ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
6247 SENATE HEALTH, EDUCATION AND SOCIAL SERVICES

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## MAINE*

### INPATIENT HOSPITAL

• Acute hospital limited to 30 days; extensions require prior authorization; same limit for psychiatric care.

### OUTPATIENT HOSPITAL

• Same coverage and limitations as those services provided in mental health clinics. (See clinic services below.) Outpatient units do not have to meet licensing requirements by the Bureau of Mental Health.

### PHYSICIAN SERVICES

• Daily hospital care visits by psychiatrist are provided as medically necessary. Other services are limited to 5 in any consecutive 7 days. If 2 covered services are provided in 1 day, only the highest payment rate of the 2 services is reimbursed.

### NONPHYSICIAN SERVICES

• Psychological services include those provided in accordance with a plan of care by a psychologist or psychological examiner, as listed in the state manual. Same limitations as those provided in mental health clinic services.

### CLINIC SERVICES

• Mental health clinics must be licensed at the comprehensive service level by the Bureau of Mental Health.

• Service providers include psychiatrists, psychologists, psychological examiners, social workers, and psychiatric nurses.

• Limitations: Services must be provided by or under the direction of a psychiatrist and are limited to diagnosis and treatment of mental, psychoneurotic, or personality disorders. Services are limited to 1 hour a day up to 5 times a week, with the following exceptions: a) psychometric testing is provided up to 4 hours and the 1 hour a day limitation does not apply when such testing is provided on the same day as other services; b) family services may exceed 1 hour a day. If direct services are provided to a parent or foster parent in conjunction with treatment of a child, or to more than 1 family member at the same time, 1 fee for individual therapy is allowed regardless of the number of family members; c) community support services are covered in addition to other clinic services provided on the same day but no more than 7 hours of clinic services per 7 consecutive days are allowed. Payment for group psychotherapy or psychosocial therapy is limited to 10 patients in a group and does not include day treatment or partial hospitalization. If 2 or more services are provided on 1 day, payment is made for only the service with the highest rate. Payment is made to the clinic for hospital daily care by a psychiatrist and for individual community support services; however, other services provided to general hospital inpatients are reimbursed directly to the hospital at its regular rate.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

• ICF.

* Coverage for categorica[l] and medically needy perso[n]s. However, ICF care for patients 65 or older in IMD and psychological services are not provided to the medically needy group.

## MARYLAND

### INPATIENT HOSPITAL

- Patients 65 or older in IMD. No limits.
- Length of stay in acute general hospital cannot exceed 20 days per spell of illness as determined medically or administratively necessary by PSRO; additional stay requires a new spell of illness. Same limit for psychiatric units.

### OUTPATIENT HOSPITAL

- Individual, family and group therapy covered. Telephone contacts and review of records are not covered.

### PHYSICIAN SERVICES

- Must be medically necessary, the same as for Medicare, unless prior authorization is obtained. Same coverage as those services listed in OUTPATIENT HOSPITAL.

### NONPHYSICIAN SERVICES

- Provided. None applicable to mental health care.

### CINIC SERVICES

- Community mental health center—Includes freestanding, associated with a general hospital, or part of the local county health department. Providers must meet criteria specified in the Medicaid contract and be approved by the Mental Hygiene Administration. Same services and limitations as those listed in OUTPATIENT HOSPITAL.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF and ICF not provided.

## MASSACHUSETTS

### INPATIENT HOSPITAL

- Patients 65 or over in IMD limited to services provided by medical assistance-certified public psychiatric hospitals. Chronic disease and rehabilitation (CD/R) hospital benefits are limited to the period in which the recipient meets CD/R levels of care guidelines unless exceptions are allowed, plus any administrative days that are allowable at SNF and ICF rates, as appropriate, while such lower level care is being sought.
- No limit on inpatient psychiatric care in general hospital.

### OUTPATIENT HOSPITAL

- Same services available as those covered in freestanding clinics. (See CLINIC SERVICES for coverage and limitations).

### PHYSICIAN SERVICES

- Psychiatric care limited to one psychiatric visit per week except in a crisis or when more than one type of service is medically necessary.
- Psychiatry includes: a) individual psychotherapy; b) couple and family therapy limited to one payment/visit regardless of number of family members; c) group therapy limited to one payment per 90-minute visit, and payment limited to a maximum of 6 persons; d) medication visits; and e) consultation.

### NONPHYSICIAN SERVICES

- Psychologists

—Covered services include only psychological testing. Department will not pay for psychological testing by a certified school psychologist or an unlicensed psychologist unless supervised by a licensed psychologist.

—Prior authorization is required for a neuropsychological examination and for more than one repetition of the same test within a 6-month period.

### CLINIC SERVICES

- Mental Health Centers—Freestanding clinics and satellite facilities of freestanding clinics certified by the Department of Public Welfare. Prior authorization is required for treatment continuing after 26 consecutive sessions per 6-month period. In rare instances where extenuating circumstances exist, treatment may be extended for one year with one request for prior authorization, if the treatment plan does not extend beyond 26 sessions. Sessions comprise any combination of individual, family, group, or couple therapy, and case consultation. (Psychological testing and medication visits are not counted as sessions).

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## MICHIGAN continued

(CMH). The CMH board is defined by Michigan law as the single point of entry to the full array of public mental health services; they provide or arrange for community-based mental health services, serve as the point of referral for persons in need of institutional care, and are responsible for aftercare/follow-up for persons exiting an institution. Thus, each CMH board acts as the case manager for comprehensive mental health services and provides access to such services on a 24-hour basis. Reimbursement for outpatient clinic services includes coverage of diagnosis, testing and evaluation; emergency mental health services; individual and group therapy sessions; and medication review. Reimbursement for medical day treatment includes coverage of diagnostic/evaluation services; habilitation/rehabilitation treatment services; psychological/behavioral treatment services; and transportation. These services must be a part of a goal-oriented care plan authorized by a physician.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital (see INPATIENT HOSPITAL).
- SNF.
- ICF.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR UNDER 22

- Facilities must be JCAH accredited. Also, "active psychiatric treatment" and prior authorization beyond 18 days are required. Services must meet Medicare standards. The attending physician must periodically recertify need for such care. Psychiatric occupational/recreational therapy is covered when provided by a psychiatrist or a registered occupational therapist and when ordered in writing by a physician as part of the recipient's active treatment plan.

### OTHER SERVICES

- Personal care services in homes for the mentally ill. Includes health-related activities or tasks orderd by a physician and provided under the supervision of an R.N. Services include those related to activities of daily living and household services incidental to and consistent with the medical and health care needs of the client.

## MINNESOTA

### INPATIENT HOSPITAL

- Inpatient psychiatric care in a general hospial is limited to 30 days a year, unless prior authorized.

### OUTPATIENT HOSPITAL

- Same coverage and limitations as under PHYSICIAN SERVICES

### PHYSICIAN SERVICES

- Psychiatrists' services*—limited to: a) individual psychotherapy—10 clinical units (1 hour or 50 minutes) a year (more with prior authorization), b) family psychotherapy—2 members: 2 clinical units a week for up to 20 weeks; 3 or more members (one under 18 years old): 26 clinical units a year; c) multiple—family and group psychotherapy—2 hours a week for up to a 10 week period; d) inpatient services—30 days; e) outpatient day treatment—prior authorization is required every 30 days; f) psychiatric diagnostic interview examination—once a month, not to exceed three times a year; g) psychological testing—once a month, not to exceed 3 times a year; h) chemotherapy management requiring antipsychotic or antidepressive medication—psychiatrists only, once a week, up to one year; j) environmental intervention on a patient's behalf and interpretation of testing an examination results—one clinical unit a year; k) outpatient chemical dependency—3 clinical units a day, not to exceed 30 days.
- These limits may be exceeded only with prior authorization.
- ECT—shock therapy.

*All of the above services are also covered for psychologists, except where noted.

### NONPHYSICIAN SERVICES

- Psychologists' services—limitation: a) up to 10 hourly sessions by a licensed psychologist per recipient a year; b) up to 26 additional sessions are covered if 3 or more family members—at least one of whom is under 18—are seen each time and the sessions extend more than 6 consecutive months; c) family psychotherapy for 2 family members is covered as needed for up to 2 hours a week for up to 20 consecutive weeks; d) multiple-family group psychotherapy is covered up to 2 hours a week for 10 consecutive weeks. Extensions of any of these limits requires prior authorization. (Also see PHYSICIAN SERVICES.)
- Inpatient services not covered for psychologists

### CLINIC SERVICES

- Mental health center services facilities must be licensed by the Department of Welfare, nonprofit, and county contracted. Same coverage and limitations as PHYSICIAN SERVICES and NONPHYSICIAN SERVICES.

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## MISSOURI*

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Covered days of service in acute general hospital limited to the lowest of: a) the number of days indicated as appropriate for the diagnosis at the 75th percentile of PAS; b) the number of days certified as medically necessary by a "Binding Review" PSRO; or c) the number of days billed as covered service by the provider.

### OUTPATIENT HOSPITAL

- Limited to three outpatient hospital visits (clinic setting) per provider, per recipient, per month and one emergency room service per day, per provider, per recipient. Additional visits must be shown to be medically necessary. (No specific reference to psychiatric care.)

### PHYSICIAN SERVICES

- Limits new patient office visits to one per provider for each recipient and limits established patients extended or comprehensive visits to one per provider per year for each recipient.

### NONPHYSICIAN SERVICES

- Provided, none applicable to mental health care.

### Clinic Services

- Limited to following provider types: independent clinic, public health department clinic, planned parenthood clinic, teaching institution department, and community health center.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF and ICF not provided.

* Categorically needy only. No medically needy program.

## MONTANA

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- No limits on inpatient psychiatric care in a general hospital.

### OUTPATIENT HOSPITAL

- No limitations other than medical necessity. No particular mental health services are specified.

### PHYSICIAN SERVICES

- No limitations.

### NONPHYSICIAN SERVICES

- Psychologists services—covered when provided by a licensed clinical psychologist, limited to: a) 1½ hour sessions with no more than 8 individuals per group; and b) 22 hours of services or the equivalent per patient per fiscal year (applies to both individual and group outpatient therapy). When a child receives these services and the psychologist consults with the parent as part of the child's treatment, such consultation counts toward the 22-hour limit.
- There are no MD supervision requirements and psychologists may provide services through an independent practice, or mental health center. Psychologists practicing independently bill in their own names; mental health center psychologist services are billed by the agency.

### CLINIC SERVICES

- Covered in licensed regional community mental health centers with subcontracts from the State Department of Institutions to provide mental health clinic services. Included are day care, group and individual therapy.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospitals—Length of stay is determined by a designated review organization.
- SNF and ICF provided. Admissions must be approved by a preadmission screening team.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

## NEBRASKA

### INPATIENT HOSPITAL

- General Hospitals—Emergency or diagnostic psychiatric care up to 5 days under a general physician or up to 13 days if a psychiatrist is consulted.
- Psychiatric Hospitals—Reimbursement for hospitalization of patients whose primary needs are psychiatric is limited to facilities licensed by state health department to give psychiatric care, except as noted above under General Hospitals. Reimbursement for care in Nebraska state regional centers for mental diseases is limited to age groups 65 and older and 21 and younger.

### OUTPATIENT HOSPITAL

- Partial Hospitalization—Half or full day; same services and limitations as those listed under CLINIC SERVICES (Day Treatment).
- Also provided are those services normally rendered in a physician's office, including: psychiatric testing/evaluation, individual, family group psychotherapy; psychotherapy subject to $500 limit per year except by prior authorization; testing and evaluation is exempt from $500 limit; all services must be medically necessary and be a part of an active treatment plan.

### PHYSICIAN SERVICES

- Limited to $500 per patient a year for psychotherapy, except by prior authorization. However, inpatient services are exempt from the $500 limit.

### NONPHYSICIAN SERVICES

- Ph.D.-licensed psychologist—May provide testing and evaluation without supervision; however, psychotherapy must be supervised by an M.D. psychiatrist.
- Ph.D.-licensed and certified clinical psychologist—Operates independently without supervision for all services rendered.
- Psychotherapy limited to $500 per patient per year, except by prior authorization.
- Services provided by other mental health professionals are eligible if services are supervised or reviewed by a physician.

### CLINIC SERVICES

- Day treatment—Available in community mental health centers. Centers must be licensed as a mental health clinic by the Nebraska Department of Health and and accredited by the Joint Commission on Accreditation for Community Mental Health Centers or certified by the Nebraska Department of Public Institutions. Programs of psychiatric day treatment and psychiatric partial hospitalization must provide the following mandatory services: individual, group and family psychotherapy; conference with family or other responsible persons advising them on how to assist client; medically necessary nursing services; medically necessary psychological testing; pharmaceutical and dietary services. The programs may include the following optional services: physical, speech, occupational and inhalation therapy; social work; dietary; recreation therapy; and self-care.
- Reimbursement for psychiatric services is limited to medically necessary primary psychiatric diagnoses.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital
- SNF
- ICF

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—No limits.

## NEVADA*

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—admissions must be certified by the Nevada Professional Review Organization.
- No limits on acute care in general hospital. Same for psychiatric units.

### OUTPATIENT HOSPITAL

- Payment limited to the same extent as PHYSICIAN SERVICES; no specific mention of psychiatric services.

### PHYSICIAN SERVICES

- May not exceed 2 office or nursing facility visits and 2 therapeutic injections per patient per month—unless prior authorized.
- Emergency care and inpatient hospital care are not limited.

### NONPHYSICIAN SERVICES

- None applicable to mental health.

### CLINIC SERVICES

- Mental health clinic services—Provided only in state-operated community mental health clinics; Each nonexempt recipient subject to a copayment of $1 per visit. Clinic visits are counted as physician office visits and may not exceed 2 per month. Services provided at clinic option.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital. (See INPATIENT HOSPITAL.)
- SNF and ICF.
- Copayment of one-half the first day's cost for patients over 65 in IMD.

* Categorically needy only. No medically needy program.

## NEW HAMPSHIRE

### INPATIENT HOSPITAL

- Patients 65 or older in public or private IMDs subject to prior authorization for services provided out-of-state.
- No limits on psychiatric care in an inpatient general hospital.

### OUTPATIENT HOSPITAL

- Limited to 12 visits per recipient per fiscal year, including psychiatric services.

### PHYSICIAN SERVICES

- Coverage is limited to 12 inpatient hospital services and 18 outpatient or ambulatory physician services per recipient a year (includes psychiatric services).

### NONPHYSICIAN SERVICES

- Psychologist services—treatment by a certified clinical psychologist, who is not on the staff of a community mental health center, is covered up to 12 services a year per recipient (see CLINIC SERVICES for limitations on psychologists who are on staff at CMHCs).
- Psychologist services must be prescribed by an attending physician.
- MD supervision is not required.

### CLINIC SERVICES

- Community mental health centers—mental health services covered up to $500 a year per recipient, except for recipients certified as severely mentally disabled and certified to receive long-term care treatment. Services include: individual and group psychotherapy; family therapy; medication check; emergency visit; comprehensive psychiatric evaluation; psychological testing; and partial hospitalization. Any of these services are covered beyond the $500 long-term care limit for recipients certified as severely mentally disabled (individuals whose primary disability results from mental illness).

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF not provided.
- ICF—for categoricaly needy only. Prior authorization is required for a specified amount of stay based on the amount and period of care recommended by patient's physician. Certification and recertification required by physician every 60 days. Extensions require a request by facility based on UR report completed by physician.

## NEW JERSEY*

### INPATIENT HOSPITAL

- Patients 65 or older, or 21 or younger in IMDs.
- Psychiatric care in a general hospital is limited to 40 days per admission unless the physician certifies a need for additional services; any additional psychiatric care requires prior authorization.

### OUTPATIENT HOSPITAL

- Psychiatric services in a hospital outpatient department are covered without prior authorization; however, a physician's certification and plan of treatment are required after 30 days. Partial hospitalization (PH) for psychiatric care is covered as an outpatient service. PH may be day, evening, or night care, and does not require prior authorization for the first 30 days. Prior authorization is required for PH after 30 days, and each authorization may be granted for up to 6 months. Additional authorizations may be requested.

### PHYSICIAN SERVICES

- Prior authorization is required for psychiatric and psychological services that exceed $300 in payment to a physician or psychologist in a 12-month period, commencing with the patient's initial visit. This applies to psychiatric services in settings other than inpatient or outpatient hospital, and to psychological services in settings other than inpatient hospital.

### NONPHYSICIAN SERVICES

- Psychologist services are covered (see limitations under PHYSICIAN SERVICES). Not a covered out-of-state service.

### CLINIC SERVICES

- Mental health clinics must be approved to provide psychiatric services by the New Jersey Department of Human Services, Division of Mental Health and Hospitals. Psychiatric services require prior authorization (see other limitations under PHYSICIAN SERVICES). Services include individual and group therapy, partial care, medication monitoring, and personal care (beginning 2/84).

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- SNF and ICF provided—prior authorization is required from the local medical-assistance unit for admission except when the patient is transferred to the facility directly from an acute care hospital or a Class A special hospital, or a Medicaid-certified psychiatric hospital.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 21

- Provided in private psychiatric hospitals. Limited to 20 days per admission unless the physician certifies a need for up to 20 additional days, and any additional care requires prior authorization.

### OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

- Other than those provided elsewhere under the program.

* Categorically needy only. No medically needy program.

## NEW MEXICO*

### INPATIENT HOSPITAL

- Payment is made only for acute hospital care, except for 1 day (or up to 3 days as certified by the PSRO) needed to secure alternate care.
- No limits on psychiatric care in a general hospital.

### OUTPATIENT HOSPITAL

- See NONPHYSICIAN SERVICES, psychologists.

### PHYSICIAN SERVICES

- Payment will not be made to physicians for more than 2 hourly visits a day per recipient.

### NONPHYSICIAN SERVICES

- Psychologist services—services of certified and licensed psychologists are covered subject to prior authorization by the PSRO for all outpatient psychiatric and psychological services beyond initial evaluation.

### CLINIC SERVICES

- Limited to payment of medical necessity. Payment not made for more than 1 clinic visit a day.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- None.

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* Categorically needy only. No medically needy program.

## NEW YORK

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Psychiatric care in a general hospital limited to 20 days unless more time is authorized by the Department of Health.
- Care in a rehabilitation hospital or rehabilitation unit of a general hospital is limited to 40 days unless more time is authorized by the Department of Health.

### OUTPATIENT HOSPITAL

- The hospital may provide clinic treatment, day treatment, and continuing treatment programs. No specific mention of psychiatric services.

### PHYSICIAN SERVICES

- Psychiatric Care—by a psychiatrist in office, patient's home, clinic, hospital, medical facility, or for person 65 or older or under 21 in a mental disease hospital. Includes psychiatric clinic, day, evening, or overnight care.

### NONPHYSICIAN SERVICES

- Ph.D.-licensed clinical psychologists—services include psychological evaluation, standard testing, group therapy, clinic sessions, and therapeutic encounter sessions. Private practicing psychologists may receive Medicaid reimbursement only for services they provide on a private practitioner basis and will not be reimbursed for services rendered in a facility from which the psychologist receives a salary. New York City Medicaid recipients are not eligible for services provided by private practicing clinical psychologists.

### CLINIC SERVICES

- Mental health services provided in CMHCs, state-operated facilities, rehabilitation centers, freestanding clinics, and hospital-based clinics. Covered services include clinic treatment, day treatment, and continuing treatment. Providers must be certified to provide mental health services, and must be given a certificate by the Office of Mental Health to provide examination, diagnosis, care, treatment, rehabilitation, or training to people who suffer from mental illness.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.
- SNF—provided. Prior authorization is required for admission except when the patient is admitted directly from a hospital, another nursing home, or another health-related facility.
- ICF—provided. Prior authorization is required for admission. Authorization must be renewed every 90 days or in accordance with utilization review regulation of the health commissioner.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

## NORTH DAKOTA

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- No limit on psychiatric care in general hospital.

### OUTPATIENT HOSPITAL

- Emergency room care is covered only in a medical or surgical emergency or when medical necessity is documented by special report, except that emergency room care can also include certain screening/examination services.
- No specific mention of psychiatric services.

### PHYSICIAN SERVICES

- No mention of psychiatric services.

### NONPHYSICIAN SERVICES

- None provided applicable to mental health care.

### CLINIC SERVICES

- Provided—no limits.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.

### OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

- Other than those provided elsewhere in the program.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided—no limits.

## OHIO*

### INPATIENT HOSPITAL

- Patients 65 or older in IMD—no limits.
- Care in a general hospital will not be paid for days exceeding the number approved by PSRO or other appropriate review committee as medically necessary, except that up to three extra days may be preauthorized. Sixty inpatient hospital days are covered in a spell of illness, but the patient may be hospitalized more than once during a spell of illness (60-day limitation does not apply to state-operated facility).
- Psychiatric units in a general hospital limited to 30 days.

### OUTPATIENT HOSPITAL

- Prior authorization is required for more than four visits by a recipient in a month and may be granted up to 10 visits for physician, EPSDT, family planning, and emergency dental services; however, a visit involved in preadmission testing may be covered outside the four visit limit (no specific reference to psychiatric services).

### PHYSICIAN SERVICES

- Prior authorization is required for more than four office visits per patient per month. In no instance are more than 20 visits per patient per month covered whether the patient is in a hospital, nursing home, or at home, or whether visits are made by more than one physician. Services must be medically necessary.

### NONPHYSICIAN SERVICES

- Psychologists services limited to those provided by licensed psychologists. Services include: psychological psychotherapy in office, clinic, hospital, home; and psychological group psychotherapy in the same settings with psychological augmentation or other methods. Psychological testing is limited to eight hours a year per case unless prior authorization is obtained for additional testing. Visits cannot exceed (a) four per month in an outpatient setting, or (b) more than 10 visits per month regardless of physical location of the patient.
- Noncovered psychologist services include: services provided by school psychologists in facilities regulated by the State Board of Education; educational testing and diagnosis; retreats or marathons for mental disorders; sensitivity training; encounter groups; and sexual competency training.
- There are no state requirments for supervision for a licensed psychologist.

### CLINIC SERVICES

- Limited to nonprofit public or proprietary community mental health

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## TEXAS*

### INPATIENT HOSPITAL

• General hospital limited to 30 days "per spell of illness" which begins when the patient enters a hospital and ends when he has not been an inpatient in any hospital for 60 consecutive days.

### OUTPATIENT HOSPITAL

• Same services and limitations listed under PHYSICIAN SERVICES.

### PHYSICIAN SERVICES

• Limited coverage for physician services for a diagnosis or treatment of a mental, psychoneurotic or personality disorder. The limitation is 62.5% of reasonable charge for the service or $312.50, whichever is less, in any calendar year. However, this limitation can be exceeded when prior authorized on a case by case basis. The specific services provided are: group therapy; psychological evaluation and testing; family therapy; psychotherapy; electroshock therapy; Metrazol convulsive shock treatment.

### NONPHYSICIAN SERVICES

• Provided, none appropriate to mental health care.

### CLINIC SERVICES

• None provided.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

• None provided.

* Categorically needy only. No medically needy program.

## UTAH

### INPATIENT HOSPITAL

• Patients 65 or older in institutions for mental diseases, i.e., the program reimburses the Utah State Hospital for the care of eligible elderly psychiatric patients in its geriatric ward—no limits.

• No limits for general hospital care.

### OUTPATIENT HOSPITAL

• Limited to 12 visits a year. Additional visits reimbursed with prior authorization.

### PHYSICIAN SERVICES

• Psychiatric care limited to 12 hours of treatment for each acute illness unless prior written approval for additional care is obtained.

• Chronic care is limited to 1 visit a month for the chronically mentally ill.

### NONPHYSICIAN SERVICES

• Psychologists' services—mental health services by a licensed psychologist in private practice outside an inpatient or outpatient facility. They include: a) diagnostic testing which requires prior authorization; and b) individual or group psychotherapy (6-10 in a group), both limited to a specific number of visits within a specific treatment time period per individual spell of illness.

### CLINIC SERVICES[1]

• Community Mental Health Clinics—services include: a) intake, evaluation, diagnosis, and initiation of treatment plan; b) individual therapy limited to 12 visits for each acute episode of illness and to 1 visit a month for a chronic psychiatric disorder (additional visits may be obtained on written request); c) group therapy; d) day hospital programs—limited to treatment expected to lead to full or partial recovery (includes individual, group, and family therapy, chemotherapy and services provided by other healing arts practitioners); e) day treatment—limited to treatment to promote emotional or psychological change to alleviate the effects of mental disorders (includes, under the supportive counseling, preventive or restorative physical exercise and instruction in self-care relating to health maintenance; includes a more than 2 but less than 12 hour per day service; all day treatment must be prior authorized; approval is granted for 90 day periods); and f) medication management. New or unusual treatment procedures require prior authorization.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

• Hospital (see INPATIENT HOSPITAL).

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## WASHINGTON continued

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- For categorically needy only—Limits are the same as those for INPATIENT HOSPITAL.

[1] Same benefits for medically needy except these recipients must pay, for each hospital admission, a deductible not exceeding ½ of the Medicaid rate for 1 inpatient hospital day.

## WEST VIRGINIA

### INPATIENT HOSPITAL

- Psychiatric care in a general or psychiatric hospital is limited to 20 days a year except for foster children under 18, where the limit can be waived if medically indicated, or except for a specialized program of inpatient psychiatric services for individuals 21 or under, which has no limit.

### OUTPATIENT HOSPITAL

- Psychiatric and psychological services include psychotherapy, chemotherapy, partial hospitalization in approved programs, group therapy, biofeedback, hypnotherapy, conjoint therapy, and consultation.

### PHYSICIAN SERVICES

- Psychiatrists—limited to 10 sessions of psychotherapy without prior approval.

### NONPHYSICIAN SERVICES

- Licensed psychologists—therapy requires prior authorization after 10 sessions. There is no MD supervision requirement.

### CLINIC SERVICES

- Provided in mental health clinics licensed by the Department of Health, and by other clinics meeting standards of the state's Medicaid program.
- Services include those listed under outpatient hospital.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Not provided.

## WISCONSIN*

### INPATIENT HOSPITAL

- Patients 65 and older in IMDs—copayment charge of $3 a day up to a maximum of $75 per stay.
- Patients 22-64 are covered in IMDs for a calendar month, with episodes of care occurring at least 90 days from the date of last discharge (no federal financial participation). Prior approval by county mental health boards required. Copayment of $3 a day up to a maximum of $75.
- General Hospital—No limit (same for psychiatric care).

### OUTPATIENT HOSPITAL

- Day treatment services in excess of 120 hours for outpatients, 40 hours for nursing home patients, or 20 hours for inpatients require prior authorization.
- Prior approval by county mental health boards is required for reimbursement of all outpatient mental health services.
- Psychotherapy limited as noted under PHYSICIAN SERVICES.

### PHYSICIAN SERVICES

- Prior authorization required for psychiatrists to provide psychotherapy in excess of 15 hours or $500 in a 12-month period. No therapy may be provided in the home.
- Psychiatric evaluations are limited to 6 hours per recipient per lifetime and must be approved by county mental health board.
- Copayments required as follows:
  - —Individual Therapy—$.50/15 minutes per recipient;
  - —Evaluations—$1.00/hour per recipient;
  - —Group Therapy—$.50/hour per recipient;
  - —Family Therapy—$2.00/hour per family.

### NONPHYSICIAN SERVICES

- Licensed psychologists and certain masters level mental health clinicians (masters of social work, psychology, and psychiatric nurses) may provide psychotherapy. Same limits as apply to psychotherapy as noted under PHYSICIAN SERVICES. Certified alcohol and other drug abuse (AODA) services counselors may provide AODA counseling. Same limits as apply to psychotherapy. Same copay requirements as noted under PHYSICIAN SERVICES.

### CLINIC SERVICES

- Covered only in clinics approved by Medicare or state Medicaid agency.
- All services except emergency require prior approval by county mental health board and all services require prior authorization for services exceeding 15 hours or $500.
- Clinic must provide or arrange for the following services: diagnosis, evaluation, outpatient, residential facility placement, partial hospitalization, pre-care prior to hospitalization, after-care, emergency care, rehabilitation, habilitation, supportive transitional services, and professional consultation.

### SERVICES FOR OVER 65 FOR MENTAL DISEASES

- Hospital.

### INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22

- Provided, no limits.

### OTHER DIAGNOSTIC SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

- Psychiatric services for problems discovered under EPSDT covered.

### WAIVERS

- Wisconsin has received a waiver to implement a case management and gatekeeping system for mental health services under Section 2175 of the Omnibus Budget Reconciliation Act of 1981. Wisconsin is attempting to expand the range of service options by using local mental health boards as case managers and prudent purchasers, with the notion that better case management will reduce inappropriate institutionalization and provide the opportunity to develop less costly community-based care.

Wisconsin's 1983-85 Budget Act (SB 83, Act 27) contains a provision which expands Wisconsin's medical assistance-mental health gatekeeper program. Under the current statewide program, established in 1981, community mental health boards authorize payment for inpatient mental health and AODA services for individuals age 22 to 64. The boards may use any portion of their funds not applied to their medical assistance liability to fund noninstitutional community programs.

Under the new mental health pilot project, the roles of the boards participating in the program are expanded in two signigicant ways: 1) prior authorization for medical assistance payment by the boards is required for all mental health and AODA services (inpatient, outpatient, day treatment, etc.), and for persons of all ages. The local boards direct Medicaid recipients to those providers of mental health services who adhere to locally established guidelines and criteria for the care and mental health treatment of recipients in their jurisdictions; and 2) the participating boards are liable for the entire state share (43 percent) of the medical assistance payment. As in the current gatekeeper program, boards may use any portion of their allocations not applied to their medical assistance liability to fund noninstitutional programs.

continued next page

1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988)

**Effect of amendments.** — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

The 1988 amendment inserted subsection (b)(10).

**Sec. 47.07.030. Medical services to be provided.** (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988)

**Cross references.** — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

**Effect of amendments.** — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in [illegible] 105.

The 1988 amendment inserted "case management and nutrition services for pregnant women" in subsection (b).

**Sec. 47.07.035. Priority of medical assistance.** If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:



Alaska Statute

1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988)

**Effect of amendments.** — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

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**Cross references.** — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

**Effect of amendments.** — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

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(1) chiropractic services;
(2) adult dental services;
(3) emergency hospital services;
(4) treatment of speech, hearing, and language disorders;
(5) optometrists' services and eyeglasses;
(6) occupational therapy;
(7) prosthetic devices;
(8) medical supplies and equipment;
(9) clinic services;
(10) physical therapy;
(11) personal care services in a recipient's home;
(12) long-term care noninstitutional services;
(13) inpatient psychiatric facility services;
(14) intermediate care facility services for the mentally retarded;
(15) intermediate care facility services;
(16) pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level;
(17) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(18) skilled nursing facility services for persons under age 21;
(19) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;
(20) individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;
(21) individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988)

**Cross references.** — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

**Effect of amendments.** — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) as present paragraphs (17)-(21).

the division before admission to the hospital; failure to obtain authorization will result in nonpayment regardless of the eligibility of the recipient or the appropriateness of the services.

(b) Except as provided in this subsection, the division will not pay for more than one physician visit in a 30-day period for a patient in either a skilled nursing or an intermediate care facility. The division will, in its discretion, pay for additional visits if written justification, acceptable to the division, accompanies the bill for the physician visit. (Eff. 8/18/79, Register 71; am 3/25/83, Register 85; am 7/1/85, Register 95; am 9/25/85, Register 95)

**Authority:** AS 47.05.010
AS 47.07.030
AS 47.07.050

**7 AAC 43.120. X-RAY SERVICES.** Diagnostic and follow-up X-rays do not require prior approval by the division, but films must be made available to the division on request. (Eff. 8/18/79, Register 71)

**Authority:** AS 47.05.010
AS 47.07.030
AS 47.07.050

**7 AAC 43.125. LABORATORY SERVICES.** (a) A physician using his or her own laboratory to provide necessary laboratory services will be reimbursed according to the medicare fee schedule in 42 C.F.R. 405.515.

(b) A physician using the services of an independent laboratory shall request services for a recipient in the same manner that services are requested for a private patient.

(c) An independent laboratory certified by the department, or certified by the state medicaid agency or medicare if located out-of-state, may bill the division directly. Reimbursement for clinical laboratory tests will be made by the division according to the medicare fee schedule in 42 C.F.R. 405.515. (Eff. 8/18/79, Register 71; am 3/30/88, Register 106)

**Authority:** AS 47.05.010
AS 47.07.050

(*)

**7 AAC 43.130. PSYCHIATRIC SERVICES.** (a) Payment to a physician for psychotherapy services will be provided without prior authorization for services to recipients on an outpatient basis.

(b) Services by a psychologist, social worker or nurse are not covered outside of a psychiatric facility or general hospital except when provided through a community mental health clinic enrolled as a provider in the medicaid program. (Eff. 8/18/79, Register 71)

(b) If the department provides or pays for medical assistance for injury or illness under this title, the department is subrogated to the rights of the recipient of that medical assistance for any claim arising from the injury or illness and to the proceeds of an insurance policy covering the injury or illness to the extent of the value of the medical assistance provided.

(c) If a recipient of medical assistance under this title settles a claim or obtains an award of judgment arising from the injury or illness for which the medical assistance was received, the department shall reimburse the recipient for attorney fees and costs commensurate with the amount of the settlement, award, or judgment to which the department is entitled under (b) of this section. Regardless of the manner in which the amount of the attorney fees is derived, reimbursement of attorney fees shall be in accordance with the applicable rules of court governing the award of attorney fees in civil matters.

(d) The department is authorized to enter into contracts for the collection of medical expenses already paid by Medicaid from potential third-party payors. The department may pay, from the funds recovered by the contractor, any amounts owing to the federal government as its share of the Medicaid paid claim, and the costs of collecting the funds. (§ 2 ch 105 SLA 1986)

## Chapter 07. Medical Assistance for Needy Persons.

Section
20. Eligible persons
30. Medical services to be provided
35. Priority of medical assistance
40. State plan for provision of medical assistance

Section
70. Payment to health facilities
180. Duties
900. Definitions

**Sec. 47.07.020. Eligible persons.** (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for

assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b) (4) of this section, a person is not eligible for medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA

(1) chiropractic services;
(2) adult dental services;
(3) emergency hospital services;
(4) treatment of speech, hearing, and language disorders;
(5) optometrists' services and eyeglasses;
(6) occupational therapy;
(7) prosthetic devices;
(8) medical supplies and equipment;
(9) clinic services;
(10) physical therapy;
(11) personal care services in a recipient's home;
(12) long-term care noninstitutional services;
(13) inpatient psychiatric facility services;
(14) intermediate care facility services for the mentally retarded;
(15) intermediate care facility services;
(16) pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level;
(17) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(18) skilled nursing facility services for persons under age 21;
(19) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;
(20) individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;
(21) individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988)

**Cross references.** — For program authorizing payment for prescribed drugs during fiscal year 1989, see ch. 120, SLA 1988 in the Temporary and Special Acts.

**Effect of amendments.** — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) as present paragraphs (17)-(21).

TABLE 1

NUMBER OF LICENSED HEALTH CARE PROVIDERS OF VARIOUS TYPES RESIDING IN EACH HOUSE ELECTION DISTRICT

| HOUSE ELECTION DISTRICT | 1985 POPULATION | SUMMARY: NUMBER OF HEALTH CARE PROVIDERS | | SUMMARY: AS PERCENT OF STATEWIDE | | NUMBER OF LICENSED HEALTH CARE PROVIDERS | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | PER 1,000 | PROVIDERS | POPN | PARAMEDICS | PHARMACISTS | PHYSICAL THERAPISTS | OPTOMOLOGISTS | CHIROPRACTORS | PSYCHOLOGISTS | REGISTERED NURSES | PRACTICAL NURSES | ADVANCED NURSE PRACTITIONERS | NURSE ANESTHETISTS | PHYSICIANS | OSTEOPATHS | PODIATRISTS | DENTISTS | DENTAL HYGIENISTS |
| ED 1 | 18,397 | 307 | 16.7 | 4.1 | 3.4 | 1 | 13 | 9 | 0 | 5 | 3 | 175 | 41 | 7 | 3 | 30 | 0 | 0 | 15 | 5 |
| ED 2 | 10,782 | 40 | 3.7 | 0.5 | 2.0 | 0 | 0 | 2 | 0 | 0 | 0 | 24 | 4 | 1 | 0 | 3 | 0 | 0 | 4 | 2 |
| ED 3 | 8,770 | 202 | 23.0 | 2.7 | 1.6 | 1 | 9 | 5 | 0 | 2 | 4 | 130 | 22 | 1 | 2 | 16 | 0 | 0 | 6 | 4 |
| ED 4 | 26,270 | 401 | 15.3 | 5.4 | 4.9 | 1 | 14 | 10 | 5 | 6 | 6 | 224 | 38 | 7 | 1 | 49 | 1 | 1 | 17 | 21 |
| ED 5 | 32,670 | 464 | 14.2 | 6.2 | 6.1 | 13 | 15 | 8 | 4 | 14 | 6 | 260 | 73 | 6 | 2 | 33 | 1 | 0 | 12 | 17 |
| ED 6 | 9,717 | 140 | 14.4 | 1.9 | 1.8 | 0 | 3 | 2 | 0 | 4 | 3 | 81 | 28 | 2 | 0 | 10 | 0 | 0 | 4 | 3 |
| ED 7-15 | 237,796 | 3,906 | 16.4 | 52.3 | 44.1 | 45 | 100 | 74 | 33 | 52 | 52 | 2,155 | 454 | 66 | 14 | 491 | 24 | 6 | 181 | 159 |
| ED 16 | 36,833 | 457 | 12.4 | 6.1 | 6.8 | 8 | 8 | 15 | 2 | 10 | 2 | 276 | 62 | 8 | 2 | 33 | 2 | 1 | 15 | 13 |
| ED 17 | 11,737 | 93 | 7.9 | 1.2 | 2.2 | 1 | 2 | 0 | 0 | 2 | 0 | 64 | 15 | 2 | 0 | 2 | 1 | 0 | 2 | 2 |
| ED 18-21 | 72,614 | 1,005 | 13.8 | 13.5 | 13.5 | 17 | 37 | 28 | 10 | 12 | 21 | 542 | 126 | 9 | 4 | 127 | 4 | 1 | 44 | 25 |
| ED 22 | 11,454 | 55 | 4.8 | 0.7 | 2.1 | 0 | 2 | 0 | 0 | 0 | 0 | 38 | 4 | 5 | 0 | 4 | 1 | 0 | 0 | 1 |
| ED 23 | 11,104 | 58 | 5.2 | 0.8 | 2.1 | 1 | 2 | 0 | 0 | 0 | 0 | 37 | 3 | 2 | 0 | 6 | 1 | 0 | 5 | 1 |
| ED 24 | 11,503 | 22 | 1.9 | 0.3 | 2.1 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 1 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| ED 25 | 11,018 | 95 | 8.6 | 1.3 | 2.0 | 0 | 1 | 1 | 3 | 0 | 1 | 58 | 6 | 5 | 0 | 10 | 1 | 0 | 8 | 1 |
| ED 26 | 15,563 | 73 | 4.7 | 1.0 | 2.9 | 0 | 1 | 0 | 1 | 1 | 1 | 48 | 5 | 4 | 0 | 6 | 1 | 0 | 2 | 3 |
| ED 27 | 13,483 | 150 | 11.1 | 2.0 | 2.5 | 1 | 5 | 6 | 2 | 3 | 3 | 85 | 16 | 0 | 2 | 13 | 2 | 0 | 8 | 4 |
| STATEWIDE | 539,711 | 7,468 | 13.8 | 100 | 100 | 89 | 212 | 158 | 60 | 111 | 102 | 4,214 | 898 | 129 | 30 | 833 | 39 | 9 | 323 | 261 |
| PERCENT OF TOTAL | | | | | | 1.2 | 2.8 | 2.1 | 0.8 | 1.5 | 1.4 | 56.4 | 12.0 | 1.7 | 0.4 | 11.2 | 0.5 | 0.1 | 4.3 | 3.5 |

NOTES:

1. Population figures are from the Alaska Department of Labor for July 1, 1985.

2. Health care provider numbers were provided by the Department of Commerce and Economic Development, Division of Occupational Licensing.

3. In addition to the medical occupations shown in the table, the State of Alaska licenses naturopaths. Currently six naturopaths are licensed to practice in Alaska: 2 Anchorage residents, 1 Wasilla resident, 1 Juneau resident and 2 nonresidents.

Prepared by the House Research Agency, November 1988 (89.020)

## COST-SAVINGS AS A RESULT OF PSYCHOTHERAPY

A number of studies have discussed the fact that overall medical costs are dramatically reduced one year after a patient has been in psychotherapy. The following are a few of those studies. Specific references will be provided upon request:

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1. Nicholas Cummings, Ph.D., with Kaiser-Permanente mental health programs stated in the October 15, 1982 Psychiatric New that "...Dispite two decades of research...showing that brief psychotherapy dramatically reduces utilization of other medical resources, policymakers continue to ignore these findings when designing health care systems...." He found in his study that resolving financial problems of HMO's was done "...by relying or brief psychotherapy to reduce the high incidence of unnecessary medical care....medical utilization declined significantly--and stayed down for the five years studied...[and]...amoung patient who completed brief psychotherapy, medical utilization dropped 75 percent." This was seen as important when, as he indicated, "...60 percent of all patient care could not be attributed to organic illness but was due, instead, to psychological problems." Patients many times reported not liking their therapists, and that therapy did not help them, but they did dramatically change their overall medical overutilization and nc longer had symptoms. There have been over 28 replications of these studies.

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2. In 1977 Sten and Young in completing a Masters degree (M.S.W.) thesis at Portland State University found that clinica social work psychotherapy of patients at Kaiser Permanente in ortland, helped to significantly reduce patient er-utilization of other medical services. There was a .47.1% decrease in physician office visits; a 48.6% decrease he number of physicians seen for office visits; a 31.2% de e in telephone contacts; a 48.6% decrease in the number of p iptions written; a 45.3% decrease in emergency room

visits; a 66.7% decrease in frequency of hospitalizations and a 77.9% decrease in the average length of stay in the hospital...intervention appeared to be positively assocated with an over-all change rate of some 53 percent....."

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3. Jones and Vischi (1979), in reviewing twenty-five (25) research projects, showed that after an individual was in psychotherapy reductions in medical/surgical expenditures averaged 57% in one study to 62% in out-patint medical visits and 68% in in-patient care.

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4. A Kaiser-Permanente study of 152 patients showed that over a five year period there was a reduction in out-patient visits of 62% and 68% for in-patients. The most important aspect of this study is that the matched non-treatment controls, also a psychologicall distressed group, showed no change in their health care utilization over the same five year period.

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5. A West German study utilizing a five year follow-up period after mental health treatment found an 85% reduction in in-patient utilization.

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6. Other studies indicated that waiting list, non-treated, groups demonstrated the highest levels of medical care over-utilization, with even increases seen in their request for more doctors appointments and hospitalizations. Other findings revealed that even one psychotherapy session was effective in reducing medical care utilization. However, greater reductions in medical utilization rates were noted with increasing frequency of psychotherpy contacts. Weekly therapy sessions, particularly on a short-term basis of 12 sessions, lead to the greatest psychotherapeutic benefits.

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7. Research conducted by Blue Cross/Blue Shield, reported in the New York Times and by the Psychotherapy in Private Practice Journal , with joint sponsorship by the National Institutes of Mental Health, found that "...psychotherapy can

significantly reduce hospital costs for physical ailments among people with heart disease--ischemic and hypertensive, air-flow limitations disease and diabetes." the findings indicated "...that people who had at least 7 visits of out-patient psychotherapy after the diagnosis of one of these 4 diseases incurred costs for medical services that were 66% lower than the costs for those who did not have psychotherapy....They found that psychotherapy was most effective when it involved moderate amounts of out-patient visits ranging from 7 to 20."

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8. A University of Colorado study reported in the September 21, 1984 Psychiatric News reviewed claims for Blue Cross/Blue Shield patients. The findings indicated that psychotherapy significantly reduced medical services, and particularly inpatient services. "...after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 8.7 days.....The average change after psychotherapy was -73.4 percent for inpatient and -22.6 percent for outpatient care.....After the initial year, the psychotherapy group had significantly lower inpatient medical care costs in each of the other four years analyzed."

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9. Emily Mumford, Ph.D. in the October, 1984 issue of the American Journal of Psyhiatry presented her findings of reviewing over 58 research projects on pschotherapy. The results demonstrated that patient costs dropped dramatically after involvement in psychotherapy. Again there were significant reductions in in-patient stays for medical problems for those patients who received psychotherapy. "...following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year....In contrast, the charges of the comparison group increased faster than the inflation rate."

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10. A study reported in Psychotherapy Finances in 1983 reported in findings by the U. S. Steel Company that there was a savings of $5.00 for every $1.00 spent on mental health services. Polaroid and several other large companies have reported similar results at the same time.

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11. Federal Employees health insurance programs, which have generous mental health benefits, showed that only 5 - 7% of the total health care costs are for emotional disorders.

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12. Studies at the local HMO, SelectCare, in studying 31 Ph.D. and M.S.W. providers, in computer analysis of records demonstrated that the average number of visits over a 3 year period was only 5.4 visits for all providers. A year later it was 4.3 visits. The analysis also indicated that mental health benefits are a very small part of their benefit package, i.e., 7/10th of 1% of their entire budget.

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13. In 1977 there were 118,767 patient contacts with 45 physicians at The Eugene Hospital and Clinic. Of these out-patients only 2,900, or 2.44% were diagnosed as having mental or emotional disorders by the physicians.

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14. The Group health Association of Washington, D.C., showed a reduction in usage of general medical care by as much as 30.7%, and a 29.8% drop in Lab and X-ray use the year after psychotherapy services were received.

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15. Kaiser Plan of California saved 250.00/yr, in the following year, for each patient who received psychotherapy services.

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20. Blue Cross of Western Pennsylvania noted a 50% decline in monthly costs per patient in the use of medical-surgical procedures/services for those patients who had received psychothe- py services.

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21. Studies of coverage of clinical social work psychotherpy services in private health insurance programs in new York State only costs $0.00 - $0.15 per month/premium (NASW in Washington

D.C. study).

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22. A 1972 study in West Germany of Insurance coverage for 1,004 patients, also in a five year follow-up study, who had averaged 100 hours of psychotherapy found that 81% felt strongly they were helped by treatment. Further, their hospital rage usage was reduced to 0.78 hospital days/year. Pre-treatment usage averaged 5.3 days/year, with the general population average being 2.5 days/year. This included hospitalization for any illness.

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23. Otto Jones, M.S.W., a clinical social worker, developed a mental health program for employees at Kennecott Copper in Utah. Before the program employees averaged 5.8 working days/month absence, weekly indemnity costs averaged $70.67/person/month, and hospital/medical/surgical costs averaged $109.04/person/month. One year after psychotherapy significant reductions were noted: Absenteeism decreased to a 2.93 average working days/month, weekly indemnity costs averaged 25.33/person/month, and hospital/med/surg. costs averaged $56.91/person/month. <u>THIS IS A 49.5% REDUCTION IN ABSENTEEISM, A 64.2% REDUCTION IN WEEKLY INDEMNITY, AND A 48.9% REDUCTION IN HOSP.-MED.-SURGERY COSTS!!</u> Those employees not invoved in psychotherapy tended to get worse and showed increases of: 2.9% increase in absenteeism, a 28.5% increase in weekly indemnity costs, and a 7.7% increase in hospital, medical and surgical costs.

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24. A 1980 letter from Blue Cross of California indicated that psychotherapy coverage for clinical social workers is "...a small part of their total health care package...[and]...have little impact on the total rates for health coverage."

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25. A 1979 study reported in <u>Psychiatric News</u> states that "...mental health claims are not a substantial portion of total claims dollars." Again the findings were that only between 5 to 7% of the claims dollars were paid out for mental heath care of all types including inpatient services. In general "...costs of mental health care.. have lagged behind the increases in other health services."

26. A 1984 NIMH study ( AMA News, November 9, 1984 ), which is the largest and most comprehensive survey to date of mental disorders indicates that 20% of all adult Americans suffers from at least one mental disorder. Such disorders were equally divided between males and females. However, only 1/5th of those so identified ever saw a mental health professional for treatment. The rest were seen by their family physician only and never referred for servces.

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27. A 1980 article in American Medical News (10/10/84) statec that "...A prepaid mental health care program...appears able to cut healh expences...." As a result of this intervention and cost-savings, "...for the first time in three years, Stationers Corp. did not have an increase in its health insurance premiums."

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28. McDonnell Douglas (and several other companies like Xeros, Hallmark Cards, Pitney Bowes, and IBM) in providing in-house mental health services for employees "calculates that it saved $4 million over 10 years...and other companies also report lowered costs for medical and disability insurance, fewer accidents and reduced absenteeism...."

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29. A 1980 article in the American Journal of Psychiatry indicates that only 7.3% of insured patients had services for mental health disorders. Of these, over half the claims for such services were submitted by general physicians and not mental health professionals.

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30. A 1981 study reported in American Medical News (9/4/81) found that treatment for alcoholism resulted in a savings of $1.5 million, with "alcoholism rehabilitation programs [having] an 85% success rate." A Stress management and health back programs also saved further money. "...the $2.7 million estimated savings are "conservative figures..." for New York Telephone employees.

31. A 1983 study in the <u>Journal of Pain</u> found that utilization of EMG Biofeedback treatment in patients with chronic rheumatic back pain resulted in significant positive changes. "...At the end of the treatment phase and at the 4 month followup the patients in the biofeedback group showed significant improvements in the duration, intensity, and quality of their back pain as well as their EMG levels, negative self-statements, and utilization of the health care system." Non-treated, control groups, and traditionally medically treated groups showed no improvements in their conditions at all."

## POINT OF VIEW *Ronald Bronow*

# Why the Prognosis Is Poor for the HMO System

Just a few years ago, everybody was saying that Health Maintenance Organizations would reshape our entire health-care delivery system.

In theory, it looked pretty good. The patient would pay a single premium and be covered for all of his medical needs, from doctor visits to surgical and hospital fees. The HMOs, by stressing preventative medicine techniques, were supposed to keep people healthy enough that they would need less medical care.

Well, it hasn't exactly worked out that way. The HMOs are in deep trouble; three out of every four plans are losing money.

Forbes magazine says, "This once-vaunted scheme for holding down medical costs has turned out to be one of the decade's most over-hyped flops."

Business Week says, "Federal investigators believe they have uncovered a nationwide conspiracy by alleged mob groups to exploit the prepaid health-care industry."

The HMOs were supposed to eliminate unnecessary medical costs without reducing quality of care. What happened?

They simply couldn't do it. The industry is being clobbered because of its inability to hold down costs. By removing medical deductibles in order to get new customers, the patients can go to their doctor any time they want, because it's free.

The end result: All of the companies' health-care costs are rising faster than their incomes. They can't raise their premiums enough to make money, because of tremendous competition from all of the other

Ronald Bronow is a dermatologist who practices in Los Angeles.

HMOs and the pressure from employers to keep prices down.

Sixteen HMOs disappeared in 1987, and several states are taking action to protect consumers, forcing solvent HMOs to set up guarantee funds to pay claims of other HMOs who go broke.

The real crisis today is with the HMOs that treat Medicare patients. Twenty-nine plans did not renew their contracts for 1988, resulting in disruption of health care for 84,000 senior citizens. Last year was the first in which there was a decrease in enrollments since the program started in 1985.

So, the HMOs are utilizing some tough options:

- Dump the Medicare patients because they get sick and use more services.
- Increase the premiums and reduce the benefits to patients.
- Renegotiate lower rates for physicians.

At the same time the HMOs are spending millions of dollars on advertising (money that used to go for patient care), trying to attract young and healthy subscribers who don't get sick — and not enrolling those who might. Then they make it inconvenient for those who really get sick to get care. Maybe the patient will quit and go somewhere else.

Finally, they put the pressure on the doctor to perform fewer services. The main way they do that is by assigning the patient to a "gate-keeper" doctor, who evaluates whether the patient needs consultations, X-rays or laboratory tests. A review committee must then rule on the doctor's requests. These judgments are frequently based more on economics than patients' needs.

On top of this, all outside services or consultations approved are deducted from the "gate-keeper's" salary. Many people have called this form of treatment "under-care," the purpose being to delay.

(Note: This discussion does not include Kaiser, a high-quality HMO that does not pay its physicians more money if they provide less care to their patients.)

To us physicians, this is immoral. We did not go to medical school to learn how to

*The industry is being clobbered because it can't hold down costs*

ration care so a corporate executive can show a profit to his stockholders. We can't accept inferior quality of care: A Northern California HMO told its physicians to "avoid aggressive or heroic measures such as resuscitating the frail elderly, where a high morbility or mortality rate can be expected."

So, what have the HMOs accomplished? By grabbing the young healthy patients, higher risks are pushed into the other insurance companies. That's why your premiums are skyrocketing.

Hospitals, because they have to discount to these "managed care" plans, are now unwilling to take care of the poor.

What has been saved by all of this? Nothing. Medical inflation continues at the same rate, while an increasing number of American citizens are subjected to rationing and second-rate care.

What should we do about this? We must start over. There should be a national dialogue on the flaws in our health-care system, with proposals to reform it.

Finally, we must protect the freedom and integrity of the physician while extending health care to more people. Don't lose your rights to receive quality care and our rights to practice quality medicine.

# Mental care seen reducing medical costs

The provision of necessary mental treatment for many medical patients can lead to a decline in subsequent medical costs, according to a study described in the October issue of the *American Journal of Psychiatry*.

The savings are particularly significant among the hospitalized and the elderly, according to the report.

The two-part study analyzed data from 58 published and unpublished research reports comparing hospitalized patients' medical costs before and after they received mental health services. "Eighty-five percent of all these studies reported a decrease in medical utilization following psychotherapy," wrote Emily Mumford, PhD, of the New York State Psychiatric Institute.

She and her colleagues concluded that the "clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. . . . Older patients show larger cost-offset effects than younger ones."

Twenty-two of the 58 studies dealt with medical-surgical patients who received emotional, psychological, and educational support during hospitalization. These studies generally found that these patients recuperated faster than those who did not receive such support, with an average reduction in inpatient length of stay of 1.5 days.

ANOTHER 26 studies compared medical utilization before and after psychotherapy. Twenty of the studies showed an average decline of 33% in the use of medical services. Five other studies comparing the use of inpatient and outpatient costs after psychotherapy showed that inpatient costs dropped more dramatically.

Dr. Mumford pointed out that psychological support had a greater effect on people older than 55. A study of elderly patients hospitalized for leg fractures showed that those who received psychiatric consultation left the hospital an average of 12 days earlier than those who did not, and "twice as many of the patients who had been provided [with] consultation returned home rather than being discharged to a nursing home or other institution," the report stated.

The second part of the study was based on a review of data from the files of the Blue Cross/Blue Shield Federal Employes Plan, which covers 6.7 million people.

Dr. Mumford and her associates, comparing claims from individuals who had received psychotherapy with those who had not, found that medical charges for all patients increased during the study. The authors reported, however, that "following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year. . . . In contrast, the charges of the comparison group increased faster than the inflation rate."

# Psychotherapy Reduces Costs For Other Care, Study Shows

Support for the contention that psychotherapy leads to lower costs for other medical services was bolstered recently with the completion of a major study at the University of Colorado Health Sciences Center.

Researchers Emily Mumford, Herbert J. Schlesinger, Gene V. Glass, Cathleen Patrick (all Ph.D.'s), and Timothy Cuerdon analyzed 58 cost-offset studies completed since 1978 and the 1974–78 claims files of the Blue Cross and Blue Shield Federal Employees Program (FEP), which contains insurance information on 6.7 million persons. They found that outpatient mental health treatment (including psychotherapy and less intensive interventions) led to significant reductions in utilization of medical services, particularly inpatient services.

Their analyses also indicated a larger cost-offset effect among older people who had received mental health treatment than among young or middle-aged psychotherapy patients. Their findings will be published in the October issue of the *American Journal of Psychiatry*.

The two sets of data the researchers analyzed produced similar results.

Data from the 58 cost-offset studies indicated that in 85 percent of the studies there was a decrease in medical care utilization after psychotherapy. The researchers analyzed only the 22 studies that could not be biased by self-selection as in the naturalistic, time-series ones that compared the individual's medical care use before and after psychotherapy. They found that after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 8.7 days.

Most of the experimental (treatment) group received only modest psychotherapeutic intervention, while the control group received just a standard medical regimen.

In five of the controlled experimental studies, Mumford and her colleagues were able to analyze data on both inpatient and outpatient medical utilization. The average change after psychotherapy was -73.4 percent for inpatient and -22.6 percent for outpatient care.

### *Inflation Rate*

The researchers also compared the FEP data with inflation rates for the five-year study period. They found that while medical charges for all groups increased during this period, the total care charges for the psychotherapy treatment group—all of whom had at least seven outpatient and no inpatient visits—increased more slowly than the average inflation rate of 13.6 percent. Similar charges for the comparison group increased faster than did the inflation rate.

After the initial year, the psychotherapy group had significantly lower inpatient medical care costs in each of the other four years analyzed. In each year the treatment group outspent the comparison group for outpatient care, and the differences remained constant throughout the period. The cost reductions were thus attributable primarily to lower inpatient costs.

### *Age*

Age turned out to be a significant factor in the degree of cost-offset following mental health treatment.

Twenty-three of the 58 studies reported the mean age of the subjects, including 15 studies of inpatients, four of outpatients, and four of alcoholic outpatients. In all three settings older people had greater reductions in medical care use after mental health treatment.

Comparable results were evident when they analyzed the FEP data for age differences. Patients 55 years of age or older showed the greatest decrease in hospital charges after psychotherapeutic intervention. Their average inpatient medical charges in 1974, the first year of the study period, were more than $160 higher than those of the comparison group. By 1978 the treatment group was spending $70 less than the comparison group. Differences in outpatient expenses were not significant.

Using research showing that elderly persons suffer more emotional distress than younger ones—due largely to chronic illnesses, loss of friends, loved ones, or income, and forced relocation—yet receive proportionally less psychiatric care, Mumford and colleagues suggest that "underutilization of mental health services by the elderly may result in needless suffering among the elderly and needless cost to society."

Physicians spend less time with their older patients, the researchers point out, and thus offer little emotional support to the group that could benefit most from a sympathetic ear. Nonpsychiatric physicians are often unaware of how important it is for them to boost the determination of older patients to continue taking medication as prescribed and to follow other medical advice.

The problem is compounded and the cost of medical care increased, they suggest, by the frequent reluctance of older patients to confide emotional problems to younger physicians, who may in turn neglect to ask about emotional and psychological problems that may be affecting their elderly patients.

No Psychiatr in out lying areas.

Extensive waiting lists (Jean Book
Ketchikan)

"under supervision"

some care better than no care

/

Shannon Kohler SB 148
Kathleen Dinius SB 29

Fed Match.

GREG SPALENKA FOR USN&WR

# The ultimate betrayal

## BEHAVIOR ■ When sex enters the equation, psychotherapy is over

This is how it begins: An attractive young woman goes to see a psychotherapist for the first time. Perhaps she is having trouble with men. Perhaps she is overly impulsive or drinks too much or has nightmares. She relaxes inside the quiet consulting room, with its Persian rugs and tall bookshelves. She tells her deepest secrets, opening up to the middle-aged man who sits across from her, his brown oxfords polished, his eyes intent, listening. Yet there is something not quite right. Is it that he is a little too personal? That he is so willing to talk about himself? She can't quite put her finger on it. She begins to dream about him. If he mentions a book, she runs out to buy it. At night, she calls his answering machine just to hear his voice. He has become her protector, her father.

This is what she does not know: The therapist has problems of his own. He is lonely. His children have left home, and in his eyes his wife is old and unappealing. To make matters worse, he is bored with his work, with the hourly grind of listening to unhappy people who never seem to change. There are medical problems—nothing life threatening, but enough to remind him of the possibility that life will end. He is losing his sense of professional boundaries, but he doesn't know it yet. At night, he pours himself a glass of brandy. Then another. Still, he cannot fall asleep.

This is what happens: One day the young woman who has come to him for help is upset at the end of the hour. She is crying, and as he ushers her to the door, he leans forward and gives her a lingering hug. Or one day she brings him an expensive gift, a pen-and-ink drawing for his wall, and he accepts it and then, suddenly, begins to talk about his own depression. What could be the harm? She is such a good listener. A few weeks later, he changes her appointment to late in the day. At the end of the hour they walk to the waiting room, then to the corner Italian restaurant for dinner and then, when he mentions that his wife is away, to his house. He makes her promise she will not tell anyone what has happened between them. Afterward, fighting waves of panic, she feels suddenly that she will never recover from this.

**Freudian warning.** Almost a century ago, Sigmund Freud cautioned his followers not to become romantically involved with the patients they treated. Freud knew that, by its very nature, the relationship between therapist and patient is unequal, a re-creation of the inequality between parent and child. As the therapy progresses, the therapist takes on a larger-than-life quality. He becomes a powerful, idealized figure, and the patient develops exaggerated feelings for him, for a time even falling in love. But these emotions are artificially created, fueled in part by the inequality in power, and the therapist's job is to help sort them out. If, instead, he turns them to his own sexual advantage, Freud warned, the result will be disas-

trous for both treatment and patient.

Yet a startling number of modern psychotherapists ignore the injunction against sexual involvement, even though it is now written into the ethical codes of professional groups such as the American Psychiatric Association and served up to beginning therapists along with the first lessons on diagnosis and treatment. Anonymous surveys of psychiatrists, psychologists, social workers and other mental-health professionals indicate that up to 12 percent of practitioners in these groups have had sexual contact with patients, many citing "client welfare" as the rationale for their actions. And these numbers, experts say, are almost certainly underestimates, since many offending therapists will not admit to their actions—even anonymously. The true incidence could be as high as 15 or even 25 percent.

**Links to incest.** In part, the figures are alarming because studies have borne out Freud's predictions, demonstrating that sexual misconduct by a therapist can have severe and long-lasting effects for the patient. Not without reason have some researchers compared the plight of sexually exploited patients to that of incest victims. The situations have much in common: Both involve a deep betrayal of trust, a demand for secrecy, a conflict between loyalty and the knowledge that something is very wrong. California psychologist Kenneth Pope has described a syndrome that is often seen in patients who have been sexually abused by a therapist. The complaints include a worsening of previously existing psychiatric symptoms, increased difficulty in personal relationships, feelings of guilt, emptiness and suppressed rage, an inability to trust and an increased risk of suicide.

Perhaps not surprisingly, the vast majority of therapists who coax or coerce their patients into bed are male, while those they prey upon are overwhelmingly female. The victims are often women who suffer from low self-esteem and who sought therapy to begin with because their sense of self was tenuous, their personal boundaries uncertain. Sometimes these women also have a history of sexual abuse by a relative or neighbor. Once inside the therapist's office, they find it difficult to assert themselves against the man to whom they have already confided their most private thoughts and feelings. The therapist, for his part, finds such patients easy to bully into keeping the relationship a secret.

Who are these men? At the extreme, they can be sadistic and mentally unbalanced, like the "Svengali" who drugs his patients into submission, or the psychiatrist—a devotee of author Ayn Rand—who re-enacted rape scenes with his patients to teach them the "positive value" of sexual submission. Some have what are termed character disorders and are blinded to the needs and feelings of others by their own narcissism and self-absorption. Yet much more common, says Dr. Robert Simon, director of the program in psychiatry and law at Georgetown University School of Medicine, is the middle-aged therapist whose marriage is in trouble and who—feeling old and isolated—turns to an attractive female patient for the intimacy missing from his own life.

Dr. Peter Rutter, author of the 1989 book *Sex in the Forbidden Zone* (Jeremy Tarcher; $17.95), argues that therapists who break the rules are acting on temptations that many—perhaps most—men feel. "To me, and to all m[illegible]n in power, the woman can easily become a sympathetic, wounded, vulnerable presence who admires us and needs us in an especially feminine way," he writes. For men, the allure of sex with a woman who trusts and depends on them reflects a wider, cultural imbalance in power between women and men that is "epidemic," Rutter asserts.

Yet some men are more vulnerable. Georgetown's Simon has found that professionals who are poorly trained, who abuse drugs or alcohol, who have not been in psychotherapy themselves or who are unable to manage the intense "countertransference" feelings that psychotherapy often evokes in those who practice it are more likely to engage in sexual relationships with patients. Nor is high achievement a deterrent: A 1988 survey by Pope and his colleagues found that the incidence of sexual abuse among prominent practitioners—tenured professors and chairmen of ethics committees—was actually higher than among therapists in general.

