ALASKA STATE LEGISLATURE

SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

March 4, 2002

1:35 p.m.

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Gary Wilken
Senator Bettye Davis

MEMBERS ABSENT

Senator Loren Leman, Vice Chair
Senator Jerry Ward

COMMITTEE CALENDAR

SENATE BILL NO. 302
"An Act defining the term 'mental health professional' for the purpose of statutes relating to the evaluation of prisoners who may need psychological or psychiatric treatment, for the purpose of statutes relating to the evaluation of children in need of aid and delinquent minors who may need to be confined in a secure residential psychiatric treatment center or who should be released from such a center, for the purpose of statutes requiring certain professionals to report the possibility that a vulnerable adult has been abused or neglected, and for the purpose of statutes relating to mental health civil commitments."

MOVED SB 302 OUT OF COMMITTEE

SENATE BILL NO. 295
"An Act relating to the disclosure of information regarding delinquent minors to certain licensing agencies; and providing for an effective date."

MOVED SB 295 OUT OF COMMITTEE

SENATE BILL NO. 342
"An Act relating to the long term care ombudsman."

HEARD AND HELD

SENATE BILL NO. 230
"An Act relating to recommending or refusing psychotropic drugs as a treatment for children and to the evaluation and treatment of children with behavioral or psychological problems."

HEARD AND HELD

PREVIOUS SENATE COMMITTEE ACTION

SB 302 - No previous action to record.

SB 295 - No previous action to record.

SB 342 - No previous action to record.

SB 230 - No previous action to record.

WITNESS REGISTER

Mr. Jerry Burnett
Staff to Senator Green
Alaska State Capitol
Juneau, AK 99801-1182
POSITION STATEMENT: Presented SB 256 for the sponsor

Dr. David McGuire
3418 Lakeside Dr.
Anchorage, AK
POSITION STATEMENT: Supports SB 256

Dr. Leonard Abel
Division of Mental Health & Developmental Disabilities
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Supports SB 302

Ms. Suzanne Price
Fairbanks Community Mental Health Center
Fairbanks, AK
POSITION STATEMENT: Supports SB 302

Ms. Sharon Bullock
Clinical Director
Fairbanks Community Mental Health Center
Fairbanks, AK
POSITION STATEMENT: Supports SB 302

Mr. Wayne McCollum
Fairbanks Community Mental Health Center
Fairbanks, AK
POSITION STATEMENT: Supports SB 302

Ms. Diane Weber

Director, Yukon-Koyukuk Mental Health
Galena, AK
POSITION STATEMENT: Supports SB 302

Ms. Anne Henry
Division of Mental Health & Disabilities
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Answered questions regarding SB 302

Ms. Wendy Hall
Staff to Senator Pete Kelly
Alaska State Capitol
Juneau, AK 99801-1182
POSITION STATEMENT: Testified for the sponsor of SB 295

Mr. Robert Buttcane
Division of Juvenile Justice
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Supports SB 295

Mr. Jeff Jessee, Executive Director
Alaska Mental Health Trust Authority
Department of Revenue
550 W 7th Ave., Ste. 1820
Anchorage AK 99501
POSITION STATEMENT: Supports SB 342

Ms. Laraine Derr
Alaska State Hospital & Nursing Home Assn.
426 Main St.
Juneau, AK 99801
POSITION STATEMENT: Expressed concerns about SB 342

Mr. Richard Benavides
Staff to Senator Davis
Alaska State Capitol
Juneau, AK 99801-1182
POSITION STATEMENT: Testified for the sponsor of SB 230

Mr. Greg Maloney
Special Education
Department of Health &
Social Services
PO Box 110601

Juneau, AK 99801-0601
POSITION STATEMENT: Expressed concerns about SB 230

Mr. Richard Warner, President
Citizens Commission on Human Rights
Seattle, WA
POSITION STATEMENT: Supports SB 230

Mr. John Breeding, Director
Texans for Safe Education
No address provided
POSITION STATEMENT: Supports SB 230

Ms. Debbie Ossiander
Anchorage School Board
Municipality of Anchorage
PO Box 196650
Anchorage, AK 99519
POSITION STATEMENT: Supports SB 230 but expressed a concern.

Mr. Richard Rainery
Alaska Mental Health Board
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Supports SB 230 but expressed a concern

Mr. Frank Turney
PO Box 70392
Fairbanks, AK 99707
POSITION STATEMENT: Supports SB 230

Ms. Betty Rollins
PO Box 55163
North Pole, AK 99705
POSITION STATEMENT: Supports SB 230

Mr. Charles Rollins
PO Box 55163
North Pole, AK 99705
POSITION STATEMENT: Supports SB 230

Mr. Brock Eidsness
No address provided
Juneau, Alaska
POSITION STATEMENT: Supports SB 230

ACTION NARRATIVE

TAPE 02-15, SIDE A
Number 001

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Committee meeting to order at 1:35 p.m. Present were Senators Wilken, Davis and Green. The committee took up SB 256.

#SB 256

SB 256-CERTIFICATE OF NEED PROGRAM

MR. JERRY BURNETT, staff to Senator Lyda Green, sponsor of SB 256, informed members that a proposed committee substitute (CS) is before the committee (Version O). The CS contains significant changes to the original bill. He explained those changes to members as follows.

- Section 1 provides that all nursing home and psychiatric beds are subject to a certificate of need regardless of their location in Alaska;
- It increases the threshold for a certificate of need to $2 million for facilities and $1 million for equipment but it exempts communities with a population of more than 55,000 from certificate of need requirements for acute care facilities;
- Section 2 removes a section in current law that only allows for replacement of ambulatory-surgical facilities and applies to smaller communities;
- Section 3 allows an exact replica of a facility to be built on the same site without a certificate of need and defines what is included in the $1 and $2 million thresholds. It says a donation or transfer of equipment is also included under the threshold for a certificate of need;
- Section 4 establishes a specific timeline for the certificate of need process;
- Section 5 sets up a time limit for decisions;
- Section 6 puts all acute care, psychiatric and nursing home beds under the same standards for review, which allows the budgetary resources of the state to be considered;
- Sections 7, 8, 9, 10, 11 and 12 address technical changes required by changes made in earlier sections of the bill;
- Section 13 contains moratorium language for certain psychiatric beds (only those beds designated for children

and adolescents);

- Section 14 creates a working group to look at psychiatric care services and the certificate of need program. The group consists of 7 members: two providers of mental health services, two mental health service consumers or their parents or guardians; a physician whose primary practice is not the provision of mental health services; an administrator of a hospital who is not a provider of mental health services; and the commissioner of DHSS or his/her designee. This working group is tasked with looking at the principles used to develop the state's psychiatric care system and certificate of need process for psychiatric care beds and to recommend changes to statutes and regulations governing the certificate of need program to clarify the standards applied during the application process.

SENATOR WARD moved to adopt Version O as the working document of the committee. There being no objection, the motion carried.

CHAIRWOMAN GREEN called Dr. David McGuire to testify.

DR. DAVID MCGUIRE, an orthopedic surgeon practicing in Anchorage, gave the following testimony.

> I appreciate the opportunity to testify on this bill – or the committee substitute and to discuss very briefly with you the issue of certificate of need in general.
>
> As most of you probably know, the certificate of need was originally enacted by the United States government during the Lyndon Johnson years in an effort to control the cost of health care. The theory was that if there were too many providers, all of the providers would be duplicating services and they would all have to charge more money for the duplication. Unfortunately, that theory doesn't work in anything else that we know about, and neither did it work in medicine.
>
> By 1987 the federal government recognized that this was not working and they repealed the law in its entirety. Unfortunately, as is seemingly the habit of the federal government, they had by then mandated that all states adopt this legislation in order to be in compliance with the Medicare-Medicaid regulations. But when the federal government got rid of the certificate of need, they left it entirely to the states. Many states have gotten rid of the CON, others have modified it, and some, like Alaska, have it pretty much intact from what

it was when it was first adopted.

It doesn’t take much of a student of the scene to know that medicine has changed dramatically in the last few decades. The way we do medicine, the things that we can do and the way that it’s delivered is radically different than what it was 20, 30 years ago. And so, the problem is, that there are many kinds of procedures that can be done better, quicker, cheaper in a setting other than a traditional hospital setting.

Well, as of not too long ago, the hospital association seemed to think the same way and they argued for the repeal of the certificate of need. Since then they’ve changed their opinion and they argue that having surgery centers will cherry pick the patients. I don’t know how many patients really think of themselves as being cherries to be picked, most of the time we think that patients would want to have a choice and be able to go where they want to go. They argue that having a surgery center will undercut the revenue base of the hospital and that it will in turn cause the hospital to go broke or to rely upon public subsidies or something of that nature. And even a superficial examination of the situation in Anchorage, Fairbanks and, to some extent, the Mat-Su, would lead you to rapidly different conclusions. The hospitals, in fact, are doing quite well. They have sufficient resources that they are able to spend on any project they want. They build any time they want and so I think the idea that they are endangered is probably not a good one.

The certificate of need process, even if it were a good idea to begin with, has now become subject to political machinations to obfuscation to uncertainties as to who needs and who doesn’t need. The department determined that a certificate of need was required in Fairbanks for two ambulatory centers. Unfortunately, the individual to whom this had been issued was not able to complete in a timely fashion the building of those two ambulatory operating rooms. The assumption would be that since Fairbanks has grown, and since the needs are greater, not less, that that same certificate of need issued some six or seven years ago would still be operant. But, we found upon application that the commissioner was able to, in short order, request an RFP for a study and the study was issued within 30 days of the RFP and the study was required to report within

60 days its conclusions. Well, it came to Fairbanks and studied the situation and came back with the following recommendation – that there was only a need for one ambulatory surgery room and that that being the case, one was not economically viable and therefore none were needed.

But, it's interesting to see how they did that study. How they did it is they said that the operating room that FMH was granted in the original CON that was given to Dr. Odom (ph), FMH got one at the same time, that was to be designated as an ambulatory operating room where you can only count minutes in an ambulatory operating room from 7 in the morning until 5 at night because you don't do elective surgery at 3 in the morning. So that gives you 5 days a week times from 7 to 5 and that's the number of minutes. But when they came back to do the study, they lumped that in as an acute care room and therefore you get to count 24-7 365 which is some 50 – 60 percent increase in the number of operating room minutes and that's how the study determined that no certificate of need is needed.

So my point, I guess, is it was a bad idea to begin with and it never worked and hasn't worked and hasn't worked anywhere else and it has become a process that is highly, highly political and subject to manipulation, is not fair, is not reasonable. To the extent that the very small communities feel their hospital care is threatened, this bill would exempt them from any such threat. Communities like Homer, Kenai, Juneau, etcetera would continue to live under the same certificate of need that's been in existence since it was first put on the books. But in larger communities where there is a demonstrable need, in my opinion, for competitive activities, the experiment could be done without a disaster occurring to any of the hospitals. For those reasons, I would urge your consideration and support of this.

CHAIRWOMAN GREEN said at this time she will set aside SB 256 to give members time to study it. She then took up SB 302.
#

#SB 302

SB 302-MENTAL HEALTH PROFESSIONALS

SENATOR WILKEN, sponsor of SB 302, explained that the measure

deals with an expansion of mental health providers. He then read the following sponsor statement.

> SB 302 recognizes the growth in the clinical, medical health profession and broadens the mental health professional definition to include: 1) a licensed clinical social worker; 2) a licensed marital and family therapist; and 3) a licensed professional counselor. The current Title 47 definition was written in 1986, prior to the passage of Alaska's licensing requirements governing these master level mental health clinicians.
>
> The more inclusive mental health professional definition increases the capacity of Alaska's mental health system to protect our youth and adult who are experiencing acute psychiatric crises in our communities. Today not enough mental health professionals are authorized under the current definition to respond to some critical public safety situations, particularly in rural Alaska. And yet there are hundreds of licensed professionals who are qualified to aid these Alaskans but cannot.
>
> SB 302 recognizes this problem and updates the Title 47 definition. The expanded mental health professional definition, as stated in SB 302, increases the number of trained professionals who will be: 1) allowed to provide mental health treatment for prisoners; 2) authorized to evaluate children and minors in custody to determine placement in residential treatment centers; 3) required to report incidents of harm to vulnerable adults; and 4) allowed to conduct civil commitment evaluation.

SENATOR WILKEN referred members to the bill's zero fiscal note and a chart in members' packets that compares the training requirements for mental health providers in Alaska. He noted that members' packets also contain about 12 letters of support. He offered to answer questions.

CHAIRWOMAN GREEN announced that Senators Davis, Ward, Wilken, Leman were present.

DR. LEONARD ABEL, manager of the Community Mental Health Services Program at the Department of Health and Social Services (DHSS), informed members one of the top priority programs in his unit is psychiatric emergency services. That is what SB 302 is about, and its passage is very important. Currently, on any given day, psychiatric emergency services happen in 32 catchment areas

around the state, delivered by about 140 mental health professionals. Any time - day or night - a psychiatric emergency occurs, those professionals go out, assess the individual to determine the presence or absence of a mental illness, and whether that illness will endanger self or others. Right now, there are not enough people who meet the current statutory definition to deliver that service; only physicians, licensed psychologists and psychological associates or MSWs with two years of experience are able to. When that definition was put in place, there was no social work licensing law. It appears that the intent at the time was to cover everyone who was practicing. Now, social workers, marriage and family therapists and professional counselors are licensed. A client must be sent to a hospital, if the mental health provider does not fall within the definition, he or she cannot file an ex parte order, the normal procedure. As a result, providers must be very creative and usually rely on 7 AAC 47.705, the order for emergency evaluation, commonly known as the peace officer's application. They must ask a VPSO or trooper to assess the client, even though the mental health provider has a master's degree in their field. The problem is that to use the emergency evaluation, the situation must be imminently dangerous. If the VPSO does not see a gun in the person's hand or a bottle of pills, they will not be shipped out. The standard is much higher.

DR. ABEL referred to the chart provided by Senator Wilken and noted that under practice definitions, psychologists, psychological associates, clinical social workers, marriage and family therapists and licensed professional counselors can diagnose and treat. Diagnosis is the essential feature of emergency services. The definition in AS 47.30.915 pertains specifically to the commitment process but it is referenced in other areas of statute, one being under the requirements for reporting on vulnerable adults. Therefore, marriage and family therapists and professional counselors are not required to report. Changing this definition would automatically require them to report. Also, AS 47.30.915 is referenced in statutes related to placement of children in juvenile detention facilities. This bill would allow more professionals to make those assessments. Finally, the statutes referring to adults in correctional facilities references the same statute so the definition change would also affect that group of people. He urged members to pass the bill.

CHAIRWOMAN GREEN asked Dr. Abel if there is anything about the legislation that makes him uneasy about authorizing a mental health provider to do something for which he or she is not qualified.

DR. ABEL said there is not because they are all qualified to do essential emergency assessment.

CHAIRWOMAN GREEN asked if there are continuing education requirements for mental health providers.

DR. ABEL said there are; to the best of his knowledge all professions must pass a qualifying examination and have professional references.

CHAIRWOMAN GREEN asked if providers who refer a person on for emergency treatment are trained adequately and regularly with continuing education courses.

DR. ABEL said the answer lies somewhere in between. Assessment for emergency treatment is a standard part of training but it is not a major part unless it is the provider's specialty area. For example, all physicians have standard training in surgery but are not necessarily surgeons.

CHAIRWOMAN GREEN asked if the passage of SB 302 would prompt additional coursework.

2:01 p.m.

DR. ABEL said the division is looking at ensuring that everyone will get training and be made familiar with the commitment process. The division does that on an ongoing basis anyway but if the bill passes, it would make another effort.

SENATOR LEMAN said that according to the chart no professional references are required for family and marital therapists, while they are for all other providers. He asked if that was an oversight.

DR. ABEL said it was an oversight that was taken care of in the licensing regulations.

SENATOR LEMAN said he is aware of another situation in which a requirement was put in regulation that required something without statutory authority. He asked if someone could refuse to provide references because they are not required by statute.

DR. ABEL said he was not sure he could answer that question.

SENATOR LEMAN said if it is true, that could be fixed in this piece of legislation, especially if it is not controversial.

CHAIRWOMAN GREEN took public testimony.

MS. SUZANNE PRICE, Fairbanks Community Mental Health Center, said she has been involved in the mental health field for almost 30 years, and in Alaska since 1986. In 1986, almost every mental health center had a licensed psychologist, and sometimes two. She cannot think of one mental health center today that is operated by or with a licensed psychologist. Most workers are Masters level MSWs, marital and family therapists, and professional counselors. She is one of a few psychological associates. The changing patterns of who is working in the field have been enormous over the last 15 years. Fifteen years ago, all case managers had Masters level degrees; now they have bachelors degrees while supervisors have masters level degrees. As the profession evolves and changes and the licensing requirements change, the statues and regulations need to change. She is finding it very difficult to provide enough services with the available manpower.

MS. SHARON BULLOCK, clinical director of the Fairbanks Community Mental Health Center, agreed that the mental health field has changed over the last 15 years. SB 302 would allow a wider range of people to do emergency assessments. However, a community mental health center often employs people fresh out of college with a masters degree therefore 24-months is a bit long to wait before that person can perform that duty. All employees are under the supervision of a licensed clinical employee anyway. She supports SB 302 but hopes the 24-month requirement can be changed to 12 months. Her center has a difficult time retaining employees because by the time they get the two years in, they move on.

MR. WAYNE MCCOLLUM, community support program director for the Fairbanks Community Mental Health Center, expressed concern about the licensed staff shortage problem in Alaska. He said that trying to recruit clinicians for the Bush is very difficult because the wages are not very competitive so they end up with people without the kinds of degrees needed to meet the existing regulations.

MS. DIANE WEBER, director of the Yukon-Koyukuk Mental Health in Galena, which represents six villages off of the road system and in very rural areas, voiced support for SB 302. The bill is important to her region because under the current statute, her clinic is required to have a clinician with a Ph.D. or a MSW to do an emergency commitment and there are none in her region. That means that civil commitment is nearly impossible. In addition, the health center is unable to use police officers to do commitments. There are no police officers in her only area and only two troopers cover a region the size of Israel. The troopers are too busy with other duties. An additional problem is that people need a psychological evaluation before her center can

access the Division of Mental Health’s transfer system to transport them to a hospital. She agreed it is very difficult to get a mental health professional with a master’s degree to take a job in the Bush, let alone one who is licensed. She said the process of supervision for licensing is thorough and requires authorization by a licensing board. Her final point was that assessment for lethality for suicide is not a terribly complex procedure and anyone with a master’s degree in a mental health field is capable of doing that. Passing SB 302 will help to save lives.

2:13 p.m.

MS. ANNE HENRY, Division of Mental Health and Developmental Disabilities, explained that in answer to a question by Senator Leman, the requirement for references for psychologists and psychological associates is also in regulation rather than statute. She said the error on the chart was on oversight on her part but noted that placing that requirement in regulation is not unusual.

SENATOR LEMAN said in that case, the committee probably does not need to make any changes.

CHAIRWOMAN GREEN suggested waiting for the sunset legislation for those professions to put the requirement in statute.

MS. HENRY then said, regarding the request to reduce the time of experience from 24 to 12 months, the 24 month requirement is in current statute as it defines what significant experience is in the field of mental illness for social workers who are allowed to do this work.

CHAIRWOMAN GREEN asked, “So, I mean, we’re sort of bound by the current statute to leave it – consistent with here?”

MS. HENRY said if the committee chooses to reduce the time of experience to 12 months, the division would be comfortable with that change as it would open up access to a few more folks to do this work.

SENATOR WILKEN said he would look into whether or not to reduce the time of experience to 12 months and bring it up to the next committee.

SENATOR LEMAN moved SB 302 from committee with individual recommendations and its accompanying zero fiscal note. There being no objection, the motion carried.
#
CHAIRWOMAN GREEN announced the committee would take up SB 295.

#SB 295

SB 295-LICENSING:DISCLOSURE OF MINORS RECORDS

MS. WENDY HALL, staff to Senator Pete Kelly, sponsor of SB 295, explained that this measure addresses a concern within the Department of Health and Social Services. State and federal laws require all child and adult day care licensing authorities to review criminal history reports of every individual aged 16 and older who is seeking either a care license, employment with the care provider, or residing in the home of a care provider seeking licensure. Current law does not explicitly authorize release of delinquency information when a juvenile is 16 or 17 years of age and is residing in the home where care services will be provided and the juvenile will not be an employee of the license holder. Therefore, the state is requiring the licensing authorities to review the criminal background of anyone living in the home, yet the department is unable to release that information unless that individual will be an employee. SB 295 will authorize DHSS to release that information so that a scenario does not arise in which an applicant is given a license even though an adolescent who is a convicted child molester is living in the home.

CHAIRWOMAN GREEN asked if SB 295 only pertains to minors since similar legislation was enacted that applies to adults.

MS. HALL said that is correct.

MR. ROBERT BUTTCANE, Juvenile Probation Officer at DHSS, stated that over the past few years, various state and federal laws have been enacted that require licensing agencies to access delinquency records information as part of their license review process. As the Department of Education and Early Development (DOEED) was working on procedures to license child daycare centers in Alaska, DHSS was unclear about its authority to give DOEED information about juveniles who reside in the home of the day care license applicant but are not employees. In some situations, those juveniles have delinquency records that brought into question the safety of providing services in that home. DHSS worked with the Department of Law and Senator Kelly and came up with SB 295, which adds a section to DHSS's confidentiality laws that gives explicit authority to release that information to care providers, whether for senior care, foster care, or child care. He stated support for SB 295.

2:22 p.m.

SENATOR WARD asked if this came about because of an applicant who had a dangerous youth living at the home.

MR. BUTTCANE said it did not actually happen but the scenario was

raised. DHSS was able to construct a strong enough justification to release the information to DOEED, according to the assistant attorney general.

TAPE 02-16, SIDE B

CHAIRWOMAN GREEN asked if criminal background information can be accessed on other adults living in the home.

MR. BUTTCANE said the information contained in APSIN (the Alaska Public Safety Information Network) for all adult criminal history records is available to licensing agencies now by statute. SB 295 is specific to delinquents because that authority is missing.

SENATOR WARD asked if an applicant must disclose anything that might be dangerous to clients on the application.

MR. BUTTCANE said he is not familiar with every licensing application process, but on some that is a requirement. Applicants sign authorizations for the licensing agency to check APSIN so that if the information is not disclosed on the application, it would be available in APSIN.

CHAIRWOMAN GREEN acknowledged that in the case of juveniles, agencies cannot access that information. She noted she has no problem moving this bill to the Judiciary Committee where it can address infringement issues.

SENATOR LEMAN moved SB 295 from committee with individual recommendations and its accompanying zero fiscal note. There being no objection, the motion carried.
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The committee took up SB 342.

#SB 342

SB 342-LONG TERM CARE OMBUDSMAN

MR. JERRY BURNETT, staff to Senator Green, sponsor of SB 342, explained that SB 342 clarifies the duties of the long term care ombudsman and increases some statutory authority. He gave the following testimony.

> Each state is required to have a long term care ombudsman under the Older Americans Act (OAA). Alaska's long term care ombudsman is located in the [Alaska] Mental Health Trust Authority and recently the long term care ombudsman resigned, citing as one of the reasons for his resignation, frustration with Alaska's statutes. Discussion with the executive director of the Alaska Mental Health Trust led to the filing of SB

342, which brings Alaska statutes in line with the federal law.

Specifically, SB 342 directs the long term care ombudsman to visit long term care facilities and identify problems, rather than assuming the more passive role of only responding to complaints. It provides that no long term care facility may deny immediate access to an employee or volunteer from the long term care ombudsman's office who is responding to a complaint and it gives the long term care ombudsman an active role in developing and providing technical support to volunteer organizations which are interested in the health, safety, welfare and rights of older Alaskans.

CHAIRWOMAN GREEN asked Mr. Burnett to address the question of why this issue is being revisited.

MR. BURNETT said, according to the executive director of AMHTA, state statutes have not been brought up to date and are not in compliance with federal law so there are tasks the long term care ombudsman should be directed to do which he or she is not.

SENATOR LEMAN asked if the subsections in Section 3 will respond to changes in federal law.

MR. BURNETT said he is not sure whether they respond to changes in federal law or to the existing federal law. He noted the development of the volunteer organizations and family councils, etcetera, is specified.

CHAIRWOMAN GREEN said that sounds like an iteration of the federal statute.

MR. BURNETT added that the long term care ombudsman is funded with a combination of state and federal money. This bill should not affect those funds.

SENATOR LEMAN referred to subsection (f) and asked what "technical support" means in this context.

MR. JEFF JESSEE, Executive Director of the AMHTA, explained that a little over a year ago, the AMHTA took over the job of overseeing the office of the long term care ombudsman. During that process he reviewed the framework under which the office operated and identified discrepancies between the federal and state laws. Section 3 of SB 295 contains a number of functions the long term care ombudsman should be undertaking that are not required in state law. The formation of resident and family councils will assist folks who either live in or have family

members in long term care facilities to organize themselves so they aren't dependent on the long term care ombudsman or other individuals. Those councils will carry out a number of roles, all of them of an oversight nature, but they are also very valuable in providing activities or other support services to residents and family members to enable them to work toward common goals. Recently, the long term care ombudsman who was hired after the office came under the purview of the AMHTA, left the position. One reason he cited for his resignation was the difficulty he encountered when looking at reinstituting the volunteer program. When the original OAA was passed over a decade ago, the volunteer ombudsman component was part and parcel of what Congress had in mind. Congress wanted to avoid another huge bureaucracy that relied only upon paid employees to provide the critical functions of providing assistance to people who live in long term care facilities. A volunteer program has been instituted in every state and the OAA sets out clearly that volunteers are a critical part of the program.

MR. JESSEE said that volunteers undergo training and testing, and are certified and supervised. He informed members that he provided copies of manuals used to train volunteers to committee members. That manual is quite comprehensive and is being used as a model around the nation. It includes education and training in ethics, the role of the long term care ombudsman, the statutory framework, the aging process, long term care facility regulations, etcetera. The AMHTA believes volunteers are an important part of the program, particularly in Alaska. If state employees were hired to do this work, the office would have a huge staff. He acknowledged there is an ongoing dispute among some assisted living home providers as to whether the current statutes allow volunteers to have access to their homes. One home provider actually got a legal opinion that said the home owner is not required to allow volunteers to enter her facility. The AMHTA hopes this legislation will clarify that matter and prevent litigation. He offered to answer questions.

SENATOR LEMAN asked Mr. Jessee if "technical support" is a term of art that means other than financial support and asked if it comes from the federal bill.

MR. JESSEE affirmed that term refers to information on how to organize those groups, their structure, regulations and patient rights.

CHAIRWOMAN GREEN said she has heard several concerns expressed, the first being about confidentiality that is referenced on the bottom of page 1 of the bill. She asked him to provide an example of how that will work.

MR. JESSEE said he will describe what it does not mean. It does

not mean that the ombudsman or employees or volunteers in the office are able to share confidential information without complying with the confidentiality requirements that apply to the office. It does mean there is a responsibility on the part of the office to provide information to public agencies about individuals who reside in long term care facilities. Without giving individual information, the ombudsman is responsible for bringing systemic issues to entities such as the legislature, the Older Alaskans Commission and other public agencies that need to be aware of the problems of older Alaskans who live in long term care facilities.

CHAIRWOMAN GREEN asked if this information will be dispensed to every agency in the state.

MR. JESSEE said it does not and, in fact, the long term care ombudsman's office is prohibited from doing so by AS 47.62.030. AS 47.62.025(b) specifically requires consent of the older Alaskans or their legal guardians or, if unable to consent with no legal guardian, a court order is required to get medical records.

CHAIRWOMAN GREEN said the other area she has heard concerns about is at the end of the bill that says a person may not deny immediate access to a long term care facility or to an older Alaskan by the ombudsman, an employee, volunteer, or other representative of the office. She noted it is the "other representative of the office" that is cause for concern. She asked who would fall under that category.

MR. JESSEE said he cannot provide a specific example at this time but he said that state and federal laws already require access to any ombudsman, employee, volunteer or other representative to investigate a complaint. They must have completed the training; they must be certified; and they must be supervised. He suggested that it might be an intern who has completed the training.

CHAIRWOMAN GREEN indicated that she thought it might be a higher level investigator or inspector.

MR. JESSEE said it could conceivably be a contractor.

CHAIRWOMAN GREEN said the bigger issue is that these people must be trained, certified, and supervised.

MR. JESSEE said that is correct. He commented that he is aware of concerns about how the volunteer program operated in the past. He assured her that the AMHTA will work with the provider community to ensure that the volunteer program operates as it should. If providers feel at any time that the program is not operating in a proper manner, he encourages them to hold that

office and the AMHTA accountable for those shortcomings.

CHAIRWOMAN GREEN asked Mr. Jessee if the AMHTA will be doing some training or transitioning with the providers when the volunteer program is reinstituted.

MR. JESSEE said he has already opened dialog with the providers and will continue to so that they are brought into the process of developing the volunteer program.

CHAIRWOMAN GREEN announced that she would hold the bill until Wednesday.

MS. LARRAINE DERR, Alaska State Hospital and Nursing Home Association, informed members that SB 342 causes long term care facilities great concern. Alaska has had three long term care ombudsmen in the last three years. The changeover was due to the fact that the ombudsmen were unable to handle the job duties they had: SB 342 adds more responsibilities to the job. She said the Association is comfortable with the ombudsman's ability to investigate and resolve problems, but is concerned about what the word "identify" means. Providers are also concerned about the word "immediate" in relation to access and would like to know that that means. She questioned whether anyone associated with the ombudsman's office can come to the door and demand immediate access. She said the bill has a "big brother" feel to it. She asked for more time to poll her membership and review the bill.

CHAIRWOMAN GREEN said more time will be provided and announced that the committee would take up SB 230.
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#SB 230

SB 230-PSYCHOTROPIC DRUGS FOR CHILDREN

MR. RICHARD BENAVIDES, staff to Senator Bettye Davis, sponsor, gave the following explanation of the measure.

> The use of psychiatric drugs in our nation's schools has more than doubled in the first half of the last decade and continues to escalate. While it is recognized that properly used, these medications have been shown to improve behavioral patterns of some children, as well as improve their ability to concentrate in a classroom, there are documented incidents of negative consequences from the use of these drugs. There is also parental concern regarding the issue of diagnosis and medication and using these drugs for what are essentially problems of discipline

that may be related to a variety of causes and their impact on student achievement.

Currently, ten states have laws on the books related to the use of psychiatric drugs on children and while there is no hard data on the total number of children in Alaska on these medications, [indisc.] hope to make clear the responsibilities of both parents and schools and the growing debate on the use of these drugs are requiring school districts to adopt policies restricting school personnel from recommending that a student be given psychiatric drugs. It would also prohibit a child from being considered to be a child in need of aid simply based on the refusal of the child's custodian to give psychiatric drugs to the child.

He informed members that several people were available to testify on different aspects of the bill.

SENATOR LEMAN asked Mr. Benavides if the words psychiatric and psychotropic are used interchangeably in relation to drugs.

MR. BENAVIDES said, "Some people identify them as psychiatric drugs, others call them psychotropic drugs. It depends on – the different drugs - what they - their full term affects on kids because a variety of drugs are used."

CHAIRWOMAN GREEN called Mr. Maloney to testify and asked him to touch on what is actually happening in school districts now and what this bill will require school districts to do regarding setting policy.

MR. GREG MALONEY, Director of Special Education for the Department of Education and Early Development (DOEED), made the following statement.

The use of psychotropic groups with children is an area of critical importance. Ongoing research on the impact of such drugs on developing brains and neural networks mandate that decisions regarding their use must be made carefully by parents and professionals with the capacity to make these decisions. SB 230 would put into law what is already an ethical, professional requirement, namely that school professionals act only in their areas of expertise. In other words, there are individuals in the school setting who are trained to provide information providing certain diagnoses and possible interventions, including at times medical

interventions. Such a person would be a school psychologist. I'm a nationally certified school psychologist myself. Part of the training is to learn more and then provide the parents information about the pros and cons, benefits, consequences of medication.

Alaska's teachers, I must say, do work hard for the interest of children and this measure would provide additional guidance to them. The tendency to think that teachers are providing this maliciously because this is a way – if the kids are not performing, this is a way that we can do something about that. However at times, teachers also may make suggestions regarding medication out of an attempt to be helpful because they are trying to help parents come up with options that may be useful. Again, this points out the need for training in that area because while the suggestion maybe from good intentions, it may not have the intended consequences.

SB 230 also requires school staff to communicate behavioral or emotional concerns to parents. The bill may be too prescriptive when it requires a letter be sent to the parent or guardian recommending an evaluation be conducted by a licensed physician. This presupposes that a student may need medication and for purposes other than medication, a physician may not be the best person suited to conduct that assessment. In other words, if a student has behavioral or emotional concerns, part of it may eventually get to the point where a medical evaluation may need to be considered. Prior to that, there are a number of kinds of interventions that are non-medical in nature. One example that you may be familiar with is called positive behavior support in which the school environment within which the student is operating is changed and positive and negative reinforcements are provided in order to help the student make better choices. Interventions other than medication, including positive behavioral supports, have been shown to have a positive durable impact.

Another issue that some of you may be familiar with is that under the Individuals with Disabilities Education Act as amended in 1997, referred to as IDEA 97, districts are expected to pay for medical evaluations that are suggested as part of a student referral for special education services. In other words, if, as part of the evaluation, it's been noted that the school

district has some concerns related to a student's medical needs or the need for an evaluation, quite likely the school district would be required to pay for that evaluation so that may have some fiscal impact on the school district.

I suggest that the language be changed to require school districts to notify parents or guardians of emotional or behavioral concerns. This may occur in the form of a letter, a telephone call, or during an intervention team meeting. One of the really nice things that has been developing in the last few years is a focus on pre-referral - in other words, prior to the referral of a student for special education services, a team meeting made up of interdisciplinary professionals. So, in other words, you may have a teacher, an administrator, a speech pathologist, a special education teacher coming together – not to talk about whether the student is eligible for special education, but what kinds of things can be done prior to the referral for special education that would enable the student to continue to make progress in the regular classroom and not require either medication or special education services.

On a final note, I also do not read this legislation to be limiting the legitimate role of trained school personnel, such as a school psychologist or school nurse, to provide important information to parents concerning potential benefits and consequences of medical interventions. And so one other possible suggestion would be to consider, instead of using the term school personnel, regarding who this is referring to – it may be teachers. Some state laws that have other states that have enacted laws have specified teachers rather than school personnel precisely because of the issue that it may limit unintentionally the services provided by a school psychologist or a school nurse. The difference we see is that it is one of the advocacy – a school psychologist or school nurse may provide information, however that is not necessarily advocating for the use of medication – but it is important that parents have quality information as they go about making this decision.

MR. MALONEY offered to answer questions.

SENATOR DAVIS commented that regarding a special education

student, a school district is already required to pay for an evaluation and SB 230 would not change that. She pointed out that SB 230 will affect students who are not in special education. She said she does not have a problem with limiting what is in the letter, but she doesn't understