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A SUCCESSFUL STRATEGY FOR CHANGE IN ALASKA'S MENTAL HEALTH SYSTEM

To the Editor:

Introduction

During 1971 Dr. Schrader was privileged to be an NIMH Fellow at the Laboratory of Community Psychiatry, Harvard University Medical School, in Boston. The Fellows were psychologists, social workers, and psychiatrists from all over the country who were interested in assuming responsible roles in the administration of mental health programs. In their meetings, a concept of the right opportunity began to emerge. It usually took the form of a well-heeled governmental or private agency that wanted to build a comprehensive mental health program. One of the Fellows, as the new director, would be hired and would develop the program from the beginning, thus avoiding all the pitfalls and problems that tarnish the image of most programs.

Somewhere during the course of these discussions, Dr. Schrader began to see that it might be equally satisfying to take an inefficient, stagnated, disorganized, but existing, program and mobilize its latent potential. This paper describes how he and his staff took just such a system, the Alaska mental health program, and moved it in a much more positive direction.

The System As It Was

In July of 1973 Dr. Schrader was appointed the director of the Division of Mental Health of the State of Alaska. The Division was originally created in 1957 and had been guided by five previous directors who had served a sum total of 3½ years. As a consequence, the Division had been without leadership for most of its existence.

The Division was responsible for services to the mentally retarded and the mentally ill. It was composed of two institutions, the Alaska Psychiatric Institute and the Harborview Memorial Hospital; three state-operated mental health clinics located in Anchorage, Fairbanks, and Juneau; and two federally funded community mental health centers located in Kodiak and Ketchikan. The Division had approximately 450 employees, and an \$8 million budget. It had a central office staff of only 6. Private mental health services in Alaska were minimal (11 psychiatrists) and were located almost exclusively in Anchorage.

The Alaska Psychiatric Institute, a 200-bed psychiatric facility, had one full-time psychiatrist and a falling admission and discharge rate. The superintendent had resigned. Even the seriously mentally ill were not being served. Many of the mentally ill were being arrested on minor criminal charges and placed in jails and lockups. The Anchorage Superior Court had required the commissioner of Health and Social Services to "show cause" to explain why services were not being delivered. The Mental Health Association had talked directly with the governor urging him to use his executive authority to do something about the poor services and the lack of a director. The private psychiatrists were advocating the end of all "state delivered" mental health services in Alaska.

The Harborview Memorial Hospital, a 120-bed facility for the mentally retarded, was built in Valdez over the protests of the Association for Retarded Citizens and

a great many other well informed professionals. Valdez, a very small coastal village, far removed from the center of Alaska's medical, educational, and other professional resources, with an inadequate transportation matrix, happened to be the governor's hometown. Nevertheless, Harborview was apparently functioning more adequately than the Alaska Psychiatric Institute, even though it was being directed by the chief nurse, who, although uncertain of her authority, said, "I assumed they wanted me to run it after the administrator's position was transferred to another city."

The community mental health program, consisting of the three state-operated clinics and the two federally funded programs, based on catchment area populations of 25,000, were operational and were functioning fairly adequately. The state operated Fairbanks Mental Health Clinic, which served the entire northern region (an area approximately as large as Texas with a population of 30,000) was composed of a psychiatrist, three mental health professionals, and two clerical staff. In Anchorage, the state-operated clinic had one unfilled psychiatrist position, two mental health professionals, four clerical positions, and a population of 125,000 to serve. The third state-operated clinic in Juneau had a newly appointed psychiatrist, two mental health professionals (one on extended sick leave), and two clerical positions. The bush communities, where the majority of Alaskan Natives resided, were almost entirely without services.

In 1973 the Office of Developmental Disabilities was transferred to the Division of Mental Health. This was only marginally acceptable to the constituency involved who felt that these programs should not be associated with mental health. There was no organized community-based system to provide services to the mentally retarded. There was little awareness of the fact that half of the Division of Mental Health's budget went to the care of the mentally retarded. Un-

fortunately, the Division's involvement with the mentally retarded was entirely with institutional programming. Community programs existed but they operated relatively autonomously and competitively. Diagnostic services were provided by the Division of Public Health and the private sector; residential services were available through a large private non-profit residential center in Anchorage, funded by the Division of Social Services; and day treatment services, social, educational, and work-activity programs were available in Anchorage, Fairbanks, and Juneau on a limited scale, funded in part by the Division of Vocational Rehabilitation.

Nationally, Alaska's mental health system was viewed as a hopeless problem. Before coming to Alaska, Dr. Schrader was told, confidentially, that mental health services received a low priority. The turnover in personnel was extremely rapid and this resulted in administrative inconsistency. Professional salaries were the lowest in the country. Mental health personnel were not allowed to travel outside of the state to attend national meetings. Mental health professionals who went to Alaska could expect to lose touch with national developments and to rapidly become outmoded.

Identification of Goals

While this may sound like a dreadful mess, we were comforted by the knowledge that it probably could not get any worse and it had the advantage of being relatively obvious what short- and long-range goals needed to be set. It was clear that we needed to improve the administrative structure within the Division to clarify authority and responsibility. We needed to hire several key people and to delegate authority to them to operate their programs. We needed to improve the image and credibility of the programs by providing quality services to those in need. We needed to pull together and co-

ordinate the existing services more effectively. We needed to expand all mental health services in the state, especially the community mental health programs to effectively include more communities. A management information system and fiscal accounting structure was needed to monitor the progress and efficiency of these programs.

Strategies for Change

Having set the goals we now needed a strategy for accomplishing them. Basically, we identified the following fundamental strategies that we intended to pursue simultaneously:

1. Develop a formal method of involving citizens in all aspects of the Division's programs.
2. Alter and/or expand our existing statutory authority.
3. Reorganize the Division with an emphasis placed on management roles and role relationships.
4. Reactivate the existing management information system.
5. Emphasize data, not just emotional rhetoric, in our program planning and evaluation, budget preparation, and testimony before the legislature.
6. Improve our public relations through informational booklets, helpful task-oriented community visits, and attendance at national meetings.
7. Hire key professional and management personnel by direct recruitment and by encouraging professionals to move to Alaska.
8. Closely coordinate our activities with the Alaska Native Health Service.
9. Broaden the funding of our program to include Medicaid, insurance, veterans' payments, etc.
10. Make full utilization of the personnel mechanisms in order to upgrade positions, clarify responsibilities, improve opportunities for advancement, and eliminate inequities.
11. Willingly share the credit for all our accomplishments with whomever was willing to join us in these causes.

Process of Change

This general set of strategies has resulted in numerous specific accomplishments that have had long-range consequences for the Division. These strategies have led to a process of change that has had a progressive, interrelated and interdependent character. In other words, the effect has been cumulative.

For example, our determination to develop a method of involving citizens led to the creation of the Alaska Mental Health Advisory Council, which has been established by statute. This occurred because we supported and worked with the Alaska Mental Health Association, through a planning contract, to draft a Community Mental Health Services Act. This Act was passed in 1975, and one of its provisions created our first Statewide Mental Health Advisory Council.

In addition, the Act allowed the Division to fund locally operated community mental health programs that required local citizen advisory boards. The support of these local citizens' boards, now numbering 20 or so, has been essential to the development of community mental health programs throughout the state. This has been particularly helpful in the bush areas of the state that were especially eager to have local control of all human services programs. The community mental health program, as a model of state-community partnership, has been enthusiastically endorsed. All these communities, through direct contact with their legislators, have given us the support in the

legislature that has been necessary to assure the appropriation of adequate funds on a continuing basis.

Meanwhile, the Division was working diligently to broaden its funding base, collect meaningful program data, and improve its management expertise in order to provide the necessary technical assistance the community mental health programs needed to be successful. As a result of the effort, the Division was able to provide accurate data-based testimony to the legislature and the administration in support of the community mental health program requests. In addition, the total cost of these services was allayed by utilizing federal funding in the institutional portions of the overall mental health budget. Efforts on behalf of the community mental health programs were also being made which, with the passage in 1976 by the Alaska legislature of the Clinic Services Option under Medicaid, created an additional source of revenue for these programs.

The Alaska Mental Health Association, continuing in its efforts as an advocacy group for the mentally ill, is now addressing itself to an even larger and more difficult task—the complete overhaul of the Alaska commitment statutes. When this happens the Division will be involved in a whole new cycle of growth and development.

Results of the Process

At present, Alaska has a reorganized Division of Mental Health and Developmental Disabilities. The Alaska Psychiatric Institute now has a full medical staff including five full-time psychiatrists. It is a much improved operation that now treats three times as many patients as it did in 1973 with a shorter length of stay. The Harborview Memorial Hospital has become the Harborview Developmental Center, emphasizing a social-educational-rehabilitative model rather than a traditional medical approach to care and treat-

ment. A new Developmental Disabilities Act is now under consideration by the legislature. The community mental health program has expanded from 5 to 19 programs since 1975 and serves many more clients including a larger percentage of natives than ever before. Although the budget for these programs has doubled, the Division now collects 63% of this expenditure from third-party sources.

Conclusion

These accomplishments are all the more remarkable because they came during a period of relatively harsh fiscal conservatism. In 1973, it was generally believed that nothing could be accomplished until the new oil revenues were realized from the Prudhoe Bay oil fields. In fiscal year 1975 Alaska spent approximately \$200 million more than it collected in revenues. The budget the Division developed for the legislature in January 1975 was reduced by the new administration and then further reduced by the legislature. Following its appropriation, the Division's budget was reduced again by the administration. In addition, a few months later the governor's Efficiency Review Task Force recommended further reductions.

This shortage of revenues was aggravated by the fact that Alaska, the last frontier, has been forced to rapidly develop its government agencies to deal effectively with an overwhelming number of complex issues such as land usage, resource development, and the development of adequate communication and transportation systems. This has resulted in a fierce interagency rivalry at all levels of the bureaucracy. The advances in mental health have been resisted by the other superordinate agencies in the bureaucracy such as the Department of Health and Social Services, the Department of Administration, and the governor's Office of Budget and Management. The priorities of these agencies were fre-

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quently in conflict with those of the Division of Mental Health. However, perhaps because these agencies themselves were somewhat disorganized, they were never able to successfully resist our expansion. The essential ingredient in the Division's ability to overcome these internal obstacles was the strength of our community support.

Considering the shortage of funds and the competition of other agencies it is worthwhile to ask why our set of strategies proved to be so effective. Although the staff of the Division deserve credit for doing their part; several other factors have contributed significantly to the progress Alaska has made. There was a widespread realization that Alaska's mental health programs had been neglected for years. There was a readiness in the legislature and the citizenry for change. Alaska is a new state with a small, well-educated, young population (50% of the population is 21 or under) who

are particularly receptive to a collaborative mode. Community-based programs with local administrative control were particularly attractive because Alaskans were tired and suspicious of centralized bureaucratically administered programs. The opportunity to utilize Title 19, a previously untapped resource, to reduce the overall increase in cost to the state was helpful.

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