Rarely does the sexual interlude occur abruptly or without prelude. Instead, there is a gradual erosion of professional boundaries, a move from handshake to hug, a period of self-confession by the therapist, an agreement to allow the patient to "pay" for sessions by cleaning the office or editing manuscripts. Says Simon: "The problem is that wher[illegible]n crossing boun[illegible] little bit here and a little bi[illegible] there, and before you know it you're on a slippery slope to sexual malpractice." A typical case, he says, is the widowed 63-year-old therapist who slowly began to talk more about his own feelings during sessions with a 45-year-old patient. The patient took on the role of confidante, sometimes putting her arm around her therapist when he broke down crying. Eventually, they began a relationship outside the office. Observes Simon: "The therapist's depression improved."

There are also cases that strain credibility. One therapist, to prove to his patient he was not attracted to her, suggested that they both disrobe. Another professional described in Rutter's book listened to a female patient talk about the pain and horror she had suffered as a child when a man forced her to perform fellatio on him. Later, the therapist approached her sexually. His first request was that she repeat the humiliation of her childhood.

Not one of the more than 400 brands of talking therapy proliferating in the U.S.

GREG C. ALANKA FOR USN&WR

*A violation of trust, a demand for secrecy*

recommends sex with patients as a beneficial treatment. Yet therapists as a group have until recently upheld a kind of "code of silence," turning a blind eye to colleagues who overstepped the bounds of professional involvement. Professional associations and licensing boards have been slow to take action against violators, experts claim. Many practitioners—among them some of Freud's disciples—even married former patients or conducted lengthy affairs with them in full public view. Even when there was blatant abuse, the private nature of psychotherapy has worked against victims of sexual exploitation who came forward to complain. It was, after all, their word against the therapist's.

**Shifting tide.** In the last few years, however, an increasing number of highly publicized sexual-malpractice suits have forced the attention of both professionals and the public. The ethics committees of several professional associations have noted an increase in sexual-misconduct claims, which in one study accounted for approximately 30 percent of total ethics complaints to the American Psychological Association. And juries are now more apt to believe the patient's charges rather than the therapist's denials—even in the rare trial cases where a therapist is unjustly accused. Large awards to victims are also common. Last October, Giant Food heiress Fredrica Lehrman Carmichael won a $1 million judgment in a combination malpractice and divorce suit against her husband and former therapist, psychologist Douglass Carmichael.

In response to public concern, a growing number of states have passed laws specifically addressing sexual malpractice, rather than subsuming it under the general category of professional misconduct. In California, for instance, a victim has cause to recover damages from a therapist if the sexual involvement takes place within two years after psychotherapy ends. Four states—Wisconsin, Colorado, Minnesota and North Dakota—have made sexual intimacy with patients a criminal offense, punishable with a fine and prison term. Other states are considering similar statutes.

Although the legal system may offer the prospect of redress, it can also prove a harrowing ordeal for victims. Witness the case of Cathy Nugent, 37, who was given drugs and sexually exploited by the psychiatrist she had been seeing for five years. In 1987, Nugent filed a malpractice suit against her therapist, Baltimore psychiatrist Dr. Francesco DiLeo. Two years later, a jury found DiLeo negligent in several areas, including having sexual contact with a patient and improperly administering drugs, and awarded Nugent $700,000 in damages. (The psychiatrist is appealing the judgment.) But Nugent says she cannot forget the defense lawyers' cross-examining her about her sexual history. Says LaVonna Vice, Nugent's attorney: "I felt like I was defending a rape victim. The whole strategy was to attack the plaintiff." Not so, replies William Taylor, one of DiLeo's attorneys, who maintained during the trial that Nugent took drugs and had sexual intercourse with the psychiatrist of her own free will. "You don't become a zombie because you are in psychotherapy."

Yet Nugent's case illustrates that even a successful courtroom battle will not ensure that an offending therapist is barred from practice altogether. DiLeo, for example, is still practicing psychiatry in Maryland. The state's Commission on Medical Discipline banned him from seeing patients privately and required that he undergo drug screening and enter therapy himself. But the commission only briefly suspended his license; after restoring it, the commission sent him to work, under supervision, at the state hospital in Sykesville.

Perhaps most disturbing, Nugent says that no amount of money can erase the damage that is the result of having her trust betrayed. She has given up her career as a mental-health worker for a less stressful job as an administrator. She continues to see another psychiatrist, a woman, in hopes that she can regain the life she once had. "Before this happened, I was a competent, confident person," she says. "This has undercut all of that." ■

by Erica E. Goode

# The politics of seduction

Any issue that brings together sex and power can quickly turn into a political hot potato, and sexual entanglement between therapists and patients is no exception. Just how inflammatory the subject has become, even among therapists, is illustrated by a recent exchange of letters to the editor of the *American Journal of Psychiatry,* a cross fire inspired by a May, 1989, article by Harvard University psychiatrist Dr. Thomas Gutheil.

**Broken boundaries.** In his article, Gutheil describes a class of psychotherapy patients who seem especially susceptible to sexual abuse. These patients, carrying the psychiatric diagnosis of "borderline personality disorder," have difficulty maintaining appropriate social boundaries between themselves and others. In addition, they are frequently manipulative, are intensely needy and often have a history of sexual abuse—all qualities, the psychiatrist argues, that increase their risk of exploitation.

JOHN LABBE FOR USN&WR

Gutheil's foray into print produced instant outrage and a flurry of letters to the journal. Psychologist Judith Jordan and four female colleagues objected: "We are gravely concerned that many courageous women who have been abused by therapists, women who are struggling with shame and guilt and who are just now beginning to find a way to voice their complaints, will be further victimized and silenced by the kind of bias represented in this article."

Gutheil's response was tart. For reasons he "cannot fathom," the psychiatrist wrote, his critics act as if treatment of patients does not occur in a situation where two people influence one another. "Can Dr. Jordan and her associates accept the complex possibility that the clinicians I described committed ethical and legal violations, malpractice, breaches of the fiduciary relationship . . . *and* that the patients played some role in this—a role that can be studied without shifting the slightest culpability from the doctor?"

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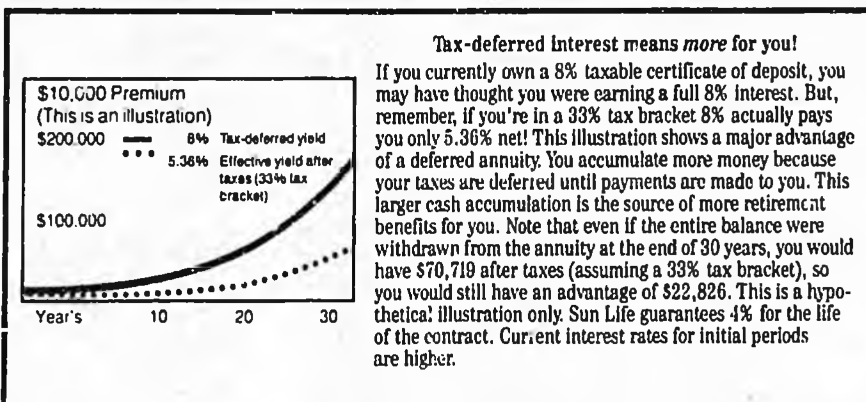


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1 IN THE SENATE

2 CS FOR SENATE BILL NO. 29 ( )

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to services of psychologists and
7 psychological associates under the state medical
8 assistance program; and reordering the priorities for
9 eliminating coverage under Medicaid."

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

11 * Section 1. AS 47.07.030(b) is amended to read:

12 (b) In addition to the mandatory services specified in (a) of
13 this section, the department may offer only the following optional
14 services: case management and nutrition services for pregnant women;
15 personal care services in a recipient's home; emergency hospital
16 services; long-term care noninstitutional services; medical supplies
17 and equipment; clinic services; inpatient psychiatric facility ser-
18 vices for individuals age 65 or older and individuals under age 21;
19 <u>services of psychologists and psychological associates;</u> physical
20 therapy; occupational therapy; chiropractic services; treatment of
21 speech, hearing, and language disorders; adult dental services;
22 prosthetic devices and eyeglasses; optometrists' services; intermedi-
23 ate care facility services, including intermediate care facility
24 services for the mentally retarded; skilled nursing facility services
25 for individuals under age 21; and reasonable transportation to and
26 from the point of medical care.

27 * Sec. 2. AS 47.07.035 is amended to read:

28 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-
29 ment finds that the cost of medical assistance for all persons

 WORK DRAFT WORK DRAFT

eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) chiropractic services;

(2) adult dental services;

(3) emergency hospital services;

(4) treatment of speech, hearing, and language disorders;

(5) optometrists' services and eyeglasses;

(6) occupational therapy;

(7) prosthetic devices;

(8) medical supplies and equipment;

(9) clinic services;

(10) services of psychologists and psychological associates;

(11) physical therapy;

(12) [(11)] personal care services in a recipient's home;

(13) [(12)] long-term care noninstitutional services;

(14) [(13)] inpatient psychiatric facility services;

(15) [(14)] intermediate care facility services for the mentally retarded;

(16) [(15)] intermediate care facility services;

(17) [(16)] pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level;

(18) [(17)] individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;

(19) [(18)] skilled nursing facility services for persons

1 under age 21;

2 (20) [(19)] aged, blind, and disabled individuals who,
3 because they do not meet the income requirements, do not receive
4 supplemental security income under Title XVI of the Social Security
5 Act, but who are eligible, or would be eligible if they were not in a
6 skilled nursing facility or intermediate care facility, to receive an
7 optional state supplementary payment;

8 (21) [(20)] individuals in a hospital, skilled nursing
9 facility, or intermediate care facility whose income while in the
10 facility does not exceed 300 percent of the supplemental security
11 income benefit rate under Title XVI of the Social Security Act, but
12 who, because of income, are not eligible for the optional state sup-
13 plementary payment;

14 (22) [(21)] individuals under age 21 under supervision of
15 the department, for whom maintenance is being paid in whole or in part
16 from public money and who are in foster homes or private child-care
17 institutions.

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S B

36

Mel — 2-28-89

Please see pg 3,
bottom of pg 5, pg 6 and
pg 11

The other material outlines
the D. Min requirements.

Please call for more
information - if needed -

Allen [illegible]

Pr? 344 6078
563-4325

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION : SB 36
PUBLISH DATE :

# FISCAL NOTE

**REQUEST:**

Revision Date:
Title : An Act relating to insurance coverage for treatment of a mental or nervous condition
Sponsor : Faiks
Requestor : Senate HESS

Agency Affected : Commerce & Economic Dev.
BRU : Insurance
Components : Operations

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

**FUNDING:** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

**POSITIONS:**

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

**ANALYSIS :** (Attach a separate page if necessary) No fiscal impact in FY 90.

No direct impact on the division's operations.

Prepared by : Joan Brown, Administrative Officer Phone : 465-2597
Division : Insurance Date :

Approved by Commissioner : Larry Merculieff Date : 5/2
Agency : Department of Commerce & Economic Development

Distribution (by preparer) :
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)



6152D-3/011990a

JAN 23 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB 36
PUBLISH DATE: 1-9-89

# FISCAL NOTE

**REQUEST:**

Revision Date:
Title: An Act relating to ins. coverage for treatment of a mental or nervous condition.
Sponsor: Faiks
Requestor: Senate HESS

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: Operations

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | -0- | -0- | -0- | -0- | -0- | -0- |
| REVENUE | -0- | -0- | -0- | -0- | -0- | -0- |

**FUNDING:** (Thousands of Dollars)

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | -0- | -0- | -0- | -0- | -0- | -0- |

**POSITIONS:**

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| FULL-TIME | -0- | -0- | -0- | -0- | -0- | -0- |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

**ANALYSIS:** (Attach a separate page if necessary)

No direct impact on the division's operations.

Prepared by: Joan Brown
Division: Insurance
Phone: 465-2597
Date: 1-17-89

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: 1/2/89

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

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011789a

page ___ of ___

FEB 0 1 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,696.2 IN INCREASED PERSONAL SERVICES COSTS. THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $2121.2 IN FY 90. See pages 2 and 3 for a detailed analysis.

Prepared By: Sally Smith, Director Sally Smith
Division: Retirement and Benefits
Phone: 465-4470
Date: 1-31-89

Approved by Commissioner: John M. Andrews
Agency: Department of Administration
Date: 2/1/89

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)


8/6K2/012603-9

Rev: 12/16/88

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

# FISCAL NOTE

REQUEST: FEB 22 1989

Revision Date: February 15, 1989
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,453.3 IN INCREASED PERSONAL SERVICES COSTS.
THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $1,957.7 IN FY 90. See pages 2 through 4 for a detailed analysis.

Prepared By: Sally Smith, Director *Sally Smith*
Phone: 465-4470
Division: Retirement and Benefits
Date: *Feb. 17, 1989*

Approved by Commissioner: John M. Andrews *[signature]*
Date: *2/21/89*
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retirees' health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance ............... $775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .297% of the PERS payroll and .236% in the TRS payroll. The FY 90 State PERS payroll, including the University of Alaska is estimated to be $521,208,708 (State $463,907,093; and University of Alaska, $57,302,615.) It is assumed to remain level each year thereafter.

   The FY 90 State TRS payroll, including the University of Alaska, is estimated to be $55,085,786 (Department of Education, $5,025,700; and the University of Alaska, $50,060,086). TRS salaries are also assumed to remain level each year thereafter.

The FY 90 increase in costs to the State due to retirement contributions of $1,678.0 is calculated as follows:

Estimated State PERS FY 90 payroll.$463,907,093
PERS contribution rate increase.... .297%
FY 90 State Total PERS cost...................... $1,377.8

Estimated University of Alaska PERS
FY 90 payroll...................$57,301,615
Pers contribution rate increase.... .297%
FY 90 University of Alaska Total PERS cost........ $ 170.2

Estimated Department of Education
TRS FY 90 payroll...............$ 5,025,700
TRS contribution rate increase..... .236%
FY 90 Department of Education Total TRS cost...... $ 11.9

Estimated University of Alaska TRS
FY 90 payroll...................$ 50,060,086
TRS contributions rate increase.... .236%
FY 90 University of Alaska Total TRS cost......... $ 118.1

Total estimated State cost increase for FY 90 for retirement system contributions ................. $ 1678.0

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .297% of PERS payroll and school districts' contribution rate to the TRS by .236% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $1853.4 is calculated as follows:

Estimated political subdivision
FY 90 payroll...................$354,521,366
PERS contribution rate increase.... .297%
FY 90 political subdivision Total PERS cost....... $ 1052.9

Estimated school district FY 90
payroll........................$339,201,043
TRS contribution rate increase..... .236%
FY 90 School district Total TRS cost.............. $ 800.5
Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions................................ $ 1853.4

# CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02-576(2/77)

The FY 90 increase in costs to the State due to retirement contributions of $1,678.0 is calculated as follows:

Estimated State PERS FY 90 payroll.$463,907,093
PERS contribution rate increase.... .297%
FY 90 State Total PERS cost...................... $1,377.8

Estimated University of Alaska PERS
FY 90 payroll...................$57,301,615
Pers contribution rate increase.... .297%
FY 90 University of Alaska Total PERS cost........ $ 170.2

Estimated Department of Education
TRS FY 90 payroll...............$ 5,025,700
TRS contribution rate increase..... .236%
FY 90 Department of Education Total TRS cost...... $ 11.9

Estimated University of Alaska TRS
FY 90 payroll...................$ 50,060,086
TRS contributions rate increase.... .236%
FY 90 University of Alaska Total TRS cost......... $ 118.1

Total estimated State cost increase for FY 90 for retirement system contributions ................. $ 1678.0

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .297% of PERS payroll and school districts' contribution rate to the TRS by .236% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $1853.4 is calculated as follows:

Estimated political subdivision
FY 90 payroll...................$354,521,366
PERS contribution rate increase.... .297%
FY 90 political subdivision Total PERS cost....... $ 1052.9

Estimated school district FY 90
payroll.........................$339,201,043
TRS contribution rate increase..... .236%
FY 90 School district Total TRS cost.............. $ 800.5
Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions................................ $ 1853.4

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91 since the health contract is not renewed until that date. The estimated FY 91 costs for these employees will increase by $104.3. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1750) times 12 months.

| | |
|---|---|
| Total health insurance increase for political subdivisions and school districts in FY 91 | $ 104.3 |

Increase in FY 90 Costs Due to Expanded Health Insurance

| | Active Employees | Retirees | Total |
|---|---|---|---|
| State | $775.3* | $1678.0 | $2453.3 |
| Political Subdivisions and School Districts | 104.3** | 1853.4 | 1957.7 |

* Shown as full year equivalent
** Shown as full year equivalent. No increase for FY 90

If this bill becomes law, the unfunded liability will increase by $4.6 million and the funding ratio will decrease by .35% in the TRS.

The unfunded liability will increase by $13.83 million and the funding ratio will decrease by .6% in the PERS.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date: December 12, 1989
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operating costs for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,564.9 IN INCREASED PERSONAL SERVICES COSTS.
THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $1,951.5 IN FY 91. See pages 2 through 4 for a detailed analysis.

Prepared by: Sally Smith, Director Sally Smith
Phone: 465-4470
Division: Retirement and Benefits
Date: 10 Jan 90

Approved by Commissioner: Frank S. Baxter Frank Baxter
Date: 1/25/90
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)


8/6K37010201-072

Rev: 11/89

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2,500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retiree's health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis, we have assumed no additional increase in the future. The total possible FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month (13,000) times $4.97 times five months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance . . . . . . . . . . . $ 775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .297 percent of the Public Employees' Retirement System (PERS) payroll and .236 percent in the Teachers' Retirement System (TRS) payroll. The FY 91 State PERS payroll, including the University of Alaska, is estimated to be $556,310,861 (State $492,656,834, and University of Alaska $63,654,027). It is assumed to remain level each year thereafter.

   The FY 91 State TRS payroll, including the University of Alaska, is estimated to be $58,159,258 (Department of Education and Legislature

$5,673,729, and the University of Alaska $52,485,529). TRS salaries are also assumed to remain level each year thereafter.

The FY 91 increases in costs to the State due to retirement contributions of $1,789.6 is calculated as follows:

| | | |
|---|---|---|
| Estimated State PERS FY 91 payroll . . | $492,656,834 | |
| PERS contribution rate increase . . . | .297% | |
| FY 91 State Total PERS cost . . . . . . . . . . . . . . . | | $1,463.2 |
| Estimated University of Alaska PERS FY 91 payroll . . . . . . . . . . . . | $ 63,654,027 | |
| PERS contribution rate increase . . . | .297% | |
| FY 91 University of Alaska Total PERS cost . . . . . . . | | $ 189.1 |
| Estimated Department of Education/ Legislature TRS FY 91 payroll . . . | $ 5,673,729 | |
| TRS contribution rate increase . . . . | .236% | |
| FY 91 Department of Education Total TRS cost . . . . . . | | $ 13.4 |
| Estimated University of Alaska TRS FY 91 payroll . . . . . . . . . . . . | $ 52,485,529 | |
| TRS contributions rate increase . . . | .236% | |
| FY 91 University of Alaska Total TRS cost . . . . . . . | | $ 123.9 |
| Total estimated State cost increase for FY 91 for retirement system contributions . . . . . . . . . . . | | $1,789.6 |

3. Political Subdivision Active and Retiree Programs. In addition to the State cost, there would also be an increase in political subdivisions' contribution rate to the PERS by .297 percent of PERS payroll and school districts' contribution rate to the TRS by .236 percent of TRS payroll. The FY 91 PERS payroll for political subdivisions is estimated to be $358,420,788. The FY 91 TRS payroll for school districts is estimated to be $344,238,828. Salaries for both systems are assumed to remain level each year thereafter. The FY 91 increase in costs to these entities due to retirement contributions of $1,876.9 is calculated as follows:

| | | |
|---|---|---|
| Estimated political subdivision FY 91 payroll . . . . . . . . . . . . | $358,420,788 | |
| PERS contribution rate increase . . . | .297% | |
| FY 91 political subdivision Total PERS cost . . . . . . | | $1,064.5 |
| Estimated school district FY 91 payroll . . . . . . . . . . . . . . . . | $344,238,828 | |
| TRS contribution rate increase . . . . | .236% | |
| FY 91 school district Total TRS cost . . . . . . . . . . | | $ 812.4 |
| Total estimated FY 91 political subdivision and school district cost increase for retirement system contributions . . . . . . . . . . . . . . . . . | | $1,876.9 |

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. The estimated FY 91 costs for these employees will increase by $74.6. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1,250) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91 . . . . . $ 74.6

Increase in FY 91 Costs Due to Expanded Health Insurance

| | Active Employees | Retirees | Total |
|---|---|---|---|
| State | $775.3* | $1,789.6 | $2,564.9 |
| Political Subdivisions and School Districts | $ 74.6* | $1,876.9 | $1,951.5 |

* Shown as full year equivalent.

If this bill becomes law, the unfunded liability will increase by $4.6 million and the funding ratio will decrease by .3 percent in the TRS.

The unfunded liability will increase by $13.83 million and the funding ratio will decrease by .6 percent in the PERS.

FEB 0 1 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars) + 20% year,

| OPERATING | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | FY 94 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,696.2 IN INCREASED PERSONAL SERVICES COSTS.
THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $2121.2 IN FY 90. See pages 2 and 3 for a detailed analysis.

Prepared By: Sally Smith, Director *Sally Smith*
Phone: 465-4470
Division: Retirement and Benefits
Date: 1-31-89

Approved by Commissioner: John M. Andrews
Date: 2/1/89
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ie[illegible]


8/6K2/012603-9

Fiscal Note/ Analysis
Dept. of Administration

Rev: 12/16/88

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retirees' health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance ............ .. $775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .34% of the PERS payroll and .27% in the TRS payroll. The FY 90 State PERS payroll, including the University of Alaska is estimated to be $521,208,708 (State $463,907,093; and University of Alaska, $57,302,615.) It is assumed to remain level each year thereafter.

   The FY 90 State TRS payroll, including the University of Alaska, is estimated to be $55,085,786 (Department of Education, $5,025,700; and the University of Alaska, $50,060,086). TRS salaries are also assumed to remain level each year thereafter.

The FY 90 increase in costs to the State due to retirement contributions of $1,920.9 is calculated as follows:

Estimated State PERS FY 90 payroll.$463,907,093
PERS contribution rate increase.... .34%
FY 90 State Total PERS cost...................... $1,577.3

Estimated University of Alaska PERS
FY 90 payroll...................$57,301,615
Pers contribution rate increase.... .34%
FY 90 University of Alaska Total PERS cost........ $ 194.8

Estimated Department of Education
TRS FY 90 payroll................$ 5,025,700
TRS contribution rate increase..... .27%
FY 90 Department of Education Total TRS cost...... $ 13.6

Estimated University of Alaska TRS
FY 90 payroll...................$ 50,060,086
TRS contributions rate increase.... .27%
FY 90 University of Alaska Total TRS cost......... $ 135.2

Total estimated State cost increase for FY 90 for retirement system contributions ................. $ 1920.9

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .34% of PERS payroll and school districts' contribution rate to the TRS by .27% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $2121.2 is calculated as follows:

Estimated political subdivision
FY 90 payroll...................$354,521,366
PERS contribution rate increase.... .34%
FY 90 political subdivision Total PERS cost....... $ 1205.4

Estimated school district FY 90
payroll.........................$339,201,043
TRS contribution rate increase..... .27%
FY 90 School district Total TRS cost............. $ 915.8

Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions................................ $ 2121.2

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91 since the health contract is not renewed until that date. The estimated FY 91 costs for these employees will increase by $104.3. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1750) times 12 months.

| Total health insurance increase for political subdivisions and school districts in FY 91 | $ 104.3 |
|---|---|

Increase in FY 90 Costs Due to Expanded Health Insurance

| | Active Employees | Retirees | Total |
|---|---|---|---|
| State | $775.3* | $1920.9 | $2696.2 |
| Political Subdivisions and School Districts | 104.3** | 2121.2 | 2225.5 |

* Shown as full year equivalent
** Shown as full year equivalent. No increase for FY 90

If this bill becomes law, the unfunded liability will increase by $5.3 million and the funding ratio will decrease by .4% in the TRS.

The unfunded liability will increase by $15.8 million and the funding ratio will decrease by .7% in the PERS.

Allen Price
3661 Hazen Circle
Anchorage, Alaska 99515

MAR 09 1989

March 5, 1989

Senator Paul Fischer
Chairperson, HESS
Post Office Box V
Juneau, Alaska 99811

Re:S.B. 36

Dear Senator Fischer,

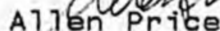
This letter concerns S.B. No. 36. and the possible inclusion of Pastoral Counselors in that bill. Representative Barnes' office may have sent material to you concerning Doctor's degrees in Pastoral Counseling and Psychotherapy and how this is of interest to the consumer in Alaska.

Pastoral Counselors are listed in the Bill on page 3, line 21. I would like to see (9) (F) added after (9) (E) (ii) which would read: "a person certified as a member of the American Association of Pastoral Counselors and who has a masters or doctors degree in pastoral counseling. There would also be an addition after (10) (B) (v) which would be (10) (B) (vi) which would read: "a person certified as a member of the American Association of Pastoral Counselors and who has a masters or doctors degree in pastoral counseling and psychotherapy.

I appreciate your help in this matter. If your office needs additional information or clarification, please contact me at (907) 563-4325 or at my home, 344-6078

My name may ring a bell with you as I worked with you and your wife in your shop in Soldotna when I worked for Community and Regional Affairs of the State.

Cordially Yours,



Allen Price

Dale:

Put with bill

If it comes up again we can discuss then.

TO: Sen. Paul Fischer

FROM: Mel Krogseng, Professional Assistant
Rep. Ramona Barnes

DATE: 3/17/89

RE: SB 36 "An Act relating to insurance coverage for the treatment of a mental or nervous condition."

It has been brought to Rep. Barnes' attention that "pastoral counselors" have not been included in SB36. We have received correspondence requesting an amendment to the bill to include pastoral counselors. Since this is a Senate Bill and is in the Senate HESS Committee, Rep. Barnes request that you address this issue when the bill comes up before the committee.

Attached you will find a letter from Allen Price outlining the changes requested. Mr. Price has stated to me he would like to see members of the American Association of Pastoral Counselors included.

In reading the General Information Brochure from the American Association of Pastoral Counselors, it appears that adequate training is required for membership.

If you have any questions, please call me or call Mr. Price at 344-6078 or 563-4325. Thanks for you help.

Allen & Nancy Price
3661 Hazen Circle
Anchorage, Alaska 99515

February 16, 1989
Honorable Ramona Barnes
Post Office Box V
Juneau, Alaska 99811

Dear Representative Barnes,

I am writing this letter as a follow up of a conversation by phone that I had with your office yesterday. It concerned S.B. 36 and the American Association of Pastoral Counselors as sighted in (8) of that bill.

I would also like to see "pastoral counseling" added to (9) (D) of S.B. 36 after "or doctoral degree in..." Also, "pastoral counseling" could be added to (10) (B) (iv) after "doctoral degree in..."

As I discussed with one of your staff last year, pastoral counselors, members of AAPC, must have a bachelor's degree, a three years master's degree, and hundreds of hours of supervision in individual, couple, family and group counseling. They are also required to have continued supervision by qualified professionals. This insures the public of quality service delivery. It also gives the consumer the option of getting service with a person who will respect and often use faith as an adjunct to therapy. As you might imagine, this is particularly important when it comes to the healing of a parent's children in stress.

I appreciate your help, and wisdom, in the matter. If your office needs additional information or clarification, please contact me at (907) 563-4325 or 344-6078.

Cordially yours,

Allen Price

# AMERICAN ASSOCIATION

# OF PASTORAL COUNSELORS

General Information Brochure

on

Individual Membership & Affiliation

SPRING 1988

## AVAILABLE AAPC MATERIALS

Copies of the following materials can be obtained prior to membership application; however, these materials are included in the application kit requested below:

**(CHECK ONLY IF NOT REQUESTING APPLICATION KIT)**

- [ ] Handbook . . . . . . . . . . . . . . . $ 3.00
- [ ] Directory. . . . . . . . . . . . . . . $10.00
- [ ] Annual Newsletter Subscription . . $10.00
- [ ] Membership Committee Operational Manual . . . . . . . . . . . . . . $ 5.00

To obtain application materials for membership or affiliation in the American Association of Pastoral Counselors, complete the following form and mail with a check for $30.00 to:

**American Association of Pastoral Counselors**
**9508A Lee Highway**
**Fairfax, VA 22031**

**(CHECK ONLY ONE)**

**Certified:** [ ] **Member** [ ] **Fellow** [ ] **Diplomate**

**Affiliates:** [ ] **Pastoral** [ ] **Professional**

[ ] **Pastoral Counselor-in-Training**

[ ] **International**

**(PLEASE TYPE OR PRINT CLEARLY)**

**NAME** ______________________________

**ADDRESS** ______________________________

______________________________

______________________________

**PHONE** (____)______________________________

## PROCESSING FEES AND DUES*

**Processing Fees** must accompany completed applications as follows:

| | |
|---|---|
| Diplomate | $300** |
| Fellow | $150 |
| Member | $150 |
| Pastoral Counselors-in-Training | $ 50 |
| Pastoral Affiliate | $ 50 |
| Professional Affiliate | $ 50 |
| International Affiliate | $ 25 |

**Annual Dues**

| | |
|---|---|
| Diplomate | $190 |
| Fellow | $150 |
| Member | $110 |
| Pastoral Counselors-in-Training | $ 36 |
| Pastoral Affiliate | $ 36 |
| Professional Affiliate | $ 58 |
| International Affiliate | $ 18 |

*Processing fees and dues change periodically. It is suggested you write/call the Association Office if this booklet is more than one year old.

**This may be paid in two installments; $150 at time application is submitted and $150 prior to meeting with the Association Membership Committee.



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## INTRODUCTION

The American Association of Pastoral Counselors was formally organized in 1963 to advance the purposes of pastoral counseling within the religious communities and the field of mental health in the United States and Canada. Setting standards, establishing criteria and providing certification for pastoral counselors were the first major tasks of the Association.

What follows is general information about AAPC in an abbreviated form. The Handbook and Membership Committee Operational Manual contain more detailed information and are included with the application kit.

## PURPOSES AND ORGANIZATION OF AAPC

The AAPC Constitution promotes the following purposes:

(1) Ministry of pastoral counseling;
(2) Exploration, clarification and guidance of human life through a theological perspective;
(3) Professional competence, support and growth among pastoral counselors;
(4) Improved pastoral care by ministers;
(5) Relationships with ecclesiastical and inter-professional groups.

To fulfill these purposes the AAPC is organized into the following nine Standing Committees:

Centers and Training Committee
Legal Concerns Committee
Nominating Committee
Professional Concerns Committee
Theological and Social Concerns
Ethics Committee
Finance Committee
Membership Committee
Research Committee

The AAPC is organized into ten regions:

**NORTHEAST**

Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, Nova Scotia, New Brunswick, Prince Edward Island, New Foundland, Quebec



## DEADLINES

Applications are reviewed twice a year. Completed applications **must be** received **in the Association Office** by:

**July 1** - Processed in the Fall (September to November)

**December 1** - Processed in the Spring (March to April)

Notification of decisions made on applications are forwarded in December after the fall processing and review and May after the spring processing and review.

## CONSULTATIVE INTERVIEWS

Upon request, consultative interviews with the Regional Membership Committee may be provided for a fee of $150.00. (Submit payment to Association Office payable to AAPC.)

person may have the formal requirements for Fellow category but lacks the seasoning qualities that come from extended practice and experience.

Pastoral Affiliate level is for persons whose primary ministry is in the parish and who do not desire more formal training in pastoral counseling. These persons usually are looking for a means to be part of the mainstream of pastoral counseling, benefit from consultative support of experienced pastoral counselors and wish to participate in the meetings and committees of AAPC.

Persons who are uncertain for which category of membership/affiliation to apply, may consult with their Regional Membership Chairperson.

**APPLICATION PROCESS AND PROCEDURES**

1. Obtain the full application kit by completing the form contained in this pamphlet. The kit contains application forms, Membership Manual, Directory, Handbook, religious endorsement information, Newsletter and other pertinent information. **A $30 payment must accompany the request.**

2. Consult with the appropriate Regional Membership Committee Chairperson IF you require additional assistance with your application. (A list of Regional Membership Committee Chairpersons is enclosed.)

3. Send ONE ORIGINAL and ONE COPY OF: completed application, **REQUIRED** transcripts, current religious body endorsement, supervisor's reports, and any other supporting documents **AND APPROPRIATE PROCESSING FEE** as stated on page 11 to the Association Office.

4. Appear before the Regional Membership Committee for review (required for Certified Membership; optional for Affiliates except where required by particular regions).



**EASTERN**
New York, New Jersey, Ontario

**ATLANTIC**
Delaware, Pennsylvania, Maryland, Virginia, West Virginia, District of Columbia

**SOUTHEAST**
North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee

**MIDWEST**
Ohio, Kentucky, Indiana, Michigan

**CENTRAL**
Missouri, Kansas, Illinois, Wisconsin, Iowa, Minnesota, Manitoba

**ROCKY MOUNTAIN-PLAINS**
North Dakota, South Dakota, Nebraska, Montana, Wyoming, Colorado, Utah, Saskatchewan

**SOUTHWEST**
Arkansas, Louisiana, Oklahoma, Texas, New Mexico

**PACIFIC**
Arizona, Nevada, California, Hawaii

**NORTHWEST**
Idaho, Oregon, Washington, Alaska, Alberta, British Columbia, Yukon, Northwest Territories

**ASSOCIATION OFFICE**

The Association Office provides leadership and coordination for the AAPC. In 1979 it was relocated in the Washington Metropolitan Area and a full-time Executive Director employed. All inquiries may be directed to the **Association Office, AAPC, 9508A Lee Highway, Fairfax, VA 22031; telephone 703-385-6967.**

## MEMBERSHIP AND AFFILIATION CATEGORIES AND REQUIREMENTS

Individual membership has three certified categories: Member, Fellow and Diplomate.

There are four categories of affiliates: Pastoral, Professional, International and Pastoral Counselor-in-Training.

Each membership and affiliate category has its own standards and criteria. This booklet briefly summarizes the purpose, criteria and benefits of each category.

### CERTIFIED MEMBERSHIP

Each category of certified membership has explicit educational and training requirements,* an examination process for demonstration of competence and endorsement from the recognized religious body. Certified membership entitles a person to a vote on the policies, procedures, programs and business of the AAPC.

These requirements are set by the Bylaws of the Association, as follows:

**Member**

B.A. and M.Div. degrees from accredited schools; endorsement as a minister in good standing in a recognized religious body; continuing responsible relationship to local religious community; one unit of clinical pastoral education in an accredited center; three years as a minister, 375 hours of pastoral counseling together with 125 hours of supervision of that counseling, one-third of such supervision to have been with an AAPC approved Center for Training in Pastoral Counseling or from a Diplomate of the Association.

* Equivalencies for membership and affiliation have been established and are included in the Membership Committee Manual as part of application materials.



10. Participation in the international dimensions of pastoral care and counseling.

Certified pastoral counselors are increasingly recognized as professional mental health providers by governmental agencies and public and private health insurance carriers. The AAPC actively works with the complex issues surrounding such recognition. Both the right to practice as mental health professionals and the preservation of the unique integrity of pastoral counselors are under constant vigilance by the AAPC.

Above all, the benefit of membership and affiliation in AAPC is participation in the mainstream development and guidance of pastoral counseling as a field of religious ministry and mental health care.

### SELECTING APPROPRIATE CATEGORY OF MEMBERSHIP/AFFILIATION

For persons who have no previous relationship with the AAPC, the usual entering categories are Pastoral Counselor-in-Training, Member or Pastoral Affiliate.

The Pastoral Counselor-in-Training is designed for persons who are in the process of supervision and course work in a pastoral counseling educational program, either in a center or in a school. This person may have some previous clinical experience but whose hours of focused work in pastoral counseling are just beginning. This category of affiliation gives the person access to the Membership Committee for consultation, support and information during the course of training as well as enjoyment of the activities and resources of the AAPC.

Member category is the usual entry point for persons seeking certification of pastoral counseling. A person applying for Member level needs the minimum formal requirements outlined above and is usually in continuing supervision and training. Those applying for Member category are persons who have recently completed a training program in Pastoral Counseling. Often a

## BENEFITS OF MEMBERSHIP AND AFFILIATION

Each person entering membership or affiliation in the AAPC has some particular professional and personal motivation or objective. Beyond such particular personal desires, the following benefits are provided:

1. Subscription to the Journal of Pastoral Care, published quarterly in conjunction with the Association for Clinical Pastoral Education, Canadian Association for Pastoral Education, Association of Mental Health Clergy, College of Chaplains, National Institute of Business and Industrial Chaplains, Inc., Correctional Chaplain's Association and the AAPC.

2. Receipt of the Newsletter, published quarterly.

3. Information on employment and training opportunities throughout the United States and Canada.

4. Attendance at the Annual AAPC Convention, held in the spring.

5. Regional Conferences, usually held in the fall of each year.

6. Workshops and special interest meetings.

7. Optional--Professional Liability Insurance coverage for additional fee for all Association member/affiliate levels with exceptions of Canadian residents and Professional and International Affiliates--currently not eligible. Individuals not affiliated with the Association are ineligible. Information current as of 12/87.

8. Participation in the overall issues and purposes of the AAPC through Association and Regional Committees.

9. Ongoing involvement with professional relationships in the religious communities and mental health professions.



**Fellow**

All the requirements for Member plus: M.A., S.T.M., D.Min. or Ph.D. in pastoral counseling, demonstrated ability to work as a pastoral counselor at an advanced level of competency; 1,000 hours of pastoral counseling while receiving at least 125 hours of supervision (totaling 250 hours of supervision, 1,375 hours of counseling).

**Diplomate**

All the requirements for Fellow plus significant performance in at least three of the following -- academic achievement (Ph.D. or equivalent), research, publication, leadership in AAPC, teaching and/or supervising pastoral care and counseling or contributions to church and community; supervision of at least five candidates for membership for a minimum of 30 hours each, while receiving 50 hours of personal supervision for the 150 cumulative hours supervised.

The examination process for all levels of certified membership is a face-to-face appearance with a Regional Membership Committee. These committees request submission of clinical materials in preparation for the examination.

## AFFILIATES

**Pastoral Affiliate**

B.A. and M.Div. degrees; religious body endorsement; three years as a minister; active in one's local religious community; consultative relationship with an AAPC Fellow or Diplomate or other consultant approved by the Association.

**Professional Affiliate**

Member of one of the helping professions and certification by that profession; an interest in pastoral counseling or pastoral counseling centers.

**International Affiliate**

Post-seminary training in pastoral counseling plus active involvement in a ministry of counseling; submission of a plan for professional development including pastoral consultation and professional affiliation.

**Pastoral Counselor-in-Training**

Persons beginning the educational process for certified pastoral counselor. Minimum requirements are: college undergraduate degree; minister in good standing or in process; endorsement from religious endorsing body; submission of a plan for completing certified membership requirements.

**Affiliates are entitled to participate in the programs of AAPC but without vote in business matters.**

## ENDORSEMENT BY RELIGIOUS BODY

Religious body endorsement is a specialized process conducted by the applicant's religious body in which the applicant holds membership. The specific qualifications and procedures for endorsement vary with each religious body. The definition for minister is made by the applicant's religious body and may or may not include ordination. **NOTE:** Religious body endorsements may take a few months to obtain and in some cases require meeting with a committee. It is recommended that requests for endorsements be made well in advance of the due date for application to AAPC.

## STANDARDS FOR CERTIFIED MEMBERSHIP

Evaluation of readiness for certified membership in AAPC is based upon two kinds of judgments. The first depends upon formal and technical requirements and can be demonstrated by academic degrees, hours of supervision, experience, supervisory evaluations, etc. The second is based upon the evaluations of one's professional peers joined in a committee interview and



involves assessment and affirmation of professional competence not measurable by formal requirements.

Educational preparation for certified membership should contribute to the pastoral counselor's training and develop a broad experience-related understanding of people. This should take place in a setting in which the pastor can relate theoretical knowledge to, and derive from, pastoral work with people, i.e., a setting in which both the school and practical situation are in mutual relation.

The following areas of study are considered important for the achievement of the educational objectives: Theories of Personality and Personality Development; Interpersonal Relations; Marriage and Family Dynamics; Group Dynamics; Personality and Culture; Psychopathology; The Psychology of Religious Experience; Theories of Counseling and Psychotherapy; Theories of the Pastoral Office including the History and Theory of Pastoral Care; Research Methods; Orientation to the Helping Professions. These studies are aimed toward the integration of theological and religious dimensions with the psychological understanding of persons.

## CONTINUATION OF MEMBERSHIP AND AFFILIATION

The AAPC is committed to the continued growth and development of its members and affiliates. Continuing education and peer support are the major functions of the Professional Concerns Committee. Each year certified members are required to submit a written self-report on the educational and training activities which enhance his or her professional growth.

Certified members are expected to maintain an active pastoral counseling practice, participate in a responsible program of continuing education and maintain a consultative relationship with peers.

Membership and affiliation must be renewed annually by the payment of dues for the new fiscal year and by submission of required reports.

## Individual Membership:

➤ Persons become members of AAPC through a process of consultation and review of academic and clinical education which leads to competent professional ministry. Categories of individual membership are:

- Membership — Member, Fellow, Diplomate
- Affiliation — Pastoral Counselor-in-Training, Pastoral Affiliate, Professional Affiliate, International Affiliate

➤ All individual members are held accountable to their faith group and to AAPC through:

- The guidelines of continuing education
- The Code of Ethics of the AAPC

## Institutional Membership:

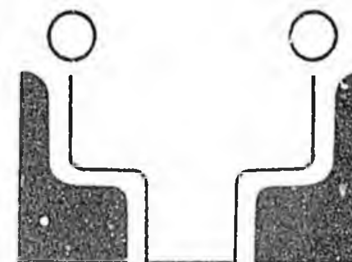
➤ Institutions which provide pastoral counseling service and education can become and remain members through regular review and adherence to the AAPC Code of Ethics as:

- Pastoral Counseling Service Centers
- Pastoral Counseling Training Programs
- Pastoral Counseling Affiliate Centers

➤ All Institutional Members are held accountable to the sponsoring religious bodies.

**AMERICAN ASSOCIATION OF PASTORAL COUNSELORS:**
9508 A Lee Highway, Fairfax, Virginia 22031 • 703-385-6967

# AMERICAN ASSOCIATION OF PASTORAL COUNSELORS



## AMERICAN ASSOCIATION OF PASTORAL COUNSELORS:

- is an international organization of clergy and other religious-oriented professionals whose ministry is helping persons grow in times of life crises.
- is a membership organization of pastors, professional pastoral counselors, other helping professionals and the institutions which train and employ them.
- establishes standards for training and supervision in pastoral counseling which leads to certification of persons for competent practice as pastoral counselors and accreditation of institutions which provide counseling service and education.
- supports its members with opportunities for continuing education, professional dialogue and on-going consultation for growth in professional competency.
- represents its members in relationships with other professional organizations, denominations and faith groups, mental health associations and agencies of government.
- serves the public by ensuring consistent quality in counseling and psychotherapy which enhances personal and social growth toward wholeness.

**The American Association of Pastoral Counselors** was formally organized in 1963 in response to the need for leadership and standards for the involvement of religious organizations in mental health care. Since that time, the Association has provided clarity in pastoral counseling practice and training, criteria for religious institutions in pastoral counseling ministry and coordination with other mental health professions.

Today's **Pastoral Counselor** walks in the centuries old tradition of **shepherding.** The work of **Pastoral Care and Counseling** has been a vital heritage and today is of increasing importance.

The **age of anxiety** and mankind's **search for meaning** has given new impetus and urgency for training with a spiritual dimension to respond to these unfolding human crises. Two national studies within the past two decades have indicated that more people turn to the minister for help when facing personal problems than to any other professional.

**The American Association of Pastoral Counselors** welcomes inquiry from persons and institutions seeking information related to certification, accreditation, standards and the extensive work of the Association in the religious and mental health fields.

Major business of the organization is conducted through a Board of Governors composed of the officers, regional chairpersons and standing committee chairpersons.

**Annual and Regional Conferences** are held as are occasions for professional growth through major addresses, workshops, colleague dialogue and policy decision making.

Financing relies primarily on annual dues of the membership. The AAPC welcomes gifts and grants to further its work as a not-for-profit corporation.

The Association Office is administered through the **Executive Director** and staff at the **Fairfax, Virginia** location. **Inquiries about AAPC are welcome.** A directory, handbook and other additional materials are available at a nominal cost.

## AAPC is at work in Local Communities...

- Helping persons discover and claim new opportunities and growth in the midst of personal, marital, family, religious, vocational or health crises.
- Serving persons in varied settings including pastoral counseling centers, local churches and synagogues, hospitals, seminaries and community mental health centers.
- Consulting with congregations and secular organizations which seek to become more authentic and humane.
- Providing both specialized in-service training and supervision in pastoral counseling.
- Developing constructive relationships with other helping professionals.

## AAPC is at Work in Ten Regions

***Nationally and Internationally...***

- Offering vital continuing educational opportunities.
- Certifying ministers trained in pastoral counseling and participating in the certification of service centers and the approval of training programs.
- Encouraging networks of members for professional support and enrichment.
- Facilitating growth and innovation in the ministry of pastoral counseling throughout the United States and Canada and other countries.
- Promoting research in religion and mental health.

# DOCTOR OF MINISTRY PROGRAM

## Pastoral Counseling/Psychotherapy Track

# A HANDBOOK

Office of Ministry Programs
Garrett-Evangelical Theological Seminary
2121 Sheridan Road
Evanston, IL 60201
312/866-3930

Allen P. Price
[illegible] hrs a week.

HANDBOOK FOR
THE DOCTOR OF MINISTRY PROGRAM
PASTORAL COUNSELING TRACK
GARRETT-EVANGELICAL THEOLOGICAL SEMINARY

## I. INTRODUCTION

The Doctor of Ministry is a professional degree program designed to facilitate a high level of competence in the practice of ministry, with special emphasis on pastoral counseling. The goals of the program are:

(1) To provide training leading to a growing understanding of and high level of competence in the theory and practice of pastoral counseling.

(2) To integrate the Biblical, theological and historical resources of the Christian tradition with current theory from the behavioral sciences as basis for improved performance in the practical skills of pastoral counseling.

(3) To encourage fraternal collaboration, conjoint leadership, and mutual accountability of learning through a climate of collegiality and partnership in learning.

(4) To make possible personal assessment and growth in the areas of clarification of vocational identity, renewal of personal faith, self-understanding, and self-directed learning.

The degree is an "in-ministry" program, with applicants to have a minimum of three years of post-M.Div., full-time experience in the field prior to entering the program. It is conducted on a contractual basis with selected Pastoral Counseling Centers, which provide supervised training in clinical skills and the context and structures for support, practice, and evaluation. These Centers are:

Pastoral Psychotherapy Institute
Parkside Human Services Corporation, Lutheran General Medical Center
1580 North Northwest Highway, #111
Park Ridge, IL 60068 Phone: 312/696-6023
Bonnie Niswander, D.Min., Director of Psychotherapy Training

The Pastoral Counseling and Consultation Centers of Greater Washington
3000 Connecticut Avenue, N.W.
Washington, DC 20008 Phone: 703/281-1870
H. Rodney Landes, Ph.D., Director of Professional Training

Indiana Counseling and Pastoral Care Center, Inc.
1717 West 86th Street, Suite 130
Indianapolis, IN 46260 Phone: 317/872-3141
Brian W. Grant, Ph.D., Training Director

Interfaith Counseling Service, Inc.
3421 North Hayden Road
Scottsdale, AZ 85251 Phone: 602/994-1329
H. Terry Kriesel, Ph.D., Executive Director

Ecumenical Center for Religion and Health
4507 Medical Drive
San Antonio, TX 78229    Phone: 512/696-9966
Homer A. Bain. Ph.D., Director of Training

Texas Research Institute for Mental Sciences
Pastoral Counseling Training Program
1300 Moursund
Houston, TX 77030    Phone: 713/797-1976 ext. 368
William D. Tallevast, Th.M., Morris Taggert, Ph.D.

Virginia Institute of Pastoral Care
Box 5184, 507 N. Lombardy Street
Richmond, VA 23220    Phone: 804/359-4321
W. Victor Maloy, D.Min., Director of Education

Des Moines Pastoral Counseling Center
632 Woodland Terrace
Des Moines, IA 50309    Phone: 515/288-6728
J. Jeffrey Means, Ph.D., Director of Training and Education

Illinois Pastoral Services Institute
702 North East Street
Bloomington, IL 61701  Phone: 309/827-5051
Clyde Getman, D.Min., Director of Training

Participants are to be staff counselors in one of these centers and will receive supervised clinical training and some didactic course work in that context. The remainder of the course work in pastoral psychology and counseling and all their study in the classical fields, as well as the ultimate guidance of the research project is done through the Seminary, in a combination of on-campus seminars, directed studies by correspondence, and individual consultations with faculty. Although the program design has a set structure, sufficient flexibility is allowed for each participant to build some aspects of his/her program around personal and professional needs and goals.

The program must be completed in no less than two and one-half years and no more than five and one-half years from the time of attendance at the first seminar. Any participant who withdraws, is asked to leave, or does not complete the program within this time, may be given a Certificate for Pastoral Leadership Development, in recognition of the amount and nature of work completed satisfactorily. This Certificate is granted only to persons who have completed at least two three-week seminars, one Directed Study (two papers), and one full year of clinical and didactic training in a cooperating Pastoral Counseling Center.

This is a competency-based degree program, with growth in competence measured by Seminary faculty, Center supervisors, and fellow participants, as a means of assessing progress toward and readiness for admission to candidacy and the granting of the degree. The high level of competence expected of a Doctor of Ministry in pastoral counseling is defined as: satisfactory completion of all components of the program, as determined by Seminary faculty, and qualification to make application for at least the Fellow level of the American Association of Pastoral Counselors, as determined by Seminary faculty and Center supervisors.

## II. EDUCATIONAL PHILOSOPHY

A. Holistic Approach. The program makes full use of the biblical, theological, and historical resources of the Christian tradition, as well as current theory from the behavioral sciences. Such theoretical studies are utilized in an integrative, inter-disciplinary approach to the practice of ministry, which balances an understanding of foundations with the development of counseling skills. Each of the learning experiences which make up the program is guided by leadership teams made up of persons representing both the theoretical and the practical competence necessary to insure such an holistic approach.

B. Areas of Competence. As a competency-based program correlated with the standards for professional practice, the Doctor of Ministry takes into account the qualifications established by the American Association of Pastoral Counselors, and has expanded upon these as follows:

1. Personal Identity and Interpersonal Competence--awareness of self, of internal dynamics and interpersonal relationships, and capacity for flexible and effective relatedness to others.

2. Academic and Theoretical Competence--knowledge of theological and behavioral sciences and their integration at both theoretical and operational levels. This includes knowledge of theories and perspectives in the following areas: Bible, theology, church history, ethics and society, personality and personality development, interpersonal relations, marriage and family dynamics, group dynamics, personality and culture, psychology of religious experience, counseling and psychotherapy, pastoral care, and personality assessment.

3. Pastoral Identity--ability to see one's pastoral role in its ecclesiastical and interprofessional contexts, and to function with integrity in that role.

4. Therapeutic Competence--ability to assess a client's therapeutic need, to establish a therapeutic relationship, and to conduct, complete, and evaluate that therapy.

5. Ethical Commitment--understanding of and assent to standards of professional ethics, as well as commitment to such basic values as respect for the worth and rights of persons as creatures of God.

6. Research Design and Methodology--ability to understand research reports, to apply research conclusions to one's practice of pastoral counseling, and to design, carry out, and evaluate an empirical research project of limited scope and complexity.

C. Collegiality and Accountability. Assuming that a professional style of ministry involves mutual collaboration, reciprocal accountability, and shared learning, the program structures these elements into the process at every step of the way. Specifically, the participant is responsible to the Seminary, the Pastoral Counseling Center, and peers in the profession. These various agencies are also accountable to the participant to contribute to his/her learning, growth,

and professional development. These accountabilities are expressed through the D.Min. Committee, Core Faculty Team, Colleague Group, and Advisory Team.

D. Contextual Focus. The locus for learning in this program is the actual place of the participant's ministry--the Pastoral Counseling Center, which provides opportunity for clinical practice and supervision, didactic training, and peer support and accountability.

E. Conjoint Leadership. Seminary, clinical, and other academic faculty, as well as the participants themselves, are all seen as resources for learning. Each has knowledge and expertise that the others lack, and is utilized at appropriate points in the learning process. Serving as Faculty Adviser or Consultant, as Adjunct Faculty, as teachers of seminars and directed studies, as members of the Colleague Group and Advisory Team, or as special resource persons, each contributes from his/her vantage point or area of competence to one or more of the following stages of the program: assessment, goal-setting, design, coordination, training, supervision, consultation, leadership of seminars, development of Research Project, evaluation. All are both teachers and learners in the program, with the result that not only do participants develop in professional competence, but others on the leadership teams also experience growth and the Centers themselves are enriched.

F. Personal Formation. A strong emphasis is placed on the minister as person. The program is designed not merely to facilitate acquisition of knowledge and skills, but also to contribute significantly to personal growth. One aspect of this is the renewal of faith. Once the participant's needs and desired directions of growth in this area have been assessed, a program of reading, journal reflection, consultation with faculty, and exposure to other resources and experiences, is developed accordingly. Another aspect is the stress on self-understanding, vocational identity, and the utilization of oneself as a resource for ministry. A third aspect is the effort to enable the participant to become a self-directed learner. The program asserts that ministers can and should become self-reliant learners who are not dependent on schools for their continuing education, but rather can identify their needs, set learning goals, and find the resources to achieve them. Hence, the participant is the key person in designing and implementing a program tailor-made to his/her own beginning level of competence, desired directions of growth, needs and goals, and particular context for ministry. Personal growth is thus achieved as participants are empowered to become perpetual self-initiated learners.

G. Flexibility. The design of this program is predicated on the principle that form should follow function in the learning process. The participant's awareness of need for knowledge, skills, or personal growth in faith, self-understanding and competence, becomes the organizing principle around which the specific design of his/her program is shaped. Hence, although certain aspects of the program structure--such as the intensive seminars, the papers and Research Projects and Directed Studies--are fixed for all participants, there is ample flexibility within each of these components and within the program as a whole for developing an individualized program to meet the specific needs and goals of each participant.

H. Practice-Reflection. Learning in this program takes place as participants carry on their counseling practice under supervision, and engage

in regular theological reflection on their experience. Reflection on practice takes place through the writing and discussion of case studies, Colleague Group meetings, Advisory Team meetings, consultations with faculty, and the carrying out and reporting of the Research Project. The mid-program Identity Paper, describing the participant's developing theology and style of ministry, provides a major opportunity for theological reflection on one's practice of ministry. By inter-relating Biblical and theological themes with professional practice through a process of disciplined reflection, the program encourages the participant to incorporate this approach as a permanent aspect of his/her style of ministry.

## III. THE ADMISSIONS PROCESS

A. Objectives. The admissions process is designed to:
1. Assist the applicant in thinking through and clarifying his/her own personal and professional goals and in developing plans and procedures for achieving them.
2. Determine whether the applicant has the capability, resources, and motivation to learn and achieve his/her goals through this program.
3. Determine whether and how Seminary resources may be utilized to assist the applicant in achieving his/her goals, within the limits of the program format.
4. Determine whether the applicant has the personal and professional capability for developing the clinical skills expected in the program, and whether s/he possesses the personal, interpersonal, clinical, and intellectual resources to do doctoral level work in pastoral counseling.
5. Link the applicant with appropriate faculty and other resources in the Seminary and a competent and supportive Advisory Team, and to begin building a working relationship among these key actors in his/her program.
6. Generate data from the applicant's participation in the entry phases of the program on which the D.Min. Committee may base a final decision on admission.

B. Criteria. Decisions on admission are based on the following criteria:
1. Academic/cognitive.
   a. Capacity to integrate theological and behavioral understandings with the practice of ministry.
   b. Capacity for clear articulation of goals.
   c. Capacity for self-directed learning.
   d. The minimum standard for admission is the M.Div. degree or equivalent from an accredited seminary with a Grade Point Average of 3.0 or equivalent, or a satisfactory score on the Weschler Adult Intelligence Scale (WAIS). The Minnesota Multiphasic Personality Inventory (MMPI), or other relevant data may be required.
2. Professional and performance.
   a. Degree of competence, capacity for growth, and openness to learning in both theoretical and clinical dimensions of training in pastoral counseling.
   b. A minimum of three years of full-time, post-M.Div. experience in ministry.
   c. Extent of openness to and participation in continuing education experience since seminary.
   d. Capacity for peer accountability.
      1) Ability to learn from colleagues in a peer setting.
      2) Ability to give and receive criticism and support from peers.
   e. A clear and growing sense of pastoral identity.
   f. A minimum of two quarters of Clinical Pastoral Education (or clinical equivalency).
   g. Ability to meet the standards for membership in the American Association of Pastoral Counselors in the following areas:
      (1) Educational Requirements
      (2) Requirements for Clinical Work Under Supervision
      (3) Requirements for Personal Therapeutic Experience
      (See AAPC Handbook, pages 29-31, for the detailed aspects of this criterion.)

3. Personal and psychological.
   a. Trainability, teachability, capacity for studenthood, capacity to learn and grow.
      1) Is the timing right? Is the person able at this juncture to assimilate new learning and growth?
      2) Is s/he integrated enough to be able to devote his/her energies to meet the demands of the program?
   b. Affective capacity; extent of being in contact with one's own emotionality.
   c. Degree of awareness of one's strengths and weaknesses.
   d. Capacity to work within the parameters of the program - to be "back in school," meet the additional time demands, benefit from clinical training.
   e. Capacity to think theologically about one's self and work; ability to reflect on, make meaning of, and communicate one's own experience.
   f. Capacity to "be with" other persons, to establish and maintain growing relationships.
   g. Degree of intentionality, sense of direction and purpose.
   h. Degree of being in touch with one's own struggles with life issues, ultimate questions, and personal and Christian identity.
   i. Capacity for self-evaluation.

C. Procedure. Admission to the program is granted to a prospective participant upon satisfactory completion of the following application steps and requirements:
1. The applicant seeks admission to the training and service delivery program at one of the cooperating Pastoral Counseling Centers and becomes accepted for clinical training, which includes the delivery of pastoral counseling services as a counseling staff member at that center.
2. The applicant submits an application form secured from the Seminary accompanied by the following supporting information and documents:
   a. All college, seminary, and graduate school transcripts.
   b. The names of three references:
      1) A seminary professor who knows the applicant's academic work and potential well;
      2) A denominational judicatory official (District Superintendent, Board of Ministry member, executive of endorsing body, etc.) who knows the applicant's present parish work and professional competence well;
      3) The Director of Training of the Center to which application is being made, who can certify that the applicant meets the standards for membership in the AAPC, report on the applicant's acceptance into that training and service delivery program, and communicate the Center's recommendation regarding the applicant's participation in the D.Min. program.
   c. A $25 application fee, which is non-refundable.*
   d. A Statement of Purpose indicating the applicant's reasons for wishing to enroll in the program, projected vocational and learning goals, and possible Research Project.

e. A Professional Identity Paper of 1500-3000 words, including the following:
   1) Applicant's present understanding of him/herself as a person, a Christian, and a clergyperson;
   2) Formative experiences which have shaped applicant's development;
   3) Case material from applicant's practice of ministry with theological reflection on this;
   4) Theological themes of special meaning to applicant;
   5) A statement regarding the fundamental theological and social issues which the applicant feels are crucial to ministry in today's church and world;
   6) Current areas of significant growth, searching, and needed development;
   7) Crises in faith and living;
   8) Satisfying and frustrating experiences in ministry;
   9) Assessment of personal strengths and shortcomings;
   10) Significant characteristics which make the applicant who s/he is.

f. A sermon or detailed outline of a Bible study course developed by the applicant, which deals responsibly with the exposition of a Biblical text.

g. An annotated bibliography of books or resources which the applicant has found stimulating in ministry since seminary.

3. On the basis of these written data, action on "Preliminary Admission" is taken by the D.Min. Committee, on recommendation of the pastoral psychology faculty. The deadline for receiving the completed application is April 15, and the applicant is notified by the Director of Admissions by June 1.
4. The Coordinator of the Pastoral Counseling track and/or a faculty member of the Pastoral Psychology faculty of Garrett-Evangelical visit the Center where the applicant is in training for an extensive interview and consultation with the applicant and the Director of Training/ Adjunct Faculty member there. The purposes of this consultation are to: a) interpret and clarify the D.Min. program and the interface of the Center and Seminary in its implementation; b) clarify the roles and responsibilities of the applicant's program; c) organize the applicant's Advisory Team; d) identify the applicant's learning goals and how s/he intends to pursue these through the components of the program, particularly the Research Project; e) develop a Learning Contract to which all present can agree.
5. On the basis of this consultation, the Coordinator of the Pastoral Counseling track: a) makes a recommendation to the D.Min. Committee regarding Final Admission, and b) enlists a Faculty Advisor for the applicant.
6. Final admission is contingent upon the acceptance of the Learning Contract by the D.Min. Committee and the agreement of the Faculty Advisor and the Coordinator of the Pastoral Counseling track, which may require personal conferences on campus between the applicant and the faculty involved.

## IV. STRUCTURE

In recognition of the fundamental corporate nature of Christian existence, as well as the empirical evidence that personal growth and learning are best facilitated and sustained in and through support systems, this program involves the Participant in a network of learning and support communities. The following groups are involved in the ways specified:

### 1. DOCTOR OF MINISTRY COMMITTEE

This Committee has general oversight of the program, and is responsible to the Seminary faculty. It is made up of: President (ex officio), Dean (ex officio), Director, Coordinators of the tracks, three faculty members appointed by the President; Participants elected from each of the tracks, a representative of the D.Min. alumni (chosen by the Committee), and a United Methodist layperson (chosen by the Committee).

The Committee meets at least once a quarter to make policy decisions, advise on administrative matters, review applications for admission, and make recommendation of Participants to the faculty for Admission to Candidacy and the granting of degrees. Only faculty members vote on matters of admission, Admission to Candidacy and granting of degrees. The faculty members of the Committee may meet on call between quarterly meetings to act on necessary business. Minutes of these meetings are submitted to the full Committee for confirmation at regular meetings.

### 2. FACULTY MEMBERS

During the Admissions Process, the Participant, in consultation with the Coordinator, selects a Faculty Advisor to resource his/her learning goals, in cooperation with the Adjunct Faculty/Training Director of the Pastoral Counseling Center.

The Faculty Advisor is a member of the Pastoral Psychology department of the Seminary faculty. S/he normally attends Advisory Team meetings on site, when possible, reads and evaluates all major papers including the Mid-Program Professional Identity Paper, chairs the Mid-Program Evaluation Conference, serves as primary resource person on the Research Project, reads and evaluates the Research Project Report and chairs the Oral Defense, and oversees the Participant's progress in development of clinical skills in consultation with the Training Director of the Center.

The Coordinator of the Pastoral Counseling track is also a member of the Pastoral Psychology faculty, who is responsible to administer this aspect of the D.Min. program.

The Director of Training at the Pastoral Counseling Center serves as an Adjunct Faculty member of the Seminary and gives direct and continuous oversight to the Participant in the clinical aspects of the program, providing linkage to the Seminary through frequent consultation with the Faculty Advisor. S/He also reads and evaluates the Mid-Program Professional Identity Paper and Research Project Report, participates in the Mid-Program Evaluation Conference and the Research Project Oral Defense, and monitors the Participant's progress in all aspects of the program.

## 3. ADVISORY TEAM

The Advisory Team is made up of the Faculty Advisor, the Pastoral Counseling Track Coordinator, the Adjunct Faculty/Training Director of the Center who normally serves as chairperson, other Center staff related to the Participant in a supervisory or training capacity, and such other persons as may be considered by the Participant and Team to have a useful contribution to make to his/her learning. The function of the Team is to guide, oversee, support, and evaluate the Participant's performance and progress in the program. The Team meets at least once per year. The agenda is made up of some or all of the following components: (1) sharing of personal and program concerns and progress; (2) consideration of faculty evaluation sheets from the previous seminar; and (3) a review of each Participant's progress in the program, including work at the Center, work at the Seminary, and the Research Project. The Track Coordinator (and whenever possible the Faculty Advisor) will attend a minimum of one Team meeting a year to provide linkage between Seminary and Center.