secure, safe, drug- and alcohol-free housing. This facility is often full and very difficult to get into. Therefore, a vital need remains for more pretreatment beds in Anchorage. Because there are waitlists for residential treatment programs in Anchorage, pretreatment is a necessary step in the recovery process. The chances of success increase dramatically for Pathways clients who are placed in pretreatment immediately following the completion of detoxification treatment. Pretreatment significantly decreases the chance of relapse.

VI. Success Stories

Interviews were conducted with six successful Pathways clients, including four Alaska Natives and two Caucasian clients. Clients were asked about the challenges they faced during alcohol treatment and how they continue to maintain sobriety. They were also asked for any advice they have for others in the program, and to provide any suggestions for improvement to the Pathways program. All six clients successfully completed alcohol treatment through the Pathways program after years of chronic alcoholism. All of them have remained sober and currently reside in permanent housing. With the exception of one client who was seeking employment at the time of the interview, all of them are employed on a full-time basis. Their stories are below. Names have been changed to protect the privacy of these individuals.



Mark, 54

Mark, a 54 year old Army and Air Force veteran originally from New York, spent several years in Dutch Harbor employed as a commercial fisherman. When he lost his job in 1999, he moved to Anchorage seeking employment. He stayed in a hotel while looking for employment in Anchorage and soon found a job driving trucks. However, he lost his job after he was arrested for a DUI. "I had a drinking problem for years, but after losing my job it became much worse. I had nowhere to go and I ended up on the street." Mark lived on the street for over six years. During multiple admissions to the Transfer Station, Mark got to know Debbie Flowerdew, a case manager with the Pathways to Sobriety Project. At Debbie's recommendation, Mark eventually agreed to enter detoxification treatment at the Clitheroe Center. Following detoxification, he was placed in temporary housing at the Henry House, a congregate, alcohol-free living facility, while awaiting alcohol treatment. Mark was soon admitted to the VA Domiciliary, where he started inpatient alcohol treatment. After successfully completing treatment, Mark moved into transitional housing at the Genesis House and continued with outpatient aftercare treatment at the VA Domiciliary. During his aftercare treatment, Mark found permanent housing and employment. "Pathways helped me to take responsibility for my life and get back on my feet. It hasn't been easy but I found a job and I am paying the bills." Mark has been in permanent housing for one year and remained sober for almost two years. He has been employed full-time for a year and a half managing a warehouse and stocking inventory. "Pathways changed my life for the better. I have a much healthier outlook on life and I am not anti-social anymore." Mark talked about the turning point in his life. "After I got out of alcohol treatment, I saw how much trouble my friends were in. I had friends who were suicidal and friends who were in trouble with the law. I knew I never wanted to go back to that lifestyle." When asked how he maintains sobriety now, Mark said "I have a job that I enjoy and that gives me a reason to get up in the morning. I also made the decision after alcohol treatment to stay away from people who are a bad influence on me." When asked if he had any recommendation for the Pathways program he said, "More case managers are needed."

Michael, 49

Michael, a 49 year old Army veteran originally from Texas, spent 9 years as a chronic alcoholic living on the streets of Anchorage. He successfully completed the Pathways program and has been sober for two years. Before entering the Pathways program, he had been admitted to the Transfer Station over 200 times and had attempted detoxification treatment 14 times, relapsing after each attempt. He also attempted alcohol treatment at the Salvation Army Adult Rehabilitation Program and relapsed. Over the years, Michael estimated that he had 15 trips by ambulance to the ER from the Transfer Station as a result of alcohol induced seizures. "It's a miracle I'm alive." Michael had known Debbie Flowerdew, the case manager for the Pathways to Sobriety Project, for several years before entering the program. In 2006, after sobering up at the Transfer Station, Michael had a discussion with her about treatment options. "It was not the first time we had this conversation, but this time I made up my mind that I had to get through treatment. I was fed up with my life and tired of being irresponsible. I didn't want to depend on other people anymore for money, food and clothing." Michael also talked about the negativity surrounding him. "I was involved in an abusive relationship and surrounded by people who were a negative influence." After surviving a stabbing, Michael decided it was time to take control of his life. He completed detoxification treatment at the Clitheroe Center and was then placed in temporary housing at the Henry House. "Going into the Henry House made the difference. Without a place to go after detox, I would have started drinking again." He started inpatient treatment at the Salvation Army Adult Rehabilitation Program; however, he withdrew from the program before he completed treatment. With Debbie's help, he moved back into the Henry House and was admitted to the outpatient program at the VA Domiciliary, which he successfully completed, along with an after care treatment program. Michael remained sober and found employment at ACMHS Inc as a Community Readiness Specialist. He spent several months employed at ACMHS Inc, before accepting a position at the VA Transitional Housing facility. Michael provides peer support at the facility and is currently training to become a chemical dependency counselor. He expects to become certified by the beginning of next year. Michael has been employed full-time for two years and lived in permanent housing for a year and a half. When asked how Pathways changed his life Michael said, "Pathways got me off the street and provided a safe and secure environment where I could remain sober. The program gave me the confidence I needed to get back on my feet and give something back to the community." When asked what advice he would give to others in the program he said, "Listen to your case manager and stay away from people who are a bad influence."

John, 54

John, a 54 year old Army veteran and lifelong Alaskan originally from the rural village of Elim, spent 8 years living on the streets of Anchorage. John was an alcoholic for over 30 years. He had been admitted to the Transfer Station 274 times and had attempted detoxification treatment 19 times and alcohol treatment 5 times before entering the Pathways Program. “For 8 years I was living in a state of numbness, just surviving day to day on the streets.” John met Pathways case manager Debbie Flowerdew in 2000. It was not until 2006, with her help and support, that John entered the Pathways Program and started treatment again after so many previous attempts. John completed detoxification at the Ernie Turner Center and then went directly into pretreatment at Nugens Ranch. “Going into pretreatment immediately after detox was vital. I never had that chance before and I always fell back into the same cycle.” Following pretreatment, he started the inpatient alcohol treatment program at the Ernie Turner Center. After completing several months of treatment, he was moved into post treatment at the Genesis House where he lived in transitional housing. From the Genesis House, John moved into permanent housing and discovered he had an incredible artistic talent and passion for carving. He set up his own carving studio at home and started his own successful business selling his carvings. He also re-established contact with his family, whom he had not been in touch with for 10 years. “My children and grandchildren bring me joy everyday.” When asked how Pathways changed his life he said, “I was stuck in a vicious cycle, there was no way for me to do this without help. I wouldn’t have made it. Pathways taught me how to be human again.” John has been in permanent housing for a year. When asked how he got through the difficult times during treatment he said, “I prayed everyday and I still pray everyday. God has never let me down.” When reflecting on his experience, John said, “When I go back to the streets and I see the way my friends are living, it reinforces my desire to stay sober. I never want to touch alcohol again.” When asked what advice he would give to others in the program he said, “Take a good look at yourself and be honest with yourself. Never be afraid to ask for help.” His only recommendation to improve the program is to add more detoxification beds and pretreatment beds. “Pretreatment beds are vital. People will relapse if they have nowhere to go after detox.”

Jason, 55

Jason, a 55 year old lifelong Alaskan, has been sober for nearly 5 years after 30 years of alcoholism. He spent several years living on the streets of Anchorage before he entered the Pathways Program. Jason met Pathways case manager Debbie Flowerdew at the Transfer Station in the winter of 2003. At her recommendation, he entered detoxification treatment. “I initially went into detox only because I wanted to escape the cold weather. At that time, I wasn’t serious about getting sober. I just wanted a warm place to sleep.” But after Jason completed detox, he decided he didn’t want to go back to the street and start drinking again. With Debbie’s help, Jason was placed in alcohol treatment at the Ernie Turner Center for one year. He successfully completed alcohol treatment and has remained sober ever since. “I finally had a safe place to stay where my basic needs were met. Before I entered Pathways, I was just trying to survive.” Jason has been in permanent housing and working full-time for 4 years. He re-discovered his passion for carving and has started a successful business selling his carvings. His carvings are displayed in local museums and sold in gift shops throughout the city. Jason also works at the Ernie Turner Center providing administrative support, as well as teaching carving classes to inpatients in the alcohol treatment program. In 2007, Jason was diagnosed with liver cancer. He was told his illness was terminal and that he had only months to live. “I refused to accept that. I prayed to God and I asked everyone else to pray with me.” The doctors removed part of his liver and he has been cancer-free since March of 2008. When asked how Pathways changed his life Jason said, “Without Pathways, I would be in jail or I would be dead. I found a higher power and I found my passion.” When asked about the challenges he faced while going through treatment he said, “It was very hard to talk about the things that I have gone through but I had a good counselor and it really helped me.”



Alex, 57

Alex, a 57 year old life-long Alaskan, was an alcoholic for 30 years. When he got married in 1991, he stopped drinking and remained sober for 7 years. When his marriage ended in 1998, he started drinking heavily again. Due to the drinking, he lost his job and his home and ended up on the street. Over the years, Alex had 451 admissions to the Transfer Station, as well as countless visits to the ER. With the help of the Pathways Program, Alex went through detoxification treatment, but relapsed shortly after. Several months later, he was again admitted to detoxification treatment and then went into an inpatient alcohol treatment program at the Ernie Turner Center. Alex walked out of treatment and relapsed again. He went back to the street, and was later incarcerated for a period of two years. After getting out of jail, he started an outpatient alcohol treatment program at the Cook Inlet Tribal Council's Clare Swan treatment facility. Alex was placed in transitional housing at the Genesis House while undergoing outpatient treatment. Alex suffered a setback during treatment when his girlfriend was killed in a car accident and both his father and sponsor passed away within a short period of time. However, despite the emotional crisis, Alex remained sober and relied heavily on friends for emotional support. "Without the support I had, I wouldn't have been able to cope." When asked how he got through treatment and remained sober, he said, "Surrounding yourself with supportive people is the key. It took a lot of time for me to trust people but I have an incredible support system from the treatment program. I couldn't have done it without my friends, my sponsor and my case manager." He successfully completed the program and currently remains in transitional housing at the Genesis House. At the time of the interview with Alex, he was getting ready to move into permanent housing the following week. He completed training and received certification as a Microsoft Office Specialist. At the time of the interview with Alex, he was seeking employment and had a job interview pending. He has been sober for a year and a half.

James, 38

James, a 38 year old lifelong Alaskan, successfully completed the Pathways program after many years of alcoholism. James has been sober for a year and a half. Before entering Pathways, James was homeless for two years. "I bounced around between friends' couches, homeless shelters and the street." After meeting Pathways case manager Debbie Flowerdew at the Transfer Station and discussing treatment options with her, James agreed to enter detoxification treatment. James completed detoxification treatment at the Ernie Turner Center and was then placed in pretreatment at Nugen's Ranch in Wasilla. "It really helped me to leave Anchorage and get away from all the bad influences in my life." From there he was transported to the Sitka Treatment Center where he underwent alcohol treatment for 6 months. Upon his return to Anchorage following treatment, he was placed in the Henry House. James soon found employment in the heating and refrigeration industry and moved into permanent housing. "Pathways gave me a second chance. I feel like a normal person again." James re-connected with his family, whom he had not been in contact with for years. "It was so important for me to re-connect with my family. I knew I had to stop drinking before I could re-build those relationships." When asked how Pathways changed his life, James said, "There is a very good chance I would still be on the street if I hadn't met Deb. I have friends who have died and I could have been one of them." When asked if he had any advice for others in the Pathways program he said, "Get away from the people who are a bad influence on you." James has been working full-time for six months and in his free time, he enjoys fishing and hunting. "My life has been forever changed. The support I received in the program was overwhelming. I could never have done this on my own."

Appendices

Appendix A – Alaska Statutes

Chapter 30. Mental Health

AS 47.30.011. Alaska Mental Health Trust Authority.

(a) The Alaska Mental Health Trust Authority is established as a public corporation of the state within the Department of Revenue.

(b) The purpose of the authority is to ensure an integrated comprehensive mental health program and to administer the office of the long term care ombudsman established in AS [47.62.010](#) .

(c) The authority

(1) shall, as provided in AS [37.14.009](#) , administer the trust established under the Alaska Mental Health Enabling Act of 1956;

(2) may sue and be sued;

(3) may retain the services of independent counsel when, in the judgment of the authority's board of trustees, independent counsel is needed;

(4) shall insure or indemnify and protect the board, a member of the board, or an agent or employee of the authority against financial loss and expense, including reasonable legal fees and costs, arising out of a claim, demand, suit, or judgment by reason of alleged negligence, alleged violation of civil rights, or alleged wrongful act resulting in death or bodily injury to a person or accidental damage to or destruction of property if the board member, agent, or employee, at the time of the occurrence, was acting under the direction of the authority within the course or scope of the duties of the board member, agent, or employee;

(5) shall exercise the powers granted to it under AS [37.14.041](#) , subject to the limitations imposed by AS [37.14.045](#) ; and

(6) shall administer the office of the long term care ombudsman established in AS [47.62.010](#) .

(d) The provisions of AS [44.62.330](#) - [44.62.630](#) do not apply to the Alaska Mental Health Trust Authority.

AS 47.30.056. Use of Money in the Mental Health Trust Settlement Income Account.

(a) The money in the mental health trust settlement income account established in AS [37.14.036](#) shall be used as provided in AS [37.14.041](#) , including to

(1) provide an integrated comprehensive mental health program as required by this section;

(2) meet the authority's annual administrative expenses; and

(3) offset the effect of inflation on the mental health trust fund.

(b) Expenditures under (a)(1) of this section shall provide for a reasonable level of necessary services to

(1) the mentally ill;

(2) the mentally defective and retarded;

(3) chronic alcoholics suffering from psychoses;

(4) senile people who as a result of their senility suffer major mental illness; and

(5) other persons needing mental health services, as the legislature may determine.

(c) The integrated comprehensive mental health program for which expenditures are made under this section

(1) shall give priority in service delivery to persons who, as a result of a mental disorder or of a disorder identified in (b) of this section;

(A) may require or are at risk of hospitalization; or

(B) experience such major impairment of self-care, self-direction, or social and economic functioning that they require continuing or intensive services;

(2) may, at the discretion of the board, include services to persons who are not included under (b) or (c)(1) of this section.

(d) In (b)(1) of this section, "the mentally ill" includes persons with the following mental disorders:

(1) schizophrenia;

(2) delusional (paranoid) disorder;

(3) mood disorders;

(4) anxiety disorders;

(5) somatoform disorders;

(6) organic mental disorders;

(7) personality disorders;

(8) dissociative disorders;

(9) other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and

(10) persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.

(e) In (b)(2) of this section, "the mentally defective and retarded" includes persons with the following neurologic or mental disorders:

(1) cerebral palsy;

(2) epilepsy;

(3) mental retardation;

- (4)** autistic disorder;
- (5)** severe organic brain impairment;
- (6)** significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;
- (7)** other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.
- (f)** In (b)(3) of this section, "chronic alcoholics suffering from psychoses" includes persons with the following disorders:
 - (1)** alcohol withdrawal delirium (delirium tremens);
 - (2)** alcohol hallucinosis;
 - (3)** alcohol amnestic disorder;
 - (4)** dementia associated with alcoholism;
 - (5)** alcohol-induced organic mental disorder;
 - (6)** alcoholic depressive disorder;
 - (7)** other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.
- (g)** In (b)(4) of this section, "senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders:
 - (1)** primary degenerative dementia of the Alzheimer type;
 - (2)** multi-infarct dementia;
 - (3)** senile dementia;
 - (4)** presenile dementia;
 - (5)** other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.
- (h)** The authority shall adopt regulations defining the disorders identified in this section to reflect revisions in the diagnostic nomenclature of the health professions serving the beneficiaries of the trust. The authority shall review and revise the regulations as necessary. Regulations adopted under this subsection must be in the long term best interest of the trust and of persons with disorders equivalent to those identified in (b) and (c) of this section.
- (i)** In this section, "an integrated comprehensive mental health program"
 - (1)** means public health programs and services that, on December 16, 1994, are separately recognizable and administered, without regard to the administrative unit directly responsible for the delivery of the service; among the services included are services for the mentally ill, community mental health services, services for the developmentally disabled, alcoholism services, and services for children, youth, adults, and seniors with mental disorders;
 - (2)** includes, at a minimum, each of the following services as appropriate:
 - (A)** emergency services on a 24-hour basis;
 - (B)** screening examination and evaluation services required to complete the involuntary commitment process under AS [47.30.700](#) - [47.30.815](#);
 - (C)** inpatient care;
 - (D)** crisis stabilization services, which may include:
 - (i)** active community outreach;

- (ii) in-hospital contact;
- (iii) mobile crisis teams of mental health professionals;
- (iv) crisis beds to provide a short term residential program for persons experiencing an acute episode of mental illness that requires temporary removal from a home environment;
- (E) treatment services, which may include
 - (i) diagnosis, testing, and evaluation of medical needs;
 - (ii) medication monitoring;
 - (iii) physical examinations;
 - (iv) dispensing psychotropic and other medication;
 - (v) detoxification;
 - (vi) individual or group therapy;
 - (vii) aftercare;
- (F) case management, which may include
 - (i) evaluation of needs;
 - (ii) development of individualized treatment plans;
 - (iii) enhancement of access to available resources and programs;
 - (iv) development of interagency contacts and family involvement;
 - (v) advocacy;
- (G) daily structure and support, which may include
 - (i) daily living skills training;
 - (ii) socialization activities;
 - (iii) recreation;
 - (iv) transportation;
 - (v) day care services;
 - (vi) client and care provider education and support services;
- (H) residential services, which may include
 - (i) crisis or respite care;
 - (ii) board and care;
 - (iii) foster care, group homes, halfway houses, or supervised apartments;
 - (iv) intermediate care facilities;
 - (v) long-term care facilities;
 - (vi) in-home care;
- (I) vocational services, which may include
 - (i) prevocational services;
 - (ii) work adjustment;
 - (iii) supported work;
 - (iv) sheltered work;
 - (v) training in which participants achieve useful work experience;
- (J) outpatient screening, diagnosis, and treatment services, including individual, family, and group psychotherapy, counseling, and referral;
- (K) prevention and education services, including consultation with organizations, providers, and the public; and
- (L) administrative services, including appropriate operating expenses of state agencies and other service providers.

(j) The authority shall adopt regulations regarding the services described in (i) of this section to reflect advances in the appropriate professions. The authority shall review and revise the regulations as necessary. Regulations adopted under this subsection must be in the long term best interest of the mental health trust.

AS 47.30.700. Initiation of Involuntary Commitment Procedures.

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS [47.30.520](#) - [47.30.620](#) or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

AS 47.30.705. Emergency Detention For Evaluation.

(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS [47.30.700](#) , may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

(b) In this section, "minor" means an individual who is under 18 years of age.

AS 47.30.725. Commitment Proceeding Rights; Notification.

(a) When a respondent is detained for evaluation under AS [47.30.660](#) - [47.30.915](#), the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admitted for treatment within 72 hours of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within 72 hours from the beginning of the respondent's meeting with evaluation personnel, the respondent is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS [47.30.700](#) - [47.30.815](#).

(c) The respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the facility or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

(1) prevent bodily harm to the respondent or others;

(2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or

(3) allow the respondent to prepare for and participate in the proceedings.

(f) A respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver

AS 47.30.730. Procedure For 30-Day Commitment; Petition For Commitment.

(a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;

(2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

(4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;

(5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 30 days;

(6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and

(7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.

AS 47.30.735. 30-Day Commitment.

(a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS [47.30.715](#) .

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS [47.30.660](#) - [47.30.915](#), the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;

(2) to view and copy all petitions and reports in the court file of the respondent's case;

(3) to have the hearing open or closed to the public as the respondent elects;

(4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;

(5) to have an interpreter if the respondent does not understand English;

(6) to present evidence on the respondent's behalf;

(7) to cross-examine witnesses who testify against the respondent;

(8) to remain silent;

(9) to call experts and other witnesses to testify on the respondent's behalf.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

AS 47.30.740. Procedure For 90-Day Commitment Following 30-Day Commitment.

(a) At any time during the respondent's 30-day commitment, the professional person in charge, or that person's professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under [AS 47.30.730\(a\)](#) except that references to "30 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during the respondent's 30-day commitment;

(3) be verified by the professional person in charge, or that person's professional designee, during the 30-day commitment.

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, the respondent's attorney, and the respondent's guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, the respondent's attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under [AS 47.30.735](#) shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

AS 47.30.745. 90-Day Commitment Hearing Rights.

(a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent and the respondent's attorney and guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to ensure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language the respondent understands.

(b) Unless the respondent is released or is admitted voluntarily following the filing of a petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS [47.30.740](#) (b) to determine if the respondent is mentally ill and as a result is likely to cause harm to self or others, or if the respondent is gravely disabled. If the respondent is admitted voluntarily following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS [47.30.740](#) or under AS [47.30.685](#) . If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS [47.30.770](#) . The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine the respondent and testify on the respondent's behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS [47.30.700](#) - [47.30.915](#), the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision has not been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the respondent shall be released.

AS 47.30.915. Definitions.

In AS [47.30.660](#) - [47.30.915](#)

- (1) "commissioner" means the commissioner of health and social services;
- (2) "court" means a superior court of the state;
- (3) "department" means the Department of Health and Social Services;
- (4) "designated treatment facility" or "treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS [47.30.670](#) - [47.30.915](#) but does not include correctional institutions;
- (5) "evaluation facility" means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS [47.30.660](#) - [47.30.915](#), or a medical facility licensed under AS [18.20.020](#) or operated by the federal government;
- (6) "evaluation personnel" means mental health professionals designated by the department to conduct evaluations as prescribed in AS [47.30.660](#) - [47.30.915](#) who conduct evaluations in places in which no staffed evaluation facility exists;
- (7) "gravely disabled" means a condition in which a person as a result of mental illness
 - (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
 - (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently;
- (8) "inpatient treatment" means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility, for a continual period of 24 hours or longer;
- (9) "least restrictive alternative" means mental health treatment facilities and conditions of treatment that are
 - (A) no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and
 - (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;
- (10) "likely to cause serious harm" means a person who
 - (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;
 - (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
 - (C) manifests a current intent to carry out plans of serious harm to that person's self or another;
- (11) "mental health professional" means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological

Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who

- (A) has a master's degree in the field of mental health;
- (B) has at least 12 months of post-masters working experience in the field of mental illness; and
- (C) is working under the supervision of a type of licensee listed in this paragraph;

(12) "mental illness" means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

(13) "peace officer" includes a state police officer, municipal or other local police officer, state, municipal, or other local health officer, public health nurse, United States marshal or deputy United States marshal, or a person authorized by the court;

(14) "persons with mental disorders" has the meaning given in AS [47.30.610](#).

(15) "professional person in charge" means the senior mental health professional at a facility or that person's designee; in the absence of a mental health professional it means the chief of staff or a physician designated by the chief of staff;

(16) "provider of outpatient care" means a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient treatment by the court or who are released early from inpatient commitments on condition that they undergo outpatient treatment;

(17) "screening investigation" means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations;

(18) "state" means a state of the United States, the District of Columbia, the territories and possessions of the United States, and the Commonwealth of Puerto Rico, and, with the approval of the United States Congress, Canada.

Article 12. PERSONAL DECLARATION OF PREFERENCE FOR MENTAL HEALTH TREATMENT

Chapter 37. Uniform Alcoholism and Intoxication Treatment Act

AS 47.37.010. Declaration of Policy.

It is the policy of the state to recognize, appreciate, and reinforce the example set by its citizens who lead, believe in, and support a life of sobriety. It is also the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment that can introduce them to, and help them learn, new life skills and social skills that would be useful to them in attaining and maintaining normal lives as productive members of society

AS 47.37.140. Public and Private Treatment Facilities.

(a) The department shall establish standards for facilities, which standards may vary in their requirements and stringency according to the population, price level, remoteness, access to transportation, and availability of ancillary services of the area to be served, and shall fix the fees to be charged for the required inspections of those facilities. A facility shall meet the applicable standards before it is approved as a public or private treatment facility. The standards shall be enacted in a manner that will provide protection of the health, safety, and well-being of clients of the affected programs and protection for the affected programs from exposure to malpractice and liability actions.

(b) The department shall inspect, on a regular basis, approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The department shall maintain a list of approved public and private treatment facilities.

(d) An approved public and private treatment facility shall file with the department, on request, data, statistics, schedules, and information which the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, shall be removed from the list of approved treatment facilities.

(e) The department, after holding a hearing under the provisions of the Administrative Procedure Act (AS [44.62](#)), may suspend, revoke, limit, restrict, or refuse to grant an approval for a treatment facility, for failure to meet its standards.

(f) Upon petition of the department and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the department authorizing the officer or employee to enter and inspect at reasonable times, and examine the books and accounts of an approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this chapter.

AS 47.37.150. Acceptance For Treatment.

The department shall adopt regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers. In adopting the regulations the department shall be guided by the following standards:

- (1) if possible a patient must be treated on a voluntary rather than an involuntary basis;
- (2) a patient must be initially assigned or transferred to outpatient or intermediate treatment, unless the patient is found to require inpatient treatment;
- (3) a person may not be denied treatment solely because the person has withdrawn from treatment against medical advice on a prior occasion or because the person has relapsed after earlier treatment;
- (4) an individualized treatment plan must be prepared and maintained on a current basis for each patient;
- (5) provision must be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will use other appropriate treatment and facilities.

AS 47.37.160. Voluntary Treatment of Alcoholics.

- (a) An alcoholic may voluntarily apply for treatment directly to an approved public treatment facility.
- (b) Subject to regulations adopted by the department, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator shall, if possible, refer the person to another approved public treatment facility.
- (c) When a patient receiving inpatient care leaves an approved public treatment facility, the patient shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the administrator shall arrange for assistance in obtaining supportive services and residential facilities.

AS 47.37.170. Treatment and Services For Intoxicated Persons and Persons Incapacitated By Alcohol or Drugs.

- (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help or a person who appears to be intoxicated in or upon licensed premises where intoxicating liquors are sold or consumed who refuses to leave upon being requested to leave by the owner, an employee, or a peace officer may be taken into protective custody and assisted by a peace officer or a member of the emergency service patrol to the person's home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility. If all of the preceding facilities, including the person's home, are determined to be unavailable, a person taken into

protective custody and assisted under this subsection may be taken to a state or municipal detention facility in the area. However, emergency protective custody under this subsection may not include placement of a minor in a jail or secure facility.

(b) A person who appears to be incapacitated by alcohol or drugs in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol or drugs in a public place shall be taken to a state or municipal detention facility in the area if that appears necessary for the protection of the person's health or safety. However, emergency protective custody under this subsection may not include placement of a minor in a jail or secure facility.

(c) A person who voluntarily appears or is brought to an approved public treatment facility shall be examined by a licensed physician or other qualified health practitioner as soon as possible. The department shall, by regulation, determine which health practitioners may be authorized to perform the examination. After the examination, the person may be admitted as a patient or referred to another health facility. The approved public treatment facility which refers the person shall arrange for transportation.

(d) A person who, after medical examination at an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment, is found to be incapacitated by alcohol or drugs at the time of admission or to have become incapacitated by alcohol or drugs at any time after admission, may not be detained at a facility after the person is no longer incapacitated by alcohol or drugs. A person may not be detained at a facility if the person remains incapacitated by alcohol for more than 48 hours after admission as a patient. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to the person's home, if any. If the person has no home, the approved public treatment facility shall assist the person in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, family or next of kin shall be promptly notified. If an adult patient who is not incapacitated by alcohol or drugs requests that there be no notification of next of kin, the request shall be granted.

(g) A person may not bring an action for damages based on the decision under this section to take or not to take an intoxicated person or a person incapacitated by alcohol or drugs into protective custody, unless the action is for damages caused by gross negligence or intentional misconduct.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment.

(i) A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, (2) until the person is no longer intoxicated or incapacitated by alcohol or drugs, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult. A peace officer or a member of the

emergency service patrol, in detaining a person under (a) or (b) of this section and in taking the person to a treatment facility, an emergency medical service, or a detention facility, is taking the person into protective custody and the officer or patrol member shall make reasonable efforts to provide for and protect the health and safety of the detainee. In taking a person into protective custody under (a) and (b) of this section, a detaining officer, a member of the emergency service patrol, or a detention facility official may take reasonable steps for self-protection, including a full protective search of the person of a detainee. Protective custody under (a) and (b) of this section does not constitute an arrest and no entry or other record may be made to indicate that the person detained has been arrested or charged with a crime, except that a confidential record may be made that is necessary for the administrative purposes of the facility to which the person has been taken or that is necessary for statistical purposes where the person's name may not be disclosed.

(j) [Repealed, Sec. 21 ch 66 SLA 1996].

(k) In this section, "minor" means an individual who is under 18 years of age.

AS 47.37.180. Emergency Commitment.

(a) An intoxicated person who (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol or drugs, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, physician assistant, advanced nurse practitioner, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application must state facts to support the need for emergency treatment and be accompanied by a physician's, physician assistant's, or advanced nurse practitioner's certificate supporting the need for emergency treatment and stating that the physician, physician assistant, or advanced nurse practitioner has examined the person sought to be committed within two days before the certificate's date.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which the person was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. However, a person may not be detained under this section for more than 48 hours unless a district or superior court judge has reviewed and approved the commitment application.

(d) The administrator in charge of an approved public treatment facility may refuse an application if in the administrator's opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, the administrator shall discharge a person committed under this section. A person committed under this section may not be detained in a

treatment facility for more than five days. If a petition for involuntary commitment under AS [47.37.190](#) has been filed within the five days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, the administrator may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's, physician assistant's, or advanced nurse practitioner's certificate, and a written explanation of the person's right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel.

(g) The administrator of an approved public treatment facility may accept an application for commitment under this section from a health facility and may authorize the health facility to hold the person who is the subject of the commitment petition at the health facility as long as medically necessary, before transferring the person to the approved public treatment facility. An administrator who accepts an application for commitment from a health facility shall comply with the provisions of (c) - (f) of this section if the person being committed is held for longer than 48 hours from the time the administrator accepts the application for commitment under this subsection. A person committed under this subsection shall be transported from the health facility to the approved public treatment facility as soon as the person is discharged from the health facility. If the person being committed under this subsection is physically present at the health facility at the time an application for extension of detention is filed under (c) of this section or is physically present at the health facility when a petition for involuntary commitment is filed under (e) of this section, the administrator accepting the application for commitment under this subsection shall inform the court of where the person being committed is being held and when the person being committed is expected to be capable of being transferred to the approved public treatment facility.

AS 47.37.190. Involuntary Commitment.

(a) A spouse or guardian, a relative, the certifying physician, physician assistant, advanced nurse practitioner, or the administrator in charge of an approved public treatment facility may petition the court for a 30-day involuntary commitment order. The petition must allege that the person is an alcoholic or drug abuser who (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol or drugs. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician, physician assistant, or advanced nurse practitioner who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition. The certificate must set out the physician's, physician assistant's, or advanced nurse practitioner's findings of the examination in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on

(1) the petitioner;

(2) the person whose commitment is sought or the person's guardian, if any;

(3) the attorney representing the person whose commitment is sought;

(4) the administrator in charge of the approved public or private treatment facility in which the committed person has been committed for emergency care; and

(5) any other person the court considers appropriate.

(c) A person who is the subject of a petition filed under this section does not have the right to a jury.

AS 47.37.200. Hearing On Petition For Involuntary Commitment.

(a) At the hearing for a 30-day commitment required under AS [47.37.190\(b\)](#), the court shall hear all relevant testimony, including, if possible, the testimony of at least one person who has examined the person whose commitment is sought under AS [47.37.180\(b\)](#) or [47.37.190\(a\)](#). The person whose commitment is sought shall be present unless the court believes that being present is likely to be injurious to the person, in which case the court may conduct the hearing telephonically. The court may examine the person in open court, or, if advisable, examine the person out of court. If the person has refused to be examined under AS [47.37.180\(b\)](#) or [47.37.190\(a\)](#), the person shall be given an opportunity to request examination by a court-appointed licensed physician, physician assistant, or advanced nurse practitioner. If the person fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or, if the court believes that more medical evidence is necessary, the court may issue a temporary order committing the person to a private or public facility for a period of not more than five days for purposes of a diagnostic examination.

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the private or public facility, the court finds that grounds for involuntary commitment have been clearly established, the court shall issue an order of 30-day commitment to the private or public facility.

(c) A person committed for a 30-day period shall remain in the custody of a private or public facility for treatment for a period of not more than 30 days. At the end of the 30-day period, the person shall be automatically discharged unless the director of the approved public facility or approved private facility, before the expiration of the period, files a petition for recommitment under AS [47.37.205](#).

(d) A private or public facility must be capable of providing adequate and appropriate treatment for a person in its custody. A public facility may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

(e) A person committed to the custody of an approved public facility or an approved private facility shall be discharged at any time before the end of the period for which the person has been committed if either of the following conditions is met:

(1) further treatment is not likely to bring about significant improvement in the person's condition; or

(2) treatment is no longer adequate or appropriate.

(f) The court shall inform the person whose commitment or recommitment is sought of the right to contest the petition, to be represented by counsel at every stage of the proceedings relating to commitment and recommitment, to have counsel appointed by the court or provided by the court, if the person is unable to obtain counsel, and of the right to a jury trial if recommitment is sought under AS [47.37.205](#) . The person whose commitment or recommitment is sought shall be informed of the right to be examined by a licensed physician of the person's choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall appoint a licensed physician for the examination.

(g) If a private treatment facility agrees with the request of a competent patient or the patient's parent, adult sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer the patient to the private treatment facility.

(h) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS [12.75](#).

AS 47.37.205. Procedure For Recommitment Following 30-Day Commitment.

(a) At any time during a person's 30-day commitment, the director of an approved public facility or approved private facility may file with the court a petition for a 180-day commitment of that person. The petition must include all material required under AS [47.37.190](#) (a) except that references to "30 days" shall be read as "180 days" and must allege that the person continues to be an alcoholic or drug abuser who is incapacitated by alcohol or drugs, or who continues to be at risk of serious physical harm or illness.

(b) Upon the filing of a petition for recommitment under (a) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on

(1) the petitioner;

(2) the person whose recommitment is sought or the person's guardian, if any;

(3) the attorney representing the person whose recommitment is sought;

(4) the original petitioner under AS [47.37.190](#) (a), if different from the petitioner for recommitment;

(5) any other person the court considers appropriate.

(c) If, not less than two days before the date set for a recommitment hearing under (a) of this section, the person being recommitted or the person's counsel or advisor files a written request with the court, the court shall summon and impanel a jury of six residents of the judicial district to hear and consider evidence concerning the condition of the person being recommitted.

(d) At the hearing regarding recommitment for a 180-day period, the court or jury shall proceed as provided in AS [47.37.200](#) (a) and (b).

(e) The provisions of AS [47.37.200](#) (c) - (h) shall apply equally to periods of recommitment under this section, except that references to "30 days" shall be read as "180 days."

AS 47.37.207. Unauthorized Absences: Return Facility.

When a person committed under AS 47.37.190 - 47.37.205 is absent from a treatment facility without authorization, the administrator, or that person's designee, may contact peace officers who shall take the person into custody and return the respondent to the treatment facility.

AS 47.37.210. Records of Alcoholics, Drug Abusers, and Intoxicated Persons.

(a) Except as required by AS [28.35.030](#) (d), the registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding (a) of this section, the department may make available information from patients' records for purposes of research into the causes and treatment of alcoholism or drug abuse. Information may not disclose a patient's name

AS 47.37.230. Establishment of Emergency Service Patrol.

(a) Cities and boroughs may establish emergency service patrols. An emergency service patrol consists of persons trained to give assistance in public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be capable of transporting intoxicated persons to their homes and to and from public treatment facilities.

(b) The department shall adopt regulations for the establishment, training, and conduct of emergency service patrols.

AS 47.37.235. Limitations On Liability; Bad Faith Application a Felony.

(a) Except as provided under (b) of this section, a person acting in good faith upon either actual knowledge or reliable information who takes a person into protective custody or detains a person under AS [47.37.170](#) - [47.37.180](#), or who petitions for commitment under AS [47.37.180](#) - [47.37.205](#), is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining or failing to detain a person under AS [47.37.170](#) - [47.37.270](#) or for releasing a person under AS [47.37.170](#) - [47.37.270](#) at or before the end of the period for which the person was admitted or committed for protective custody or treatment if the persons have performed their duties in good faith and without gross negligence:

- (1) an officer of an approved public or private treatment facility;
- (2) the administrator of an approved public or private treatment facility, and the staff of an approved public or private treatment facility;
- (3) a public official performing functions necessary to the administration of AS [47.37.170](#) - [47.37.270](#);
- (4) a peace officer or other person responsible for detaining or transporting a person under AS [47.37.170](#) - [47.37.270](#).

(c) A person who knowingly initiates an involuntary commitment petition under AS [47.37.180](#) - [47.37.205](#) without having good cause to believe that the other person is an alcoholic or drug abuser and is incapacitated or at risk of serious physical harm or illness if not treated is guilty of a class C felony.

AS 47.37.270. Definitions.

In this chapter:

- (1) "alcoholic or drug abuser" means a person who demonstrates increased tolerance to alcohol or drugs, who suffers from withdrawal when alcohol or drugs are not available, whose habitual lack of self-control concerning the use of alcohol or drugs causes significant hazard to the person's health, and who continues to use alcohol or drugs despite the adverse consequences;
- (2) "approved private treatment facility" or "private facility" means a private agency meeting the standards prescribed in AS [47.37.140](#) (a) and approved under AS [47.37.140](#) (c);
- (3) "approved public treatment facility" or "public facility" means a treatment agency operating under the direction and control of the department or providing treatment under this chapter through a contract with the department under AS [47.37.130](#) (g) or through a grant awarded under AS [47.30.475](#) , and meeting the standards prescribed in AS [47.37.140](#)(a) and approved under AS [47.37.140](#) (c);
- (4) "commissioner" means the commissioner of health and social services;
- (5) "department" means the Department of Health and Social Services;
- (6) [Repealed E.O. No. 108, Sec. 88 (2003)].
- (7) [Repealed E.O. No. 108, Sec. 88 (2003)].
- (8) "drugs" means a drug that is included in the controlled substance schedules set out in AS [11.71.140](#) - [11.71.190](#);
- (9) "emergency service patrol" means a patrol established under AS [47.37.230](#);
- (10) "hazardous volatile material or substance"
 - (A) means a material or substance that is readily vaporizable at room temperature and whose vapors or gases, when inhaled,
 - (i) pose an immediate threat to the life or health of the person; or
 - (ii) are likely to have adverse delayed effects on the health of the person;
 - (B) includes, but is not limited to,
 - (i) gasoline;
 - (ii) materials and substances containing petroleum distillates; and
 - (iii) common household materials and substances whose containers bear a notice warning that inhalation of vapors or gases may cause physical harm;
- (11) "incapacitated by alcohol or drugs" means a person who, as a result of alcohol or drugs, is unconscious or whose judgment is otherwise so impaired that the person (A) is incapable of realizing and making rational decisions with respect to the need for treatment and (B) is unable to take care of the person's basic safety or personal needs, including food, clothing, shelter, or medical care;
- (12) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(13) "inhalant abuse" means the misuse of a hazardous volatile material or substance by inhaling its vapors;

(14) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol or drugs;

(15) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to alcoholics, intoxicated persons, or drug abusers, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling;

(16) "work therapy"

(A) means an activity that involves a patient in basic employment skills and assists the patient in reintegration into a community;

(B) does not include

(i) activities such as personal housekeeping chores or cooperative responsibilities expected of each patient in the program; or

(ii) work that produces goods or services for sale or distribution, the proceeds of which would be returned to the owners, operators, or businesses of the rehabilitation program.

Appendix B – Substance Abuse Treatment Programs

1. Akeela Treatment Services

Contact: Outpatient Services
4111 Minnesota Drive
Anchorage, AK 99503
www.akeela.org

Phone: **565-1200**
Fax: 258-6052

Akeela, Inc. is a non-profit organization offering a comprehensive array of services for the prevention and treatment of substance abuse, and alcohol abuse, in Anchorage, Alaska and communities throughout the state. A group of concerned citizens founded Akeela in 1974; it serves the community by striving to “enhance the ability of citizens and their families to succeed in life.”

Alaska Division of Behavioral Health Licensure and Commission on Accreditation of Rehabilitative Facilities Accreditation.

Akeela House Recovery Services

Contact: **Jim Morgan**
2804 Bering St.

Phone: **561-5041**

Akeela House Recovery Services program provides 30 beds of space to persons suffering from chronic chemical dependency and in need of long-term, intensive residential treatment. Program length varies from 12 to 18 months. Group, individual, and recreational therapy combined with high expectations demand a growing level of responsibility - the hallmarks of Therapeutic modality. Seventeen (17) additional beds are available in this facility to house ex-offenders in a Community Correctional Residential Center. The agency also provides transitional housing (29 beds) in three multiplex apartment buildings for persons who have completed at least ninety (90) days of treatment for chemical dependence or a program addressing dually diagnosed needs.

Alaska Women’s Resource Center (AWRC) a Program of Akeela Treatment Services

Contact: **Diane Ogilvie**
505 W. Northern Lights Boulevard, Suite 104-106

Phone: **276-0528**
Fax: 279-6754

- a. **Substance Abuse Assessments**
- b. **STOP Program-** Level I: Outpatient substance abuse program for women including dual diagnosis (chemical dependency and mental illness).
- c. **IRIS Program-** Level II: Intensive outpatient substance abuse program for women including dual diagnosis (chemical dependency and mental illness).
- d. **Stepping Stones-** Level III: Long-term residential substance abuse treatment program including dual diagnosis (chemical dependency and mental illness) for up to one year for mothers with children up to age 13. Capacity: 15 women and up to 41 children.

2. Ernie Turner Center

Contact: **Rebecca Ling (Ernie Turner Center)**
4330 Elmore

Phone: **562-7332**

The Ernie Turner Center offers 4 to 6 months residential drug and alcohol treatment and 5-10 day detoxification services for Alaska Natives and non-native participants. The Center provides 12 detoxification beds and 20 residential beds, case management and after care for participants 18 years of age and older who have been clean and sober for a minimum of 72 hours prior to admission. The Ernie Turner Center operates on a sliding fee scale for participants without insurance benefits. Schedule assessments through Cook Inlet Tribal Council, Inc., Connections Recovery Services 3600 San Jeronimo Drive, Suite 210, Anchorage, AK. 99508 call 907-793-3200. Assessment fee is \$100; sliding fee scale is available on a case-by-case basis.

3. Genesis Recovery Services, Inc.

2825 West 42nd Ave.
Anchorage, AK 99517
Contact: **Dr. Tony Longval**

Phone: **243-5130**

Fax: 248-8350

Genesis Recovery Services provides residential facilities for men recovering from substance abuse. A 20-bed halfway house offers counseling in addition to housing and meals for an average length of stay of three to six months. Fees are negotiable. Two other adjacent rental facilities are available, one with six (6) beds and the other with 12, operate as "dry houses" in which men may work and reside for extended periods in a sober living environment.

4. Nugens Ranch

P. O. Box 871545
Wasilla, AK 99587
Contact: **Jacqueline Cox**
24 Hour Services
www.nugensranch.org

Phone: **376-4534**

Toll Free: **1-800- 376-4535**

FAX: 376-2348

Nugens Ranch serves both male and female adults and provides long-term residential substance abuse treatment (20 beds) for the public inebriate and the chronic alcoholic with psychosis. The program provides transportation to and from the facility (3701 Palmer-Wasilla Highway) for consumers of the program. Fees are based on a sliding scale.

5. Providence Behavioral Health Breakthrough

Providence Medical Center
2401 E. 42nd Ave, Suite 103
Anchorage, AK 9950

Phone: **562-7325**

Toll Free: **1-800-478-0615**

Fax: 562-6193

www.breakthrough@provak.org

Drug dependency and alcohol abuse problems are correctable through services available through the Breakthrough program. Breakthrough provides services for adults from evaluation through all levels of treatment and continuing care on an outpatient basis.

6. Rural Alaska Community Action Program - Homeward Bound Project

120 North Hoyt Street
Anchorage, AK 99508

Phone: 279-7535
Fax: 279-9428

www.ruralcap.com

Transitional housing (24 beds) for chronic, homeless, public inebriates through intensive case management, individualized life skills training, social and cultural re-integration, and supportive housing.

7. Salvation Army, Clitheroe Center

P.O. Box 190567
Anchorage, AK 99519
24 Hour Services

Phone: 243-2898
Fax: 279-8526

www.salvationarmyusa.org

Services: Provides assessment, placement, outpatient treatment, and residential treatment ranging from 28 to 180 days. Treatment programs are available for men or women; as well as vocational services, and referrals. Services are offered to those men or women over 18 years of age with a dual diagnosis (chemical dependency and mental illness). Telephone assessments are available to remote areas. Outpatient/Assessment/Aftercare unit located at 1709 S. Bragaw, Suite B.

Eligibility: Serves men and women with alcohol, chemical dependencies. Assessment fee is \$50. All treatment fees are based on client's ability to pay.

Clitheroe Center's Residential Treatment Programs:

Contact: Assessment Counselor

Phone: 276-2898

Different types of residential substance abuse treatment programs are offered to meet differing client needs as determined by an Assessment Counselor.

1. The *Intermediate Care Unit (ICU)* provides a 28-56 day program involving intensive individual and group counseling supplemented by vocational and other related services.

- The *Long-Term Care (LTC)* offers a slower-paced counseling and educational program for a maximum of six months to serve those who have less community support and/or may be more physically impaired by substance abuse.

ICU and *LTC* provide residential treatment services for up to 12 persons combined.

- The *12-bed Dual Diagnosis Program* is designed to address the problems of those with a dual diagnosis (chemical dependency and mental illness). Charges for each program are on a sliding fee scale. Continuing Care services are provided through the Outpatient Counseling Unit.

2. Clitheroe Center - Reflections Program:

Contact: Assessment Counselor

Phone: 276-2898

The Reflections Program is a 16-bed residential substance abuse treatment program for women. Treatment services include the *Evidenced Based Practices Program (EBPP)* for women with Office of Children's Services (OCS) involvement.

Priority placement assistance provided to pregnant women with OCS involvement, intravenous drug users, and/or physically endangered women. Counseling and other supportive services also provided during the 28-90 day stay. Program eligibility is based on assessment of an applicant's substance abuse and related problems. Assessment fee is \$50.00. Adjustments to treatment fees are made according to the client's ability to pay.

8. Southcentral Foundation (SCF) Dena A. COY

Contact: **Cynthia Holmes**
430 San Ernesto Avenue
Anchorage, AK 99508
www.scf.cc/denaacoy.cfm

Phone: **729-4955/729-5070 EXT 507**
Fax: 729-5071

Southcentral Foundation Dena A. Coy Program provides outpatient, intensive outpatient, residential and dual diagnosis treatment services for pregnant and parenting women recovering from substance abuse. The residential capacity is 12 women and six (6) children from birth to three years of age. Parenting skills, individual and group counseling, life skills, FASD education, the Twelve-Step Program, food wellness, and transportation are provided. The minimum length of stay is four (4) months, maximum length of stay is determined on a case-by-case basis.

9. Starting Point

341 W. Tudor Road, Suite 205
Anchorage, AK 99503

Phone: **562-6116**
Fax: 562-6350

Intensive outpatient substance abuse treatment and aftercare program for men, women, and minors. Based on the 12-step program. State approved. Evaluation Fee varies/hr

10. Volunteers of America (VOA) ARCH and ASSIST

Contact: **Elaine Dahlgren or Karen Schaff**
1675 C Street, Suite 201
Anchorage, AK 99501
www.voaak.org

Phone: **279-9634**
Fax: 279-0148

Operated by VOA, **Adolescent Residential Center for Help (ARCH)** is a 16-bed long-term residential substance abuse treatment program for youth 12-19 years of age. Those in the program attend school while receiving individual, group, and family counseling, and other supportive services. Fees are based on ability to pay. **ASSIST** provides outpatient counseling and aftercare services for youth with identified substance abuse problems.

Appendix C – Social Detoxification

CHAPTER 75-09.1-08

SOCIAL DETOXIFICATION ASAM LEVEL III.2-D

Section

75-09.1-08-01 Definitions

75-09.1-08-02 Program Criteria

75-09.1-08-03 Provider Criteria

75-09.1-08-04 Admission and Continued Stay Criteria

75-09.1-08-05 Referral to Acute Care Criteria

75-09.1-08-06 Criteria to Determine That Social Detoxification Is Not Necessary

75-09.1-08-01. Definitions.

1. "CIWA-Ar" means the revised clinical institute withdrawal assessment for alcohol scale published in the archives of general psychiatry 48:442-447, May 1991, which is a ten-item scale for clinical quantification of the severity of alcohol withdrawal syndrome.
2. "Detoxification" means the process of interrupting the momentum of compulsive use in an individual diagnosed with substance dependence and the condition of recovery from the effects of alcohol or another drug, the treatment required to manage withdrawal symptoms from alcohol or another drug, and the promotion of recovery from its effects.
3. "Social detoxification" means detoxification in an organized residential nonmedical setting delivered by appropriately trained staff who provide safe, twenty-four-hour monitoring, observation, and support in a supervised environment for a client to achieve initial recovery from the effects of alcohol or another drug. Social detoxification is characterized by its emphasis on peer and social support and it provides care for clients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require twenty-four-hour structure and support but the full resources of a medically monitored inpatient detoxification are not necessary.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-31

75-09.1-08-02. Program criteria. A social detoxification program must provide:

1. Hospital affiliation providing twenty-four-hour medical backup;
2. A trained staff member familiar with complications associated with alcohol and other drug use and with community resources awake on all shifts; 1
3. A quite, positive atmosphere;
4. Use of detoxification time as preparation for referral to another level of care; and
5. Recognition of the chronic nature of the disease of substance dependence and the fact that some clients will require multiple admissions.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-31

75-09.1-08-03. Provider criteria. A social detoxification provider shall:

1. Maintain a safe, comfortable, positive environment in a residential setting;
2. Have an agreement with local medical providers that ensure readily accessible emergency care when needed;
3. Implement a protocol so that the nature of the medical interventions required are developed and supported by a physician knowledgeable in addiction medicine;
4. Have available specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems;
5. Have awake staff twenty-four hours per day to monitor clients' conditions;
6. Have staff trained in admission, monitoring skills, including signs and symptoms of alcohol and other drug intoxication and withdrawal as well as appropriate treatment of those conditions, supportive care, basic cardiopulmonary resuscitation technique, assessment, and referral procedures;
7. Have services including close observation, supportive staff-client interaction, provision for proper fluid and nutritional components, and provision for client space that offers low to moderate sensory stimulation;
8. Implement a clearly defined policy for admission, care, discharge, and transfer of a client to another level of care;
9. Develop a method of documentation of care and train staff in documentation procedures; 2
10. Develop linkage with providers of other levels of care so the client may begin a therapeutic process as soon as the client is physically and mentally able to do so;
11. Administer a range of cognitive, behavioral, medical, mental health, and other therapies on an individual or group basis designed to

meet the client's ability to participate in order to enhance the client's understanding of addiction, the completion of the detoxification process, and referral to an appropriate level of care for continuing treatment;

12. Develop a preliminary individualized treatment plan with the client that includes problem identification in ASAM PPC dimension two through six and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives; and

13. Implement a policy for medication storage, security, and self-administration to assure that the client receives the client's medication and for observation of the medication taking behavior.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-31

75-09.1-08-04. Admission and continued stay criteria. Before a client may be admitted to a social detoxification program, the client must meet the diagnostic criteria for a substance-induced disorder of the current DSM and current clearance by a physician or a CIWA-Ar score of less than eight and the presence of any of the following:

1. Diffuse mild central nervous system symptoms such as:
 - a. Cerebral symptoms, including slow responses to questions, difficulty in following complicated instructions, mild impairment of immediate memory, slurred speech, and mild disorientation to time but not to place or client;
 - b. Coordination symptoms, including mild abnormality in movement or gait, difficulty in finger-to-nose or finger-to-finger testing and rapid movements;
 - c. Reflex abnormalities, including normal or slightly depressed but symmetrical; or
 - d. Motor abnormalities, are normal or slightly depressed but symmetrical.
2. Onset of any stated symptoms listed in subsection 1 over a few hours;
3. Intoxication; 3
4. The absence of other more serious symptoms, including medical or psychiatric histories of significant problems and the absence of suicidal ideations or suicidal ideation of low lethality without plan or means;
5. Presence of any one of the following physical findings:
 - a. A temperature of ninety-seven degrees to one hundred degrees Fahrenheit [36.1 to 37.6 degrees Celsius] taken orally;
 - b. Tachycardia up to one hundred twenty beats per minute;
 - c. Blood pressure of up to one hundred sixty over one hundred twenty at rest;
 - d. Respiration of twelve to twenty-six breaths per minute;
 - e. Flushed skin color;
 - f. Pupils have a sluggish reaction to light; or
 - g. Other, such as alcohol odor on breath; or

6. Ability to comprehend and function in an ambulatory setting.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-31

75-09.1-08-05. Referral to acute care criteria. A social detoxification program shall refer a client to an acute care facility or consult with a physician upon an increase in score to greater than a seven CIWA-Ar score scale or when a client has any one or more of the following symptoms:

1. Seizures or a history of seizures;
2. Current persistent vomiting or vomiting of blood;
3. Current ingestion of vomit into lungs;
4. Clouded sensorium such as gross disorientation or hallucination;
5. A temperature higher than one hundred and one degrees Fahrenheit [38.1 degrees Celsius] taken orally;
6. Abnormal respiration such as shortness of breath or a respiration rate greater than twenty-six breaths per minute; 4
7. Elevated pulse such as a heart rate greater than one hundred twenty beats per minute or arrhythmia;
8. Hypertension such as blood pressure greater than one hundred sixty over one hundred twenty;
9. Sudden chest pain or other sign of coronary distress or severe abdominal pain;
10. Recent head injury or any trauma other than minor;
11. Unconscious and not arousable; or
12. Other signs of significant illness such as jaundice, unstable diabetes, acute liver disease, severe allergic reaction, progressively severe Antabuse reaction, poisoning, progressively worsening tremors, chills, severe agitation, exposure, internal bleeding, shock, uncontrollable violence, suicidal or homicidal ideations.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-31

75-09.1-08-06. Criteria to determine that social detoxification is not necessary. Social detoxification will not be necessary if:

1. The client exhibits no withdrawal symptoms at a blood alcohol level of 0.0 percent;
2. The client has no medical complications present;
3. The client's nutritional status is moderate to good;
4. The client has a relative, friend, or other support system who can stay with the client for the time necessary to complete detoxification; or
5. The client prefers outpatient detoxification.

History: Effective October 26, 2004.

General Authority: NDCC 50-06-16, 50-31

Law Implemented: NDCC 50-315

**Provided by the
Municipality of Anchorage
Department of Health and Human Services
Human Services Division
Safety Links Program
(907) 343-6589**

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**For questions or comments on this report contact the following staff of the
Safety Links Program.**

**Carrie D. Longoria
Safety Links Program
Manager
(907) 343-4876
longoriacd@muni.org**

**Karen McIntyre
Emergency Human
Services Coordinator
Safety Links Program
(907) 343-6594
mcintyrekl@muni.org**

**Emily Davies
Pathways to Sobriety
Data Analyst
Safety Links Program
(907) 343-6321
davieseb@muni.org**

**Municipality of Anchorage
Department of Health and Human Services
PO Box 196650
Anchorage, AK 99519-6650
Email: wwhhs@muni.org**