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9509 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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PRESENT.:
ALASKA
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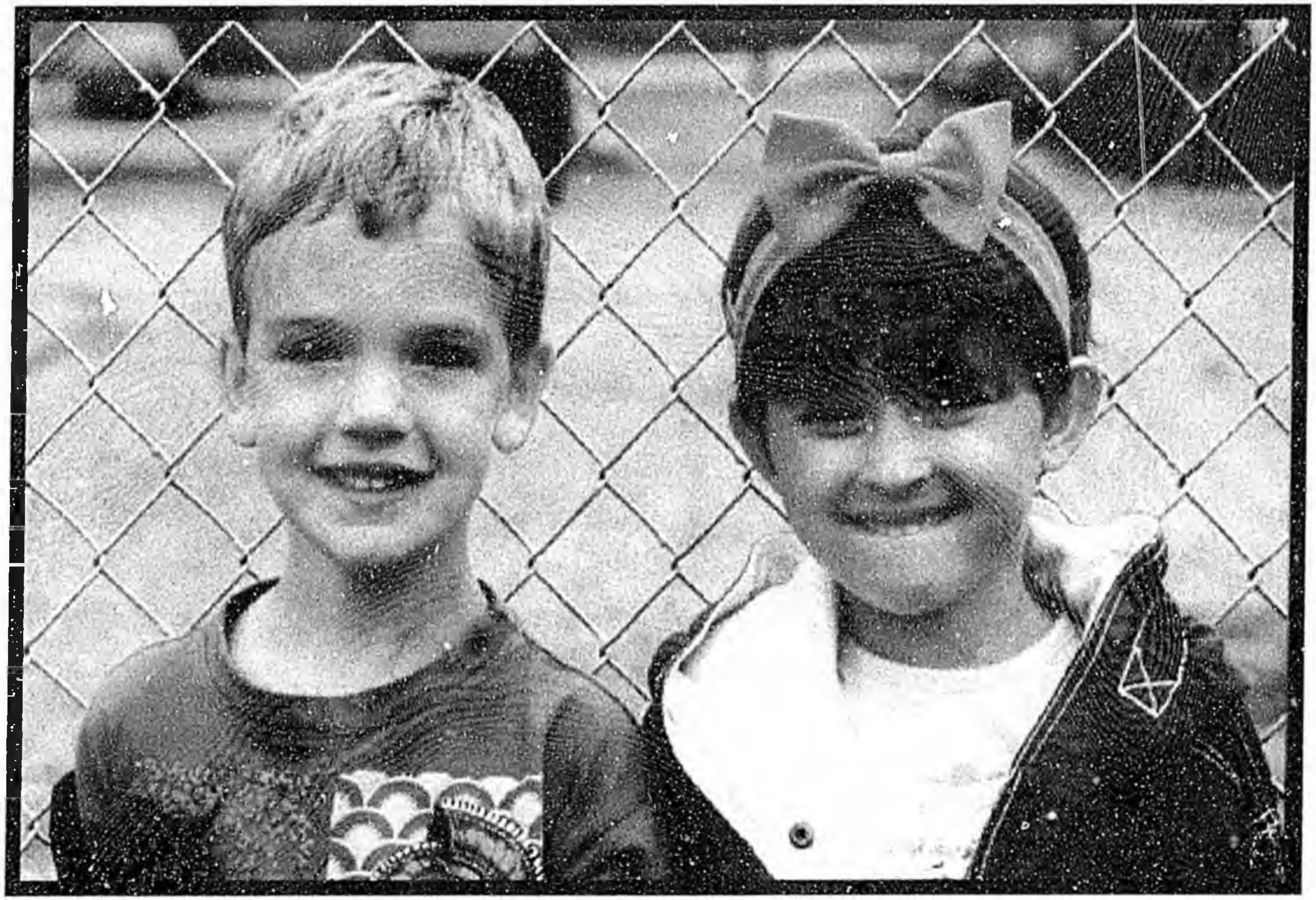
UPDATE

ALASKA CHILDREN'S TRUST



ANNUAL REPORT — 1996

Strengthening communities — supporting families — preventing child abuse

Contents

History

The Alaska Children's Trust (ACT) was created by the legislature in 1988 (AS 37.14.200 - 37.14.270) to address rising rates of child neglect, abuse, community violence, and juvenile crime. The trust is designed to promote and financially support community-based initiatives to strengthen families and children. Until this year, the trust remained idle with no funds.

Purpose

The primary purpose of the Alaska Children's Trust is to work in partnership with communities, private business, and government to reduce and prevent child abuse, neglect, and family violence.

Mission Statement

Alaska's children require and deserve to grow up in a safe and nurturing environment. The mission of the Alaska Children's Trust is to improve the status of children in Alaska by generating funds and committing resources to promote healthy families and to assist in developing healthy communities.

Alaska Children's Trust (ACT) Board of Trustees

Alaska Children's Trust Goals

To accomplish the trust's mission, the board of trustees has established four goals:

- Change the climate of tolerance for child abuse and neglect by promoting an awareness of the current plight of many of our children;
- Support the development of safe and nurturing community environments;
- Promote responsible parenting and care giving;
- Ensure children are eager and ready to learn.

The goals are to be achieved through:

- Funding community-based child abuse prevention programs;
- Educating the public, initiating media campaigns and providing information;
- Coordinating resources and sharing information;
- Encouraging collaboration and developing partnerships with public and private organizations.

Why Alaska Needs the Trust – The State of Alaska's Children

Although many Alaskan children grow up in loving homes with parents and other family who tend to their needs, there are many who do not.

Economic hardship, rapid social and cultural change, and many other stresses result in increasing cases of child neglect and abuse, community violence, and juvenile crime.

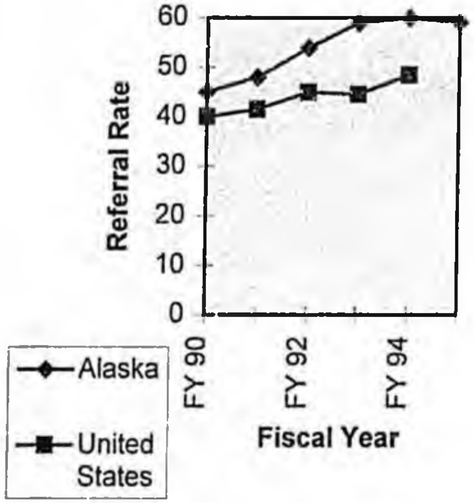
The statistics support an unsettling conclusion that children in our state are in trouble.*

- Alaska leads the nation in per capita cases of child sexual abuse and neglect.
- Each year 125 babies die before their first birthday. Another 160 are born with alcohol-related disabilities.
- More than 10,000 Alaska preschoolers live below the poverty line.
- The suicide rate for Alaska teens is four times the national average.
- Every year 1,450 children are arrested for offenses including assault, rape, robbery, and drug sales.
- Every year 2,200 children drop out of school.
- Each year 3,500 children are reported as runaways.

The goal of the trust is: to give all Alaskan children the opportunity to grow up in a safe and healthy setting so they become responsible and productive adults. The Alaska Children's Trust can support initiatives that directly and creatively address the problems of our youth; it can make a difference.

CHILD ABUSE AND NEGLECT

Rate of Reported Child Maltreatment, Alaska and the United States



From: Fiscal Years 1994 and 1995 Annual Report, State of Alaska Department of health and Social Services

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* From Invest in Our Children: An Investment in Our Future, an interim report from the child health planning work group to the governor and the people of Alaska (October, 1994).

How the Trust Works

- The Children's Trust is a savings account for children. The principal of the trust is maintained -- only the interest income can be spent.
- The trust relies on gifts, bequests, and contributions of cash or other assets from individuals, corporate entities, legislative appropriations, and federal funds.
- The income from the trust is distributed to community organizations through a grant application and review process.
- The treasurer of the trust is the Commissioner of Revenue. The Commissioner is the official custodian of the cash and investments.
- The trust is administered by a seven-member board of trustees; the trustees are appointed by the Governor. The board of trustees include the Commissioner of Health and Social Services, the Commissioner of Education, the Governor or designee, and four public members.
- The trust board is established in the Office of the Governor.
- The trustees set priorities, award and monitor community grants, and assist in raising funds.

> *"The Alaska Children's Trust was founded on the notion that every Alaskan child ought to get the help they need along the road to adulthood. . . help a kid and you've changed a life. Nobody said it was going to be easy, just worth it. Alaska Children's Trust – everybody deserves to be a kid once."*
>
> **– Tom Bodett,**
> Alaskan Author

Highlights and Accomplishments

- The Alaska Children's Trust board of trustees was appointed in April 1996.
- A strategic plan is established which includes a mission, goals, and action steps to begin moving forward the trust's purpose of preventing child abuse and neglect.
- The current trust balance includes $6 million from a 1996 legislative appropriation and approximately $11,000 from individual contributions – a good beginning.
- The Alaska Children's Trust has received letters and resolutions of support from over 100 communities, local governments, organizations, and individuals.
- The trustees have established a core group of volunteers – Friends of the Alaska Children's Trust, a non-profit corporation, to raise money on behalf of the Alaska Children's Trust.
- The Alaska Children's Trust is working in collaboration with state agencies to maximize resources and avoid duplication.
- The Alaska Children's Trust board has initiated a statewide media campaign featuring well-known writer Tom Bodett. The promotional radio spots will be broadcast across Alaska during 1997. Bodett donated money, his time, and his talent to produce the radio spots.

> *"It's not just another source of funding for traditional programs—we intend to be at the cutting edge of preventing child trauma."*
>
> **—Mark Williams, ACT Chairman**

How the Trust Will Benefit Alaskans

In the summer of 1997 the Alaska Children's Trust board will launch the trust's first direct activities to begin fulfilling its purpose, by making grants to community-based child abuse and neglect prevention projects.

Applications for the Alaska Children's Trust child abuse and neglect prevention funds will be funded on a competitive basis. The annual funding level for the Alaska Children's Trust is based upon annual income earnings from the trust. The amount of funds available for community projects in FY'98 is projected at $250,000.

The Alaska Children's Trust board of trustees will set priorities and award projects that the board determines will aid in the prevention of child abuse and neglect. Some examples of potential child abuse and neglect prevention projects are listed below:

- Parent support and education projects for at-risk parents through in-home instruction and weekly and monthly classes and seminars;
- Projects to help new fathers with parenting skills;
- Home visits to parents with new-born children to help them connect with parenting resources and to capitalize on the interest of new families in learning how to nurture and protect their children.
- Violence-prevention and conflict-resolution training for school-aged children to teach peaceful alternatives to conflict;
- Mom-to-mom mentoring projects;
- Workshops to help teachers learn how to detect, report, and support abused and neglected children;
- Child development classes in schools.

Information about the application process can be obtained by writing to the Alaska Children's Trust, Office of the Governor, P. O. Box 110001, Juneau, AK 99811-0001, or by calling 1-800-643-KIDS (5437).

How You Can Help

All citizens of Alaska can help prevent child abuse and support families. Here are a few things you can do to help:

- Volunteer your time at a community-based child abuse prevention program.
- Offer to care for the children of a parent under stress.
- Talk to leaders in your community about public policies that support families and children.
- Take a parent education class or join a parent support group.
- Donate to the Alaska Children's Trust on behalf of your own children – your contribution will help for generations.
- Call the Alaska's Children's Trust hot line. Call toll free: 1-800-643-KIDS (5437) for information about the Alaska Children's Trust and Children's Cabinet initiatives.

Directory of Staff and Work Groups

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mouzer1228@aol.com

Deborah Bonito, Chair
PO Box 200445
Anchorage, AK 99520-0445
(907) 338-7251
(907) 333-9389 – fax

Alaska Children's Trust Toll-Free Phone Number

1-800-643-KIDS (5437)

Friends of the Alaska Children's Trust

- Deborah Bonito, Chair, Small Business Owner, Anchorage
- Dennis Demmert, former Executive Director of Sealaska Heritage Foundation and University of Alaska Southeast faculty, Juneau
- Diane Kaplan, Diane Kaplan and Co. Consulting Firm, Anchorage
- Mike Porcaro, Porcaro Blankenship Advertising, Anchorage
- Mike Burns, President and CEO, KeyBank, Alaska

Contributions to the Alaska Children's Trust

Tax-deductible contributions can be sent to:

Alaska Children's Trust
State of Alaska
Department of Revenue
PO Box 110400
Juneau, AK 99811-0400

PRESENT.:
ALASKA DISABILITY POLICY PROGRESS

Resolutions
Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

Distributed by the Division of Vocational Rehabilitation, Department of Education

COMMUNITY INCLUSION AND SUPPORTS

Desired Outcome: Individuals with disabilities use the same community resources to live, learn, work and play as do nondisabled persons and participate in the same local communities activities as do nondisabled persons.

Background: As long as people with disabilities remain segregated, nondisabled people do not get to know them. Segregation - whether the result of stairs or attitudes- creates harmful myths or stereotypes; or worse, sets up aself-fulfilling prophecy for failure. That people with disabilities are invisible or separated, Americans have long assumed is proof that they do not need inclusion or are not capable or worthy of it.

However, reducing or eliminating the need for specialized programs results in reduced costs. Inclusion also enables people with disabilities to be full contributors to their communities. Physical accessibility and access to transportation may be all that is needed for many persons with disabilities to participate in their communities. However, other people with disabilities may require individualized supports such as a personal assistant to help with such tasks as getting out of bed, bathing, dressing and eating or on-the-job training and support. Still others may need assistive technologies such as teletypewriters (TTYs), voice synthesizers, grab bars, Braille keyboards or adapted skis to help them be included in their communities.

Inclusion also means that communities and ordinary citizens see themselves as competent and willing to become involved in the lives of people with disabilities. As long as inclusion is not a reality and people with disabilities remain strangers, nondisabled individuals will continue to believe that special training, considerable patience and clinical certification are required to support people with disabilities in their communities.

Inclusion helps citizens and communities realize that they have the capacity to be with, befriend, care about, work alongside and learn with and from people with disabilities. A shared sense of competency means a willingness and desire to live, learn, work and play together.

Proposed Administrative Strategies:

- Enforce existing laws such as the Americans with Disabilities Act.
- Ensure better voter access.
- Designate American Sign Language as a foreign language under Bachelor of Arts requirements.
- Ensure that programs as well as facilities are accessible to people with disabilities.
- Promote better agency/service collaboration.

- Develop the statewide availability of individualized supports such as Interpreters for the Deaf or Orientation and Mobility Specialists for the blind.
- Develop supported avocations.
- Develop training programs for transition from specialized programs to inclusionary ones (e.g. from Special Olympics to Parks and Recreation programs).

Proposed General Public Strategies:

- Work with local sports associations and build upon National Soccer Association's activities (e.g. training re: the Americans with Disabilities Act, how to include people with disabilities, grant funds).
- Develop additional inclusive recreation opportunities.

Proposed Legislative Strategies:

- Change the Assistive Technology Loan Fund to make it more consumer friendly.
- Pass a Lemon Law for assistive technology devices and equipment.
- Enact Puppy Guide Dog Legislation.

Proposed Disability Community Strategies:

- Advocate for more funding for family/individual supports and recreation.
- Let consumers and families know what their options are for recreation (e.g. Girl Scouts).
- Provide legal training and advocacy re: consumer choice, rights and responsibilities, and access to justice.
- Establish recreation subcommittees on councils and committees. Make more effective use of existing natural supports.
- Establish a State Traumatic Brain Injury Advisory Board.
- Encourage people with disabilities to get on community boards and commissions.
- Provide information about disability issues to community groups and civic organizations.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

EDUCATION

Desired Outcome: Children and youth who experience disabilities are receiving specially tailored education programs in classrooms with nondisabled students to help them achieve in accordance with their potential.

Background: All children and youth are entitled to a Free Appropriate Public Education. Special education means the program of service recommended by the Individualized Education Program (IEP) team, which must include parents, to meet the educational needs of a student with a disability.

The IEP sets forth in writing a commitment of resources necessary to enable a student with a disability to receive needed special and related services. It is also used as an evaluation tool to determine the extent of progress toward meeting the stated goals and objectives. The IEP also includes a statement of the extent to which the student will participate in regular education classes.

Many parents, advocates, educators and policymakers are advocating for every student's full participation in a regular education class with "ownershic" of that student shared by both regular and special educators. Many parents with disabilities have found that their children make greater gains academically and socially in integrated classrooms than they did in segregated classrooms. The friendships that their children made with nondisabled students would not have occurred in segregated placements.

Parents report that their children are happier and eager to be doing what their peers are doing. Since academic standards are higher in inclusive settings, students are motivated to achieve at higher levels, whatever their initial level of ability and functioning. Integrated placements often lead to a greater ability to achieve independence and employment as adults. Both parents and students feel that inclusion helps students without disabilities to become more compassionate and understanding.

The costs associated with inclusion and integration can be modest, with possible savings because of fewer due process hearings, fewer mediations, fewer referrals to special education, fewer nonpublic school placements and lower transportation costs. However, in order for inclusion to work, training, planning time and support - which means enough staff and technoiccical assistance - must be made available in local schools.

Proposed Administrative Strategies:

- Provide training for regular educators and support staff (e.g. bus drivers) so they are able to provide inclusive services for all children and youth.
- Conduct a study recording the optimal class size of inclusive classrooms.
- Work with the university system to ensure that disabilities issues are included and addressed in all academic disciplines.
- Provide opportunities for urban school districts to learn how rural school districts include children and youth with disabilities in their regular education classes.
- Assure the success of the Alaska Transition Initiative.
- Provide low incidence disability training to special and regular education teachers and link training to hands-on technical assistance.
- Ensure that all policy initiatives and programs having an impact on educational attainment and transition to adult life are designed and implemented to meet the needs and maximize the talents of all students, including those with disabilities.

Proposed General Public Strategies:

- Conduct a media campaign to inform the general public about the long term benefits of special education.

Proposed Legislative Strategies:

- Review and monitor proposed changes to the education foundation funding formula.

Proposed Disability Community Strategies:

- Inform parents about their rights and options regarding a Free Appropriate Education for their children.
- Advocate for increased funding for education.
- Celebrate successes and get the word out about these successes.
- Attend meetings of the State Board of Education and local school districts.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

EMPLOYMENT

Desired Outcome: People with disabilities have the same opportunities to secure employment consistent with their interests and abilities as do people who do not experience disabilities.

Background: 66% of all Alaskans with disabilities are unemployed compared to the average 1996 state unemployment rate of 7.9%. According to a 1994 poll conducted by Lou Harris and Associates, 79% indicate that they want to work. Even when people with disabilities have jobs, they earn far less than their coworkers and are far less likely to be promoted - even when such things as the possibility of their lack of experience or lowered productivity are considered.

There are several reasons for these discrepancies. First and foremost is discrimination. Despite the positive attitudes of many employers and the effectiveness of job accommodations, many companies are still not hiring people with disabilities. Employer prejudice and underestimation of the skills of employees with disabilities--rather than actual work limitations--also translate into lower wages, fewer opportunities for promotion and loss of jobs during times of retrenchment.

Access to health care is the second major obstacle to employment. Even if private health insurance is available, underwriting practices, preexistingcondition exclusions and limits on benefits act as critical disincentives to employment. Many people with disabilities are forced to secure public health insurance through Medicaid or Medicare, which is only available to people who are not working.

Public policy is also a barrier to employment. State workers' compensation and private disability insurance too often emphasize compensation for the acquisition of a disability and retirement from the workforce. Little attention is given to assessing functional capacities and productivity with appropriate accommodations. In addition, people with disabilities have never been routinely considered as a potential part of the labor force; disability is poorly understood and communicated in the state's larger employment policy agenda. The implicit assumption is that Alaskans with disabilities are not expected to be part of the workforce.

Proposed Administrative Strategies:

- Ensure that generic employment and labor policy and programs presume that people with disabilities are part of the Alaskan workforce.
- Vigorously support full enforcement of the Americans with Disabilities Act.
- Convene work group to identify state policy work disincentives and determine what can be done to address them.
- Improve the state purchasing regulations regarding bidder pref provide training for purchasing agents, ensure existing policies and procedures are being followed),
- Issue an executive order directing the Department of Labor to promote the employment of people with disabilities and establish employment goals to be reached by the year 2007.
- Add people with disabilities as a group within the state labor force statistics and monitor

reasons people with disabilities report for not working across types of disability, local areas, and diverse cultural and ethnic groups.

- Establish a working group of employers and people with disabilities to identify and expand meaningful financial incentives.

Proposed General Public Strategies:

- Work with targeted businesses and industries (e.g. airlines, tourism), unions and public employers to promote the employment of people with disabilities and establish employment goals to be reached by the year 2007.
- Conduct state and local media campaigns designed to change public attitudes and promote employment opportunities for people with disabilities.
- Provide training for line supervisors and personnel directors.
- Provide information about financial incentives to employers.

Proposed Legislative Strategies:

- Establish a separate insurance pool for people with preexisting-conditions.
- Enact legislation ensuring that adequate health care and long-term supports--including personal assistance services and assistive technology-are available to people with disabilities who are employed, are seeking employment or are changing jobs.
- Enact legislation enabling local government entities to give preferential hire to people with disabilities.
- Develop and fund initiatives to promote innovative employment and entrepreneurship among people with disabilities.

Proposed Disability Community Strategies:

- Provide training to people with disabilities regarding their employment rights and responsibilities.
- Identify ways to better employ and support people from undersexed groups.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

HEALTH CARE

Desired Outcome: Accessible, affordable and comprehensive health care is available to all Alaskans without regard to a person's health, functional status or sociodemographic factors (e.g. age, ethnicity, employment, income).

Background: Alaskans with disabilities have identified the lack of access to adequate health care and insurance as a major barrier to independent living and employment. The existing health care system is designed to address acute rather than chronic health conditions and, as such, rarely provides for the longterm services and supports that are often needed by people with disabilities.

As the cost of health care and health insurance has risen, people with disabilities have found it increasingly difficult to meet their needs through private insurance. The high cost of health insurance means that many people with disabilities go without health care; even those individuals who are able to secure health insurance are not insured for preexisting conditions. Although Alaska has a high-risk pool, the cost is prohibitive. Some parents have had to relinquish custody of their children to the state to get medical coverage for them until a Medicaid waiver can be obtained.

While the majority of Alaskans with disabilities have some private health insurance, few have adequate coverage that they can depend on to meet their needs, given preexisting-condition exclusions, minimal benefit packages and benefit caps. In addition, the common needs of people with disabilities for durable medical equipment, assistive technology and personal assistance services are rarely fully covered.

Public health care is often the only avenue available to Alaskans with disabilities; people with disabilities are more likely to receive health care through public sector programs than people without disabilities. Since public health insurance is generally available to those who are not working, access to adequate and affordable health insurance is a major barrier to employment. In addition, Medicaid is virtually the only source of reimbursement for long-term services and it is generally unavailable to those who are working. The Medicaid program itself has taken significant cuts in funding over the past few years; people with disabilities no longer have funding for eyeglasses, hearing aids, acute dental care and occupational therapy.

Proposed Administrative Strategies:

- Ensure that managed care initiatives are consumer-friendly.
- Assess number and impact of loss of benefits by legal aliens in Alaska.
- Transform Medicaid's institutional bias into a presumption that long-term services and supports should be provided in the home and community.
- Work with both public and private insurers to update benefits more accurately reflect the health needs of people with disabilities, particularly in the areas of assistive technology and personal assistance services.
- Assess implications of Tort Reform.

- Develop mental health services for persons who are both developmentally disabled and mentally ill.
- Promote access for people with disabilities to generic public health services such as health education, wellness, nutrition counseling, smoking cessation programs and prevention of secondary disabilities.
- Develop and implement training programs that will sensitize health care providers to the ongoing health care needs of people with disabilities.
- Ensure easy access to diagnosis and treatment and streamline paperwork.

Proposed General Public Strategies:

- Secure input from the general public on strategies for achieving a health care system that spreads risk, is driven by consumers of health services and covers everyone.

Proposed Legislative Strategies:

- Restore Medicaid funding of vision, hearing, acute dental care and occupational therapy services for adults.
- Enact legislation limiting preexisting-condition exclusions and improving portability and renewability of private insurance coverage.
- Ensure that whatever health care reform is implemented in Alaska is consumer-driven and includes the following features: adequate consumer information; quality standards; adequate appeals and grievance processes; and consumer governance.

Proposed Disability Community Strategies:

- Provide training to enable people with disabilities to become more informed consumers of health plans and services.
- Provide training to people with disabilities on how to make effective use of Social Security and Internal Revenue Service work incentives.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation AdvisoryCouncil

HOUSING

Desired Outcome: Alaskans with disabilities are able to secure accessible nd affordable housing in the community.

Background: Accessible, available and affordable housing is key to the independenceand full participation of Alaskans with disabilities in their local communities. Historically, people with disabilities led "out of sight, out of mind" lives in segregated institutions. Despite recent downsizing of institutions, freedom of choice in where to live remains an elusive goal for many Alaskans with disabilities.

Multiple obstacles prevent people from disabilities from securing adequate housing in the community. To start with, low income levels make rent payments unaffordable or limit access to mortgage loans; even when people with disabilities secure government assistance, they are the group most likely to live in severely inadequate housing.

For those individuals who do own or rent their own homes, the cost of modifications to make them fully accessible and usable is often prohibitive. Even if modifications are affordable, people with disabilities may be forced to settle for inadequate ones because designers and contractors skilled in barrierfree and universal design are unavailable.

For some Alaskans with disabilities, the choice of where to live is limited by funding agencies or service providers. Funding for support services is often tied to congregate living situations or service providers are only able to provide support services within a group setting. Service providers rather than people with disabilities own the homes where services are provided. Developing a community-based support structure independent of housing programs requires considerable redirection of funds and extensive program development time.

Accessible housing stock is extremely limited in Alaska. While there is considerable evidence that home modifications and appropriate design can decrease service costs, make caregiving easier and prevent institutionalization, there is no state policy guiding the funding and delivery of home modifications and repairs or the design of housing that maximizes the independence of people with disabilities.

Universal design is a concept that addresses the scope of accessibility and seeks to make all elements and spaces accessible to and usable by all people to the greatest extent possible; it means buildings and items that are usable by most people regardless of their level of ability or disability (e.g. lever handles rather than round doorknobs). It need not increase costs or result in special or different-looking structures or features (Center for Universal Design).

Proposed Administrative Strategies:

- Review the accessibility standards of other states (e.g. Washington, Texas) and assess applicability to Alaska.
- Provide grantwriting and other technical assistance to service providers on accessing available state and federal dollars for housing.
- Strengthen the enforcement of existing fair housing and civil rights laws by including people with disabilities in monitoring and testing the housing, banking, real estate, design and construction industries.
- Develop initiatives to ensure affordable housing (e.g. home modification programs, requiring that housing vouchers be considered as income by rental agents, building owners, banks and mortgage companies).
- Develop initiatives to promote the universal and accessible design of housing (e.g. require a basic level of access in all new dwelling units and in all renovations, promote a level of accessibility that would enable people with disabilities to comfortably visit homes in all single family construction through code changes and education).

Proposed General Public Strategies:

- Provide information and training on universal design to architects, contractors, designers and building inspectors.

Proposed Legislative Strategies:

- Fully fund the Alaska Housing Finance Corporation's (AHFC) proposed FY98 budget, including $2.5 million in special needs housing, $750,000 in homeless services and $3.0 million in HOME match funds.
- Target state housing dollars towards rural communities which are not eligible for federal housing funds.
- Redirect housing funding away from separate housing or housing that requires special terms or conditions and toward housing in the most inclusive settings with maximum control by people with disabilities.

Proposed Disability Community Strategies:

- Supply information regarding numbers and extent of need to the legislature, the Alaska Mental Health Trust Authority and the AHFC.
- Request training from AHFC on ways to acquire state and federal funds for people with disabilities to own their own homes.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

TRANSPORTATION

Desired Outcome: Accessible transportation is available to all Alaskans with disabilities.

Background: Accessible transportation is one of the keys to employment and community participation for people with disabilities. Alaska has seen an increase in both the accessibility of the generic fixed-route bus system and the use of paratransit since the implementation of the Americans with Disabilities Act, although full accessibility remains a long term goal.

However, only a few Alaskan communities have public transportation. Where it does exist, it is limited. In addition, uncoordinated transportation systems create additional barriers in some communities (e.g. eligibility restrictions or limited hours of service). Many people with disabilities do not live in areas served by public transportation and thus rely on private vehicles. However, buying a car may be difficult because of the additional expense of adapting a vehicle and the general low income level of people with disabilities.

Alaska's rail and ferry systems are also increasing their accessibility. Other forms of transportation such as private shuttle vans, cruise ships and other large boats, taxis and airplanes are increasingly accessible, although people with disabilities cannot take accessibility for granted when traveling. Despite progress, persistent problems remain, including poorly maintained equipment and untrained or poorly trained operators and service staff.

In addition to the elimination of physical barriers, transportation access for people with disabilities includes the removal of structural, communication and environmental barriers. Expanded visual access (e.g. signage, electronic message boards) and teletypewriters (TTYS) are needed by people with hearing disabilities. Auditory detectable warnings as well as Braille and large print copies of activities and timetables are needed by people with vision loss.

Two other common transportation obstacles for people with disabilities in Alaska are lack of curb cuts from sidewalks to streets and inadequate sidewalk snow removal. Without curb cuts and snow removal, use of fixed-route bus systems and other means of transportation is limited, possibly resulting in greater use of the more costly paratransit services.

Proposed Administrative Strategies:

- Fully implement the Governor's Executive Order to facilitate coordination of transportation at the state and local levels.
- Aggressively enforce existing transportation statutes and regulations related to people with disabilities.
- Ensure communication accessibility in transportation facilities, services and vehicles, as well as on streets and highways (e.g. improved signage for people with visual impairments; flashing and audible emergency alarms in facilities and vehicles).

Proposed General Public Strategies:

- Work with hotels and hospitals to designate places for lift-equipped vehicles to load and unload passengers with disabilities.
- Provide training targeted toward transportation operators and related service personnel.
- Work with local government entities to enforce existing laws for curb cuts and sidewalk snow removal and budget funds for these activities.

Proposed Legislative Strategies:

- Change the Assistive Technology Loan Fund to make it more consumer friendly.
- Provide additional operating and capital funds, including flexible capital, in order to expand public transit.
- Fund more accessible rural transit services and other forms of rural transportation for the general public and for people with disabilities.

Proposed Disability Community Strategies:

- Congratulate and publicly acknowledge the collaborative and supportive activities (joint planning and funding) of the Department of Transportation and Public Facilities, the Department of Health and Social Services and the Alaska Mental Health Trust Authority.
- Secure additional information on the transportation needs of people who are deaf or hearing impaired and people who are blind or visually impaired.
- Publicize the availability of assistive technology loans for vehicle modifications and other assistive technology.
- Provide training to people with disabilities about laws and practices affecting accessible transportation.

Jointly Developed by:

Assistive Technologies of Alaska Advisory Board
Governor's Committee on Employment of People with Disabilities
Governor's Council on Disabilities and Special Education
State Independent Living Council
Vocational Rehabilitation Advisory Council

PRESENT.:
ALASKA
PUBLIC
HEALTH
IMPROVE...

Traveling the Road to a New
Century in Public Health

Traveling the Road to a New
Century in Public Health

From Alaska's Letter of Intent to Apply for a Turning Point Grant from the Robert Wood Johnson and W.K. Kellogg Foundations; March 27, 1997

Executive Summary

Alaska's public health system has been successful during this past century in protecting and promoting the health of our citizens. Public health activities such as population-based screening for infectious disease, providing immunizations, and assuring safe restaurant foods and clean drinking water, are primarily responsible for improved health status and increased longevity. The need for improvement in the public health system has been recognized for some time though. Discussions regarding system reform began during the last decade. These discussions took on more urgency during the health care reform debates of the early '90s, and have culminated in the implementation of a strategic process to improve Alaska's public health system.

Public health leaders in Alaska recognize the opportunities present in the many changes taking place today throughout our society. Examples of some of the issues that now compel Alaskans to examine and reform our public health system include: movement in the clinical care sector towards managed care; movement in the Native health care system towards increased self-determination; changes in the way businesses and governments are conducting business in the new information age; the movement towards smaller, more efficient government; and shifts in values that are reemphasizing personal responsibility and community involvement and control.

The Alaska Public Health Improvement Process began in December, 1996, and is focusing on developing partnerships to evaluate and revitalize the mission of public health in the state. The nexus of these partnerships will be a common vision of healthy Alaskans in healthy communities. This vision will be realized through the re-invention of the public health system. The role of public health in the lives of Alaskans, and in Alaska's communities, will be defined; a strategic process for assessing and addressing critical issues affecting the system will be implemented; the capacity required in the system to protect and promote the health of Alaskans will be identified; strategies for achieving needed capacity will be developed; the responsibilities of the different levels of government and other important partners will be determined; new relationships will be formed; and old relationships will be strengthened.

Partners in the statewide process include traditional public health sector organizations, as well as clinical health care providers and payers, business, consumers, academia, and the faith community. Participating local community partnerships will strengthen the statewide process by focusing the statewide partnership on the needs of communities and the value of local participation, responsibility, and control.

Alaska welcomes the opportunity to receive support from the foundations under the *Turning Point* initiative. There are unique opportunities and challenges present here that the foundations and other states will find engaging. For example, the Indian Health Service has played a strong role in Alaska's public health system during this past decade. There is currently a significant shift in responsibilities from federal to tribal control, as the 226 federally recognized tribes in Alaska continue to assert their self-determination rights to administer their own health care services. Another example is that, unlike most other states, Alaska has no HMO penetration. This situation presents a valuable opportunity to work with the clinical health care sector from the beginning of managed care system development to identify public health's role in managed care, and to redefine the clinical health care system's role in public health. Because of issues such as these, the public health community is committed to continuing this most important project.

Alaska Public Health Improvement Process

Challenges & Opportunities

- Lack of Clear Public Health Policy
- Tribal Compacting
- Government Downsizing
- Federal Block Grant and Performance Partnership Proposals
- Health Care Reform
- Welfare Reform
- Medicaid Reform
- Changing Demographics
- New Technologies & Public Health Threats

Alaska Public Health Improvement Process

Expected Outcomes

- Assessment of Alaska's Public Health System
- Identification of the Appropriate Alaska Public Health System Capacities and Infrastructure for the 21st Century
- Strategic Plan for Strengthening Alaska's Public Health System
- Development of Benchmarking and Performance Measurement System for the Alaska Public Health System
- Improved Public Health Performance
  - Increased coordination and collaboration of public health planning, decision-making, and service delivery
  - Strengthened relationships with public health system partners
  - Improved information-based decision-making
  - Improved accountability in the public health system
  - Clarification of the role of public health for the public

Turning Point:
Collaborating for a New Century in Public Health
An Initiative of the Robert Wood Johnson and W.K. Kellogg Foundations

Purpose: *"To transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies may respond to the challenge to protect and improve the public's health in the 21st Century."*

Turning Point:
Collaborating for a New Century in Public Health
An Initiative of the Robert Wood Johnson and W.K. Kellogg Foundations

Foundations' Goals for State Grantees:

- Assess and redefine public health mission, roles, and responsibilities
- Define relationships with clinical health care sector and other community stakeholders
- Establish systematic ongoing collaboration among state and local health agencies, as well as other public health-related agencies
- Identify technical, organizational, legal, and revenue changes needed to strengthen public health's capacity to address challenges to community health
- Develop a public health improvement plan describing the infrastructure needed to improve population-based health
- Establish priorities for implementation and a timetable for achieving needed changes
- Identify a strategy for financing and maintaining proposed changes

Alaska Public Health Improvement Process

PROCESS FLOW CHART

By 12/31/97

1 What Are We Building?

Steering Committee,
Action Team, &
PHSA Workgroup
- Define Public Health and the parameters of the public health system

10/28/97 - 7/31/98

2 Assess What We Have Now

Public Health System Assessment Workgroup
- designs process to create a picture of what the current public health system in Alaska looks like today
  - *Inventory of Current Services, Resources & Mandates*
  - *Customer Surveys*
  - *Provider Surveys*
  - *Health Status*

-conducts a Best Practices Analysis to compare current system to standards and models
  - *lit search*
  - *Consult with National/ International Experts*

8/1/98 - 9/30/98

3 Develop a Vision of What's Possible

Steering Committee
- Develop the specifications for the appropriate public health system for Alaska (i.e., required functions and capacities)

10/1/98 - 5/31/99

4 Design Alaska's New Public Health System

Public Health System Design Workgroup
-recommend roles and responsibilities of different levels of government, private health care sector tribal health orgs., and other public health partners
-recommend appropriate organizational structure for Alaska's public health system
-identify technical, legal, and revenue changes needed to implement public health system reform

<u>Pilot</u>
Turning Point Communities
-test new public health system design at the local level

6/1/99 - 1/1/00

5 Implement Public Health System Redesign

Steering Committee
- Approve public health system design
-implement/advocate system reform strategies

6 Evaluate/Reframe

Steering Committee

7 On-Going Planning and Management

Steering Committee

1-21-98

Alaska Public Health Improvement Process

MANAGEMENT STRUCTURE

Alaska Public Health Improvement Process Steering Committee

Role: To assure that the project achieves intended outcomes by:

1) Assuring that the project has resources and support to get the work done;
2) Creating a vision of the outcome that is realistic and supportable;
3) Reviewing products from workgroups to:
    a) assure supportability;
    b) provide reality checks; and
    c) maintain momentum; and
4) Advocating for and implementing the final plan.

Planning Subcommittee of the Steering Committee

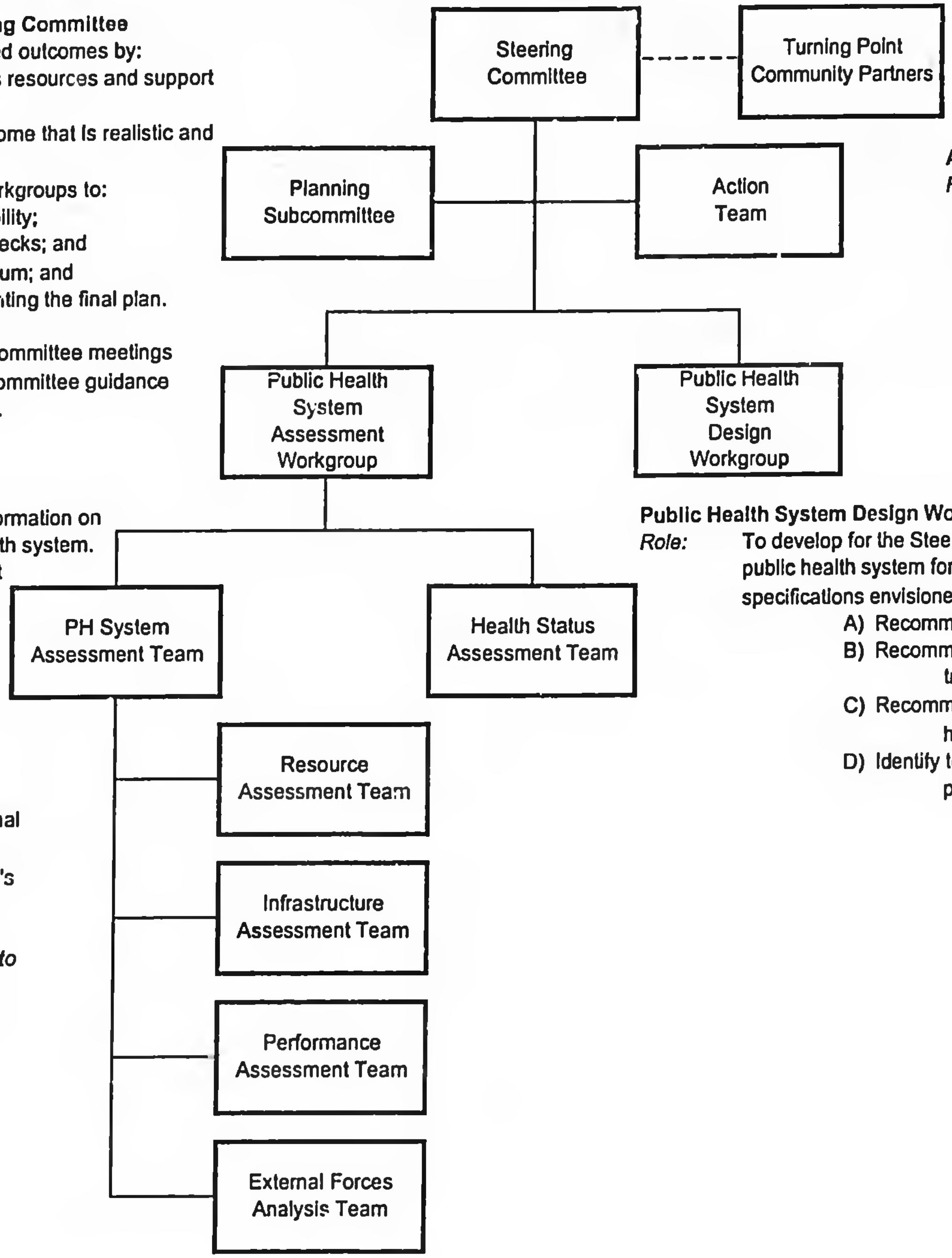
Role: Works with Action Team to plan Steering Committee meetings and address issues that require Steering Committee guidance during interims between quarterly meetings.

Public Health System Assessment Workgroup

Role: To provide the Steering Committee with information on the condition of Alaska's current public health system.

A) Define Assessment Process and Collect Information
    - Inventory of current services, resources, and mandates
    - Provider surveys
    - Customer surveys
    - Health status assessment
B) Conduct Best Practices Analysis
    - lit search
    - consult with national/international experts
    - compare information on Alaska's system against models and standards

Note: Full workgroup provides oversight and guidance to smaller teams responsible for data collection.



Alaska Public Health Improvement Process Action Team

Role: Provide staff support to the Steering Committee; manage process support functions such as communications and marketing; and coordinate the work of the various workgroups.

Public Health System Design Workgroup

Role: To develop for the Steering Committee the design for a new public health system for Alaska that meets the system specifications envisioned by the Steering Committee.

A) Recommend roles and responsibilities of different levels of government
B) Recommend roles and responsibilities of private health care sector, tribal health organizations, and other public health system partners
C) Recommend the appropriate organizational structure for Alaska's public health system
D) Identify technical, legal, and revenue changes needed to implement public health system reform

1-21-98

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Central Microfilm Services
Departement of Education
State of Alaska

Rev. 6/98

Alaska Public Health Improvement Process
Steering Committee

CONFIRMED MEMBERS[1]
as of December 15, 1997

Tribal Health Organizations

Anne Walker, Executive Director, Alaska Native Health Board [Anchorage]
Carolyn Crowder, President, Norton Sound Health Corporation (and current Chair of the Tribal Health Directors) [Nome]

Tribal Government

Deborah Vo, Executive Director, Alaska Inter-Tribal Council [Anchorage]

Local Government

Kevin Ritchie, Executive Director, Alaska Municipal League [Juneau]

Local Health Departments

Elaine Christian, Director, MOA Department of Health & Human Services [Anchorage]
Doreen Knodel, Director, North Slope Borough Department of Health & Social Services [Barrow]

State Government

Karen Perdue, Commissioner, DHSS [Juneau]
Peter Nakamura, MD, MPH, Director, Division of Public Health [Juneau]
Michele Brown, Commissioner, DEC [Juneau]
Janice Adair, Director, Division of Environmental Health [Anchorage]

State Legislators

Senator Jim Duncan
Senator Johnny Ellis
Representative Con Bunde

Federal Government

David Schraer, MD, Acting Director, Alaska Area Native Health Service/IHS [Anchorage]
Rick Albright, Director, Alaska Operations, Environmental Protection Agency [Anchorage]
Major Danny Glover, Elmendorf AFB Chief of Public Health [Anchorage]

Alaska Public Health Association

Delisa Culpepper, President [Anchorage]

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[1] In addition, there is a seat on the statewide steering committee for a representative from each community that organizes a local public health improvement partnership and implements a local public health improvement process.

Alaska Environmental Health Association

Peter Wallis, President [Fairbanks]

Private Health Care Providers

Jim Jordan, Executive Director, Alaska State Medical Association [Anchorage]

Laraine Derr, Executive Director, Alaska State Hospital and Nursing Home Assn. [Juneau]

Cheryl Kilgore, Executive Director, Interior Neighborhood Health Clinic (and Assembly member on the Fairbanks North Star Borough Assembly) [Fairbanks]

Gail McGuill, President, Alaska Nurses Association (and Director of Quality Management with Columbia Alaska Regional Hospital) [Anchorage]

University of Alaska

Jerome Komisar, President, University of Alaska [Fairbanks]

Community-Based Non-Profit Health/Social Service Organization

Dennis McMillian, Executive Director, United Way of Anchorage [Anchorage]

Private Business

Response Pending. Pamela LaBolle invited, Alaska State Chamber of Commerce [Juneau]

Mary Beth Whitehurst, Acting Executive Director, Alaska Cabaret, Hotel, Restaurant, and Retailers Association [Anchorage]

Private Environmental Services Provider

William Ashton, Consultant, EcoSynergy [Anchorage]

Labor Union

Response Pending. Mano Frey invited, Alaska State AFL-CIO [Anchorage]

Education System

Carl Rose, Executive Director, Association of Alaska School Boards [Juneau]

Behavioral Health System

Jeff Jessee, Executive Director, Alaska Mental Health Trust Authority [Anchorage]

Faith Community

Pastor Bill Allen. Ministerial Alliance, Inter-Faith Council, Evangelical Council [Anchorage]

Consumers

Carmen Rosa Mallipudi, MPH, 4As employee and YWCA employee, member of Alaska Health Education Consortium, reports on health issues for La Voz (Anchorage-based Hispanic newspaper) [Anchorage]

Response Pending,Eric Jorgensen, Sierra Club Legal Defense Fund, invited. Environmental Advocacy Group

PRESENT.:
BUILDING BRIDGES -
MENTAL HEALTH

Field Notes

Tricia Edwards, Editor

A Publication of the Mental Health Association in Alaska Special Edition, 1997

Community Services

Where America's Mental Health Works

This issue

Special Edition on Stigma

Working for Alaska's Mental Health

Stigma is Everywhere

A mental illness is, more accurately, a brain disorder; and brain disorders -- like epilepsy -- are biologically based medical problems. The newest medical technology can take "pictures" that show differences between brains with disorders and normal brains.

In any given year, about 5 million American adults suffer from acute episodes of one of five serious brain disorders: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder. Even many of America's children -- more than 3 million-- suffer from these disorders.

Untreated, disorders of the brain profoundly disrupt a person's ability to think, feel, and relate to others and to his or her environment.

Brain disorders are shrouded in stigma and discrimination. For centuries they have been misunderstood, feared, hidden, and often ignored by science. Only in the last few decades has the first real hope for people with brain disorders surfaced, and that hope has grown from pioneering research that found both a biological basis for brain disorders and treatments that work.

Brain disorders are treatable. The current success rate for treating schizophrenia is 60 percent. The success rate for treating bipolar disorder, also known as manic depression, is 65 percent, and for major depression it is 80 percent. Mental illnesses can now be diagnosed and treated as precisely and effectively as other medical disorders. But the stigma -- and the discrimination caused by that stigma -- remains.

Stigma is an ancient evil. It still limits all aspects of life for people with brain disorders: housing, education, insurance, science, research, services, jobs, religion, and personal relationships.

By the NAMI Campaign to end discrimination against people with severe mental illness. Contact Sylvia Matthews at the Alaska Alliance for the Mentally Ill at 1-800-478-4462 or 1-907-277-1300 for more information.

REMOVING THE STIGMA OF MENTAL ILLNESS

Former Mental Patients Talk About Stigma

Example A

Ten years ago I was a professional actress in Los Angeles, and one day I came offstage and had a breakdown. The doctor told my parents that I was chronic and would be hospitalized all my life. Eventually, I found respite, became a resident, and I have been without hospitalization for 8 years. Since leaving respite, I have used it as a crisis center whenever I have had a problem. I worked my way back to the point where I could finish my college education and hold a job as a teacher.

At this point, I am unemployed and looking for work. But I have come to realize that I must rely on the technique of "the cover-up." I will do everything I can to conceal the fact that I was once diagnosed as chronic, that I was hospitalized, and that I once lived in a halfway house. If I am asked by an employer if I have ever had a nervous breakdown, I will answer, "No." If I am asked why there was a gap in my employment, I will say, "I traveled." If they notice my hands are trembling because of my medication, I will say, "It's due to my thyroid." I must do all of this because there is a stigma attached to anyone who has had mental illness.

I hope that, in my lifetime, the ignorance of emotional illness turns to understanding; that fear turns to security; and that the cover-up will no longer be necessary.

Example B

The great stigma that is attached to people who have been or who are mentally ill often results in open discrimination. I have had some difficulty with both my resident manager and with the Federal agency where I was seeking employment. The fact that I was being prejudged was upsetting and annoying.

Only recently questions about an individual's history of nervous breakdowns were eliminated from the official form required for all applications for Federal jobs. The equal employment opportunity law, as amended, now includes prohibitions on discriminating against the physically and mentally handicapped. Because of the existence of these rights, I have more self-confidence. By supporting myself, I am proving that I am a responsible individual.

We need these kinds of changes in the law to protect our rights as individuals. Specifically, we truly need anonymity in order to cope with a difficult life, without carrying forever the label of "mentally ill." I like to use the expression: "Everyone is different; therefore, we should be treated the same."

Let's Talk About Mental Illness

Attitudes of Stigmatized Persons

How do stigmatized persons feel about being stigmatized? What do they do about it? Erving Goffman has written about these feelings and actions.

Stigmatized individuals hold the same beliefs about their identity as we do. Their deepest feelings are that they are normal human beings like anyone else, persons who deserve a fair chance and a fair break. Yet they perceive, quite correctly, that, whatever others may profess, they are not really accepted.

Shame becomes a central possibility, arising from stigmatized persons' perceptions that one of their attributes is a defiling thing and one that they can see themselves as not possessing.

The primary feature of a stigmatized individual's situation in life is a question of acceptance. Those who have dealings with them fail to accord them respect and regard.

How do stigmatized persons respond to this situation?

In some cases they make a direct attempt to correct the failing, as when a physically deformed person undergoes plastic surgery or an illiterate person undertakes remedial education. Ironically, when such repair is possible, what often results is not the acquisition of a fully normal status but merely the transformation into someone who has had a blemish corrected.

Another approach that stigmatized persons use is to devote great effort to the mastery of areas that are usually closed to people with their shortcomings. The lame person learns to swim, ride, play tennis; the blind person becomes expert at skiing and mountain climbing.

Finally, persons with differences which causes them shame can break with what is called reality and obstinately attempt to employ an unconventional interpretation of the character of their social identities.

Stigmatized individuals may use their stigma for "secondary gains," as an excuse for failures that have really come about for other reasons. Or stigmatized individuals may see the trials they have suffered as a blessing in disguise, especially because they feel that suffering can teach them about life and other people. Or they may reassess the limitations of normal people and believe that they can be of special help to normals.

When "Normal" and Stigmatized Persons Meet

A crucial question, especially for the mentally ill, is what happens when normals and the stigmatized are in the same social situation. Goffman has analyzed these "mixed contacts."

The very anticipation of contacts with each other can lead normals and the stigmatized to arrange life so as to avoid them. This will have greater consequences for the stigmatized, since more arranging will usually be necessary on their part.

All too often the stigmatized person withdraws from social contacts and becomes a social isolate. Lacking the salutary feedback of social intercourse, a self-isolate can become suspicious, depressed, hostile, anxious, and bewildered.

When normals and stigmatized do in fact enter one another's immediate presence, especially when they attempt to sustain a conversation, the causes and effects of stigma must be directly confronted on both sides.

The stigmatized individuals may feel unsure of how normals will identify and receive them. They feel that they do not know what others are really thinking about them. Further, stigmatized persons are likely to feel that they are "on," having to be self-conscious and calculating about the impressions they are making--to a degree not required of others.

Also they are likely to feel that the usual interpretations of everyday events have been changed. Minor accomplishments may be assessed as signs of remarkable and noteworthy capabilities. For example, a criminal or a mentally ill person who reads the "classics" may be complimented profusely.

At the same time, minor failings or incidental impropriety may, they feel, be interpreted as a direct expression of their stigmatized differentness. Former mental patients are sometimes afraid to engage in a sharp interchange with spouse, employer, or friends, for fear of what a show of emotion might be taken as a sign of.

Given what stigmatized individuals face when entering a mixed social situation, they may respond with defensive cowering. Or they may attempt to approach such contacts with hostile bravado which can induce its own troublesome reciprocations. Stigmatized persons sometimes vacillate between cowering and bravado, racing from one to the other, thus demonstrating how ordinary face-to-face interaction can run wild. Here again, the mentally ill person's understandable reaction to a social situation can result in behavior that reinforces an opinion that the person is indeed mentally ill.

With what both the stigmatized and "normals" introduce into mixed social situations, it is understandable that not all will go smoothly. We "normals" often try to carry on as if the stigmatized persons fit naturally into the situation, thus treating them as people who are better or people who are worse than we really believe them to be. If that doesn't work, we often act as if they're not even present, giving them only ritual notice. Stigmatized persons are likely to go along with these strategies, at least initially.

Even when no explicit reference is made to the handicap, the interaction often is articulated too exclusively in terms of it--the unspoken evidence felt in under-lying awkwardness, self-consciousness, and heightened awareness. The familiar signs of discomfort and stickiness emerge--guarded references, common words suddenly made taboo, a fixed stare elsewhere, artificial levity, compulsive talking, awkward solemnity.

Stigmatized individuals, because they frequently are exposed to such sticky uneasiness, become more adept at managing awkward situations than we "normals" do.

The Mentally Ill – and the Stereotype of Dangerousness

A person who is found to be mentally ill and dangerous can be involuntarily committed to a mental institution. Saleem Shah, a psychologist specializing in studies of crime and delinquency at the National Institute of Mental Health, has pointed out serious issues in preventive detention and the prediction of dangerousness

Typically, an individual cannot be involuntarily confined to a mental institution simply because of anticipated--or even demonstrated--dangerousness. First, there has to be a finding of mental illness and then of an associated propensity of predicted likelihood for engaging in dangerous behavior.

Since involuntary civil commitment represents an exercise of State power that may deprive individuals of their liberty and also compel them to undergo psychiatric treatment, it raises a fundamental question: What potential harms to society or to the individual are sufficiently serious to justify resorting to coercive confinement?

The question involves public policy, sociopolitical and legal issues, not medical, psychiatric, psychological, or mental health issues. In the existing situation, however, public policy and legal issues are confounded with psychiatric and mental health concerns.

It is difficult to discern how the link between mental illness and dangerous behavior came about and why it continues to be maintained with such enduring zeal.

Several studies have examined the arrest records of patients discharged from mental hospitals. These studies do not support the stereotype of the mentally ill as highly dangerous and unpredictable. Although persons diagnosed as seriously mentally ill (those likely to be hospitalized) are not any less dangerous than persons not so diagnosed, the evidence also points to the conclusion that the mentally ill do not constitute one of the most dangerous groups in our society.

It should be noted that some of the most predictably and demonstrably dangerous persons are not preventively detained or handled with greater concern for public safety. For example, numerous studies have shown that about 50 percent of all fatal auto accidents involve drunken drivers. Our society demonstrates a truly astonishing tolerance for this group of dangerous persons.

Given the numerous court proceedings in which the dangerousness of a mentally ill person is at issue and grave decisions affecting life and liberty must be made, one might assume that some reasonable accurate means of predicting dangerous behavior are available. This assumption is false. No instrument has been developed that can predict violent and other dangerous behavior accurately or satisfactorily. In fact, no test has been developed that can adequately identify such behavior retrospectively--let alone predict it.

Stigma and the Violation of Rights

The stigma of mental illness has been reflected in many laws that restrict the freedom of mentally ill persons to make their own choices. Robert Plotkin, a lawyer formerly with the Mental Health Law Project, has summarized some of these restrictions.

Certain groups of Americans are "protected" by law from enjoying the freedom to make their own choices. The chief "beneficiaries" of the State-sponsored paternalism are the mentally different, those who are thought to be incompetent to make rational choices. The result is a double-track system: one law for "normal" people and another for the mentally different.

Voting: Virtually half the States have statutory language flatly forbidding mentally handicapped persons to vote. The range of exclusions runs from "idiots" to "insane persons" to "persons under guardianship." These laws bar mentally handicapped persons from participation in the political process, without regard for individual ability to exercise this right rationally.

Marriage: Many States have statutory bans which prevent the "feeble-minded," incompetent, or those under guardianship from marrying. If such marriages occur, they can be annulled or speedily ended by no-fault divorce. Given the problems of some so-called normal people--rising divorce rate, high incidence of child abuse, and sexual maladjustment--it is puzzling that the mentally disabled are singled out.

Adoption: In more than half the States children can be adopted without the consent of mentally disabled parents. There may be situations where parents cannot care for children and adoption is in everyone's best interest, but requirements that protect the rights of "normal" parents are forgotten when a child's parents are mentally different.

Sterilization: Some States have statutes allowing involuntary sterilization of the incompetent. Other statutes allow sterilization in "voluntary" situations, without addressing the question of how an "incompetent" decides to consent "voluntarily" to sterilization. In some States there is no judicial inquiry into the sterilization if the person's parent or guardian gives "consent."

Guardianship: Guardians have the authority to admit persons "voluntarily" into institutions, to have them sterilized or experimented upon, to invest their money and manage their affairs. Generally, a guardian sincerely believes that he or she is honestly protecting the interests of an incompetent person, and usually this is so. But there have been instances of overzealous or unscrupulous persons acting as guardians, and the law should provide greater protection to the person being "guarded."

If the law has any obligation to the mentally handicapped, it is to increase their options and to expand their opportunities, not to limit their choices and physically and legally segregate them.

Using Mental Health Advocacy to Reduce Stigma

Mental health advocacy is a recent and fruitful attempt to provide better care for the mentally ill and to decrease their stigma. Louis E. Kopolow, Chief of the Patients Rights and Advocacy Program at the National Institute of Mental Health, outlines the elements of a comprehensive advocacy program.

Mental health advocacy provides a unique mechanism by which psychiatry can respond constructively and effectively to the dilemma of delivery of mental health care in a system increasingly influenced by legal requirements and consumer demands. Advocacy is a method by which psychiatrists, lawyers, and patients' representatives can work cooperatively in meeting the patients' wishes, needs, and rights.

A comprehensive advocacy program consists of a tripartite system:

The primary element is the patient's representative, who is concerned with screening patients for such matters as the appropriateness of commitment or guardianship, of forced medication and other forms of treatment, and of transfer or release to large institutions. The patient's representative also devotes his or her efforts to preserving "the right to noninstitutionalization" and to arranging transfer of patients to other mental health programs in the community.

The second element of the program involves the legal advocates. They are necessary in handling the multitudinous legal problems, especially those of an indigent and deprived population. In carrying out the role, the legal advocate uses all the skills of the legal profession, bringing court action on behalf of the patient against the institution, filing class action suits, and lodging complaints regarding specific violation of patients' rights in order to secure redress. The active involvement of mental health staff in assisting attorneys to represent their clients' wishes goes a long way toward assuring that alternative clinical regimens have been explored. The attorney's main task, however, is to be available as a last resort for serious problems which the patients' representative has failed to solve through less formal adjustment mechanisms.

The ombudsman is the third element in a comprehensive advocacy program and is especially relevant for a mental health system undergoing rapid change. The ombudsman addresses problems throughout the entire mental health system.

This model for patient advocacy is helpful in preventing the unfortunate situation of patients being caught in a tug of war between two opposing forces--the psychiatric and the legal professions--battling for their custody. Such a comprehensive advocacy program can become an important and lasting alternative to litigation and can help to create a mediated flexible system of care for the mentally ill.

A Bill of Rights for Mentally Ill Patients

Title V, Section 501 of the Mental Health Systems Act, 42 U.S.C. 9501, for the first time defines in United States law a Bill of Rights for mentally ill patients.

A person admitted to a program of facility for the purpose of receiving mental health services should be accorded the following:

The right to treatment and services under conditions that support the person's personal liberty and restrict such liberty only as necessary to comply with treatment needs, law, and judicial orders.

The right to an individualized, written, treatment or service plan (to be developed promptly after admission), treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan, including a description of services that may be needed after discharge.

The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the treatment plan, and the right to be provided with a reasonable explanation of all aspects of one's own condition and treatment.

The right to refuse treatment, except during an emergency situation, or as permitted under law in the case of a person committed by a court for treatment.

The right not to participate in experimentation in the absence of the patient's informed, voluntary, written consent; the right to appropriate protections associated with such participation; the right and opportunity to revoke such consent.

The right to freedom from restraint or seclusion, other than during an emergency situation.

The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy.

The right to confidentiality of records.

The right to access, upon request, to one's own mental health care records.

The right (in residential or inpatient care) to converse with others privately and to have access to the telephone and mails, unless denial of access is documented as necessary for treatment.

The right to be informed promptly, in appropriate language and terms, of the rights described in this section.

The right to assert grievances with respect to infringement of this Bill of Rights, including the right to have such grievances considered in a fair, timely, and impartial procedure.

The right of access to a protection service and a qualified advocate in order to understand, exercise, and protect one's rights.

The right to exercise the rights described in this section without reprisal--including reprisal in the form of denial of any appropriate, available treatment.

The right to referral, as appropriate, to other providers of mental health services upon discharge.

Mental Health Association in Alaska

Membership Application

Please count me among the
"People Helping People"

Date: ________

Name ______________________________ Phone ______________

Street ______________________ City/State ______________________ Zip Code __________

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Student/Senior	Sustaining	Contributing	Patron	Corporate
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☐ I would like more information about the Association

☐ I would be willing to devote time to the efforts of the Association
(Your membership contribution is tax deductible and includes a subscription to COPING Magazine.)

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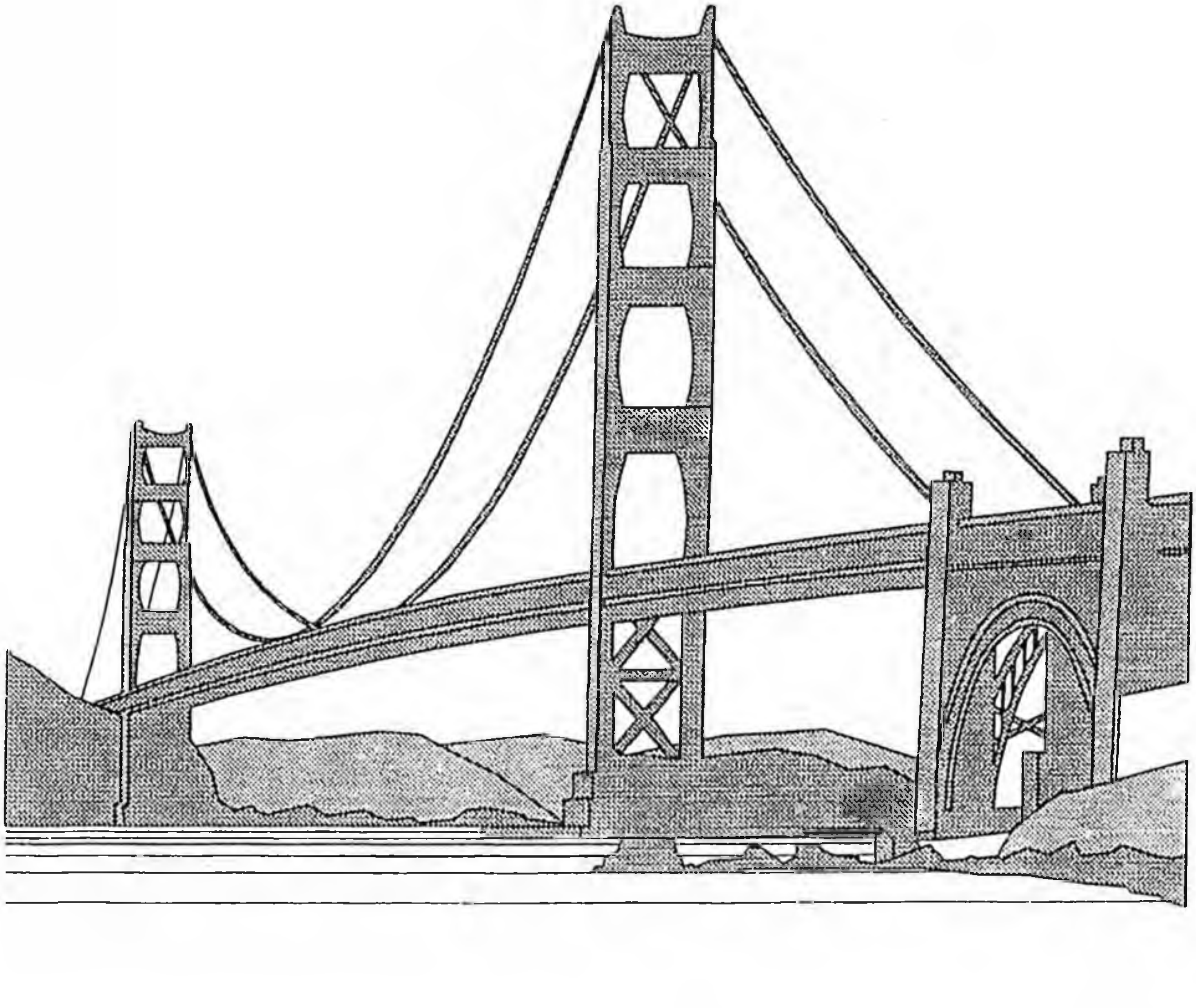
Please Join & Support the Mental Health Association

Mental Health Association in Alaska
4050 Lake Otis Parkway, Suite 202
Anchorage, Alaska 99508

Advocating to Reduce Stigma

Mental Health Parity

Resource Kit



Update on Mental Health Parity Laws

Seven States Pass Laws, Four Others Vote To Study Proposals

In October 1996, the American Managed Behavioral Healthcare Association (AMBHA) updated the status of behavioral health parity laws that have been passed or are proposed in 11 states. Five states passed laws requiring health plans to offer mental illness treatment equal to the treatment offered for physical illness. The states are: Maine, Maryland (parity for coverage of mental illness and substance abuse), Minnesota, New Hampshire, and Rhode Island. Maryland and Minnesota require parity coverage for all mental disorders. Maine, New Hampshire and Rhode Island require parity coverage for certain enumerated serious mental illnesses.

In other states, North Carolina and Texas have passed parity laws that require health plans to offer state and local government employees mental illness treatment equal to the treatment offered for physical illness. North Carolina also offers chemical dependency treatment Louisiana, North Dakota, Oklahoma, and Virginia adopted resolutions to study parity and make recommendations to their legislatures on whether a parity law should be introduced and enacted in those states.

Following is a summary of the states' parity laws and resolutions.

Maine

Definition of mental illness covered by the law
The law requires that health care policies provide coverage for treatment of the following mental illnesses:

- schizophrenia;
- bipolar disorder;
- pervasive development disorder, or autism;
- paranoia
- panic disorder
- obsessive-compulsive disorder; and
- major depressive disorder.

The act defines "a person suffering from a mental or nervous condition" as "a person whose psychobiological processes are impaired severely enough to manifest problems in...social, psychological or biological functioning."

Scope of parity provision
The law requires that all contracts provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than benefits provided for medical treatment. The act's provisions exclude coverage for the treatment of alcoholism or drug dependencies through the diagnosis of a mental illness.
Effective date: July 1, 1996

Maryland

Definition of mental illness covered by the law
The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses. Note: the law also prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder.

Scope of parity provision
The act provides that each contract providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder by failing to provide befits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract for treatment of physical illness. The law requires companies with 50 or more employees to provide inpatient coverage for mental health and substance abuse treatment on par with physical illnesses.
Effective date: July 1, 1994

Minnesota

Definition of mental illness covered by the law
The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses.

Scope of parity provision
The law requires that cost-sharing requirements and benefit or service limitations for inpatient and outpatient mental health and chemical dependency services must not place a greater financial burden on the insured or enrollees, or be more restrictive than those requirements and limitations for outpatient and inpatient medical services.
Effective date: August 1, 1995

New Hampshire

Definition of mental illness covered by the law
The law defines "mental illness" as "a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." The following mental illnesses are covered by the law:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia & other psychotic disorders;
- obsessive-compulsive disorder;
- panic disorder;
- pervasive developmental disorder, or autism.

Scope of parity provision
The law requires that health plans must "provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.
Effective date: January 1, 1995

Rhode Island

Definition of mental illness covered by the law
The law defines "serious mental illness" as 'any mental disorder

that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness." The term includes, but is not limited to:

- schizophrenia;
- schizoaffective disorder;
- delusional disorder;
- bipolar affective disorder;
- major depression; and
- obsessive-compulsive disorder.

Scope of parity provision
The law applies to inpatient hospitalization and outpatient medication visits. The law also requires that insurance coverage include the same durational limits, amount limits, deductibles, and co-insurance factors for serious mental illness as for other illnesses.
Effective date: January 1, 1995

Texas

Definition of mental illness and/or chemical dependency covered by the law
The law applies to "biologically based mental illness" which is defined as "a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain and that substantially limits the life activities of the person afflicted with the illness." The term includes:

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (manic-depressive disorders);
- major depressive disorders; and
- schizo-affective disorders.

Scope of parity provision
The law applies to state and local government employees.
Effective date: September 1, 1991

North Carolina

Definition of mental illness and/or chemical dependency covered by the law
The law applies to health care coverage for mental illness and chemical dependency. The law defines "mental illness" as:

1. For adults, "an illness which so lessens the capacity of an individual to use self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control"; and
2. For minors, "a mental condition, other than mental retardation alone that so impairs the youth's capacity to exercise age adequate self-control, or judgment in the conduct of his activities and social relationships so that he is in need of treatment."

Scope of parity provision
The law applies to state government employees.
Effective date: January 1, 1996

Louisiana

Purpose of the study
The Louisiana legislature created the Louisiana Study Commission on Parity and Nondiscrimination in Health Care For Serious Mental Illnesses to study the feasibility of enacting legislation to prohibit discrimination in health insurance policies against persons with severe mental disorders.

Action to be taken by those studying parity
The commission is charged with providing the governor, the speaker of the House of Representatives, and the president of the Senate with a report of its findings and recommendations on enacting parity legislation no later than February 25, 1997.
Date adopted: June 10, 1996

North Dakota

Purpose of the study
The resolution directs the Legislative Council to study the feasibility and desirability of implementing recommendations made by the North Dakota Health Task Force. The task force recommended that a standard health care benefit plan provide coverage for mental illness and chemical addiction equal to the coverage provided for physical illness.

Action to be taken by those studying parity
The legislative council is to study the feasibility and desirability of implementing the recommendations and also monitor the rate of health care cost increases, review the impact of newly enacted programs to improve the health status of state residents and address unmet medical needs in rural areas.
Date adopted: March 20, 1995

Oklahoma

Purpose of the study
The resolution creates a Legislative Task Force on Parity for Mental Illness Insurance Coverage to study the issue of health insurance coverage for mental illness resulting from biologically based chemical disorders, including the cost of such coverage with special emphasis on parity of cost with that of other health care insurance, the extent of such coverage, the savings to society as a result of such coverage, and other pertinent issues.

Action to be taken by those studying parity
The task force is directed to file a written report of its findings and recommendations with the president of the Senate and the speaker of the House by January 7, 1997.
Date adopted: May 31, 1996

Virginia

Purpose of the study
The resolution directs the Parity Task Force, established by the Special Advisory Commission on Mandated Health Insurance Benefits, to attempt to reach consensus on what constitutes adequate mental health and substance health insurance benefits.

Action to be taken by those studying parity
The resolution directs that the task force is to complete its work and submit its findings to the special Advisory Commission on Mandated Health Insurance Benefits. The commission is directed to report the task force findings to the governor and the 1996 session of the General Assembly.

For more information, call E. Clarke Ross, Executive Director, American Managed Behavioral Healthcare Association, 700 Thirteenth Street, Washington, D.C. 20005, 202-434-4565, fax: 202-434-4564.

from Open Minds, January 1997, pages 8 and 9
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E-mail: openmind88@aol.com, Web Site: http://www.openminds.com

BUILDING BRIDGES
4050 Lake Otis Parkway, Suite 202 Anchorage, Alaska 99508
(907) 563-0880● Fax (907) 563-0881●Toll Free 800-478-0880
EMail mhaa@alaska.net

MENTAL HEALTH STATISTICS

PREVALENCE

More than 51 million Americans have a mental disorder in a single year. (NIMH & CHMS, 1994)

During the course of any given year, while more than 40 million adult Americans are affected by one or more mental disorders, 5.5 million Americans are disabled by severe mental illnesses. (NIMH, 1990)

Preliminary studies indicate that 1 in 5 children/adolescents (20 percent) may have a diagnosable disorder. Estimates of the number of children who have mental disorders range from 7.7 million to 12.8 million. (CMHS, 1993). These youth are estimated to have severe emotional or behavioral problems that significantly interfere with their daily functioning.

Less than one-third of the children under age 18 with a serious emotional disturbance receive mental health services. Often, the services are inappropriate. (Children's Defense Fund) (CMHS-Mental Health, U.S., 1994)

An estimated 19.9 million Americans--8.8 percent of the population--experience phobias. About 9.1 million--5.1 percent--live with major depression. Some 3.9 million have obsessive compulsive disorder; 2.0 million have schizophrenia; 2.4 million have panic disorder; and 2.0 million experience bipolar disorders. (NMHA, 1993), (Mental Health, U.S., 1994)

At least two thirds of elderly nursing home residents have a diagnosis of a mental disorder such as major depression. (NIM, 1990)

Up to 25 percent of the population with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all people with AIDS will develop neuropsychiatric problems. (Mental Health Liaison Group, 1993)

A majority of the 29,000 Americans who commit suicide each year are believed to have a mental disorder. Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among people aged 15 to 24. (NIMH, 1994)

Source: For further information on these statistics, contact: Office of External Liaison, Center for Mental Health Services, 5600 Fishers Lane, Room 13-103, Rockville, MD 20857

Nearly one-third of the nation's estimated 600,000 homeless individuals are believed to be severely mentally ill adults. (CMHS, 1992)

More than 1 in 14 jail inmates has a mental illness. Twenty-nine percent of the nation's jails routinely hold people with mental illnesses without any criminal charges. (National Alliance for the Mentally Ill and Public Citizens Health Research Group, 1992)

ECONOMIC COSTS

Mental illnesses impose a multibillion dollar burden on the economy each year. Total economic costs amounted to $147.8 billion in 1990. More than 31 percent of those costs--$46.6 billion--are for anxiety disorders. (The Economic Burden of Affective Disorders, Dorothy P. Rice, Sc.D., and Leonard S. Miller, Ph.D., 1993)

Direct costs--expenditures for professional health care for persons suffering from mental disorders, including care in mental specialty institutions, hospitals and nursing homes, physician and other professional services and prescription drugs--accounted for $67 billion, or 11.4 percent of all personal health care expenditures in 1990. (Rice and Miller, 1993)

Three independent studies between 1971 and 1985 found that mental health costs remained relatively constant during the past 20 years, ranging from 9 to 11 percent of direct treatment costs for health care (Bazelon Center for Mental Health Law, 1993)

Direct treatment and support costs comprise 45.3 percent of the total economic costs of mental disorders. The value of reduced or lost productivity comprise 42.7 percent of the total economic costs of mental disorders. Mortality costs comprise 8 percent and other related cots, including expenditure for criminal justice, the value of lost time due to incarceration and an imputed value for caregiver services, comprise 4 percent. (Rice and Miller, 1993)

Morbidity costs-the value of goods and services not produced because of mental disorders--amounted to $63.1 billion for all mental disorders in 1990. Morbidity costs for anxiety disorders account for $34.2 billion; for schizophrenia, $10.7 billion. The morbidity costs for anxiety disorders reflect their prevalence in the population and the high rate of lost productivity. (Rice and Miller, 1993)

Mortality costs--the current value of lifetime earnings lost by all who died in 1990 because of mental disorders-amounted to 11.8 billion in 1990. (Rice and Miller, 1993)

Other related costs--the costs indirectly related to the treatment and lost productivity of people with mental disorders--amounted to $6 billion in 1990. (Rice and Miller, 1993)

FUNDING

The mental health system relies on a high proportion of funds from public sources rather than private insurance and out-of-pocket payments. In 1990, 28 percent of funds for mental health care came from state and local governments. In general health care, the comparable figure was 14 percent. Medicare, Medicaid, VA and other Federal programs accounted for an additional 26 percent. (National Advisory Mental Health Council)

Parity in Benefit Design: Existing Law

Below are the parity requirements used in 7 states (ME, MD, MN, NC, NH, RI, TX) and the recent national government mandate (DW: Domenici/Wellstone amendment).

1. Requirements apply only to designated diagnoses:
   4: ME, NH, RI, TX

2. Requirements apply to all contracts which provide mental health benefits:
   2: ME, DW (private sector only)

3. Requirements apply to all contracts which provide healthcare benefits:
   3: MD, NC, TX

4. MH coverage must not be more restrictive than requirements and limitations imposed on physical illness:
   5: MN, NH, NC, RI, TX

5. MH coverage must use the same durational limits, amount limits, deductibles, and coinsurance as physical illness coverage:
   2: NC, RI

6. Requirements apply only to the application of lifetime and annual financial caps:
   1: DW

7. Policies must not place a greater financial burden on the uninsured person or enrollee:
   1: MN

8. Medical necessity criteria must be the same for mental illness and physical illness:
   1: ME

9. Medical necessity criteria may be collected to determine whether they are consistent with other illnesses:
   1: RI

10. Requirements apply to addictions disorders:
    2: MD, NC

Information provided by the American Managed Behavioral Healthcare Association.
E. Clarke Ross, D.P.A., Executive Director
700 Thirteenth Street, NW, Suite 950, Washington, DC 20005.
Phone: (202) 434-4565 Fax: (202) 434-4564

For more information contact: Bazelon Center for Mental Health Law
1101 Fifteenth Street N.W., Suite 1212, Washington, DC 20005-5002\
Phone: (202) 467-5730

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Rev. 6/98

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JUDGE DAVID L.
BAZELON
CENTER
FOR
MENTAL
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LAW

Civil Rights and Human Dignity

PAYING FOR PARITY

A Review of Costs in Two States with Health Insurance Laws Mandating Equal Coverage of Mental Health Care

May 1996

1101 Fifteenth Street N.W.
Suite 1212
Washington D.C. 20005-5002
202/467-5730

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This report compares the Minnesota and Maryland statutes with the statutory language of the national parity amendment as approved by the Senate and summarizes data from the two states highlighting the minimal cost-impact of such a requirement.

The Domenici-Wellstone Amendment

The Senate's parity amendment to the House-passed insurance-reform act (HR 3103) was sponsored by Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) and passed the Senate by a roll-call vote of 68-30. It states:

> — an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health

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THE BAZELON CENTER

The Bazelon Center is a national nonprofit organization formed in 1972. As the leading national legal advocate for people with mental illness or mental retardation, the Bazelon Center has successfully challenged many of the barriers to dignity and choice that confront adults and children with disabilities. Our precedent-setting litigation has outlawed abuse, won protections against arbitrary confinement and opened up public schools, workplaces, housing and other opportunities for community life. Now, as all low-income people face loss of federal assistance, we work for access by children, adults and elders with mental disabilities to health and mental health care and other needed services and supports.

PAYING FOR PARITY was written by Chris Koyanagi with assistance by Lee Carty as part of the Bazelon Center's campaign for equity and fairness in health coverage for people with mental illness. Permission is hereby granted to quote from or reproduce this document with attribution to the Bazelon Center for Mental Health Law.

For additional information, contact Chris Koyanagi or Lee Carty at the Bazelon Center.

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services if similar limitations or requirements are not imposed on coverage for services for other conditions.

—Nothing in (this section) shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

The impact of the Senate amendment would be:

- to eliminate arbitrary day and visit limits for mental health services when similar arbitrary limits are not imposed on other health care;
- to eliminate the common practice of requiring individuals with mental illness to pay higher out-of-pocket costs, in the form of co-payments and deductibles, than people who have other health conditions;
- to eliminate separate (usually very much lower) lifetime limits on payments for mental health treatment than the lifetime limit for all other health care;
- to continue health plans' use of managed care techniques that, over the past five years, have proven very effective in controlling the utilization and cost of mental health services.

The amendment does not specify that substance abuse or chemical dependency services would be included under the term "mental health services," though it could be interpreted that such services are included.

The Minnesota Statute

In August 1995, a Minnesota law took effect prohibiting greater financial burden or more restrictive coverage for individuals needing mental health or chemical dependency services.

The Minnesota statute is similar to the Senate-approved amendment. It prohibits cost-sharing and service limitations for inpatient and outpatient mental health and chemical dependency services from being more restrictive or placing a greater financial burden on the enrollee than is the case for inpatient and outpatient medical services.

The Minnesota statute would therefore have a very similar impact to the Domenici-Wellstone amendment. Both eliminate the common practice of having lower visit and day limits on mental health services than on other forms of care and the equally common practice of charging individuals more in out-of-pocket costs when they need mental health care. Both also prohibit lower lifetime caps on mental health care.

The differences between the Minnesota law and the Senate amendment are:

- the Minnesota law specifically includes chemical dependency, while the Senate-approved provision is not explicit on this issue;
- the Minnesota law does not specifically allow for the use of managed care, though it also does not in any way inhibit it.

Accordingly, the Minnesota law is, if anything, more generous that the Senate-approved amendment.

The impact of the Minnesota law:

Because the Minnesota statute only took effect in August 1995, specific studies of its impact have not yet been conducted. However, health plans' response to the mandate yield consistent and very interesting information:

- Allina Health System, a large managed care organization in Minnesota, reported that the mandate on mental health and chemical dependency would add 26 cents per member per month for the 460,000 persons enrolled in Allina plans.
- After nearly a year's experience under the Minnesota parity law, Blue Cross/Blue Shield announced a premium *reduction* of 5%-6% in the plans it writes for small businesses in the state. Blue Cross/Blue Shield uses managed care techniques to control inappropriate utilization. While there is no indication that this reduction is related to the parity provisions, it makes clear that parity did not drive up costs.

- The state runs a high-risk re-insurance pool for people who are uninsurable (the Minnesota Comprehensive Health Association), which also must adhere to the parity mandate. Recently, this plan was able to *raise* its lifetime cap and provide greater protection to all its enrollees. Again, while there is no evidence that the parity law caused this improvement, the mandate clearly did not impede it.
- The Minnesota Department of Employee Relations, Employee Insurance Division, reported in a fiscal note that the cost of this mandate on the health insurance plans for all state employees would be an added 1%-2% premium increase.
- In implementing this mandate for state employees, two companies that offer plans to state workers handled the mandate in distinct ways. One (Allina) absorbed the increase and made no increase in individual cost-sharing requirements. The other (Health Partners) redistributed the cost across all users of health services by requiring a new $10 per doctor visit co-payment for all health services.

It is also noteworthy that in the recent legislative session no attempt was made either to repeal the Minnesota parity statute or to weaken it through amendment.

Accordingly, while data are preliminary, all evidence suggests that the Minnesota law requiring parity for all mental illnesses, including chemical dependency, has a minimal impact on the cost of health insurance. This is particularly true when health plans use managed care.

The Maryland Experience

On July 1, 1994, a new law prohibiting discrimination against persons with mental illness in health care contracts went into effect in Maryland. This law covers companies with 50 or more employees.

The Maryland law is also similar to the Domenici-Wellstone amendment. It provides that each contract in the state (including health maintenance organizations) that provides coverage for health care may not discriminate against any person with a mental illness, emotional disorder or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply for treatment of physical illness. The law applies to companies with 50 or more employees.

Like the Senate-approved amendment, the Maryland law prohibits arbitrary and lower day and visit limits for mental health care than for other health care services. For inpatient services, the law requires parity in terms of out-of-pocket costs; for outpatient services it permits varying co-payments (80% coverage for the first five visits; 65% for visits 6-30; 50% for more than 30 visits per year). Partial hospitalization (day-long treatment) is also a required service. As in Minnesota, substance abuse services are specifically included.

The most important difference between the Maryland law and the Senate-passed amendment is in the outpatient cost-sharing.

The Maryland law went into effect in July 1994, but for the first year, inpatient benefits could be capped at 60 days per year. In July 1995, full parity was implemented.

The impact of the Maryland law:

The Maryland law built upon a substantial mental health benefit that was already in place, which required coverage of 30 days inpatient care and unlimited outpatient services (with variable co-payments). However, the parity bill greatly expanded inpatient services.

Data are now available on the first year's impact of the Maryland parity law on inpatient utilization. Data on outpatient services are not available because such information is not comprehensively collected in the state.

According to a recent study from the Maryland Health Resources Planning Commission, prior to passage of this law, inpatient stays in Maryland hospitals were declining each year. Blue Cross, other insurance, HMOs, Medicare and Medicaid and other payers all experienced a year-by-year decrease in the length of inpatient stays in psychiatric units of general hospitals. For example, the number of people staying longer than 20 days in private psychiatric hospitals in 1993 was about 24%. In 1995, the year after the law's enactment, it was less than 18%. Over the same period, the number of people staying 10 days or less went from 50.4% to 61.44%.

With a requirement of parity for inpatient mental health treatment, hospital stays continued their decline for all but one payer (in the "other" category) of stays in private psychiatric hospitals. There has been no dramatic increase in utilization of the most expensive mental health service as a result of this law; in fact, cost savings have continued to accrue with respect to inpatient care.

The data from general hospital psychiatric care are even more positive. In general hospital acute care, HMO and private insurance inpatient stays longer than 30 days accounted for less than 0.4% of admissions in 1995, the first full year of the parity requirement. Only 11 people were hospitalized for more than 60 days in 1995, compared with 21 in 1993. The parity amendment was important in offering these few people a guarantee of appropriate continuing care.

As in Minnesota, the Maryland legislature has made no attempt to repeal or amend this law, suggesting that insurers and employers have not had much difficulty meeting the requirements.

In another similarity with Minnesota, Maryland has seen enormous growth in the use of managed care, first under its mental health mandate law and now under its parity amendment.

The overall data on utilization of hospital services reported here indicate that in Maryland, as in Minnesota, requiring an equitable mental health benefit that is essentially the same as the benefit for other health care does *not* result in overutilization of services and therefore would not drive up health care costs significantly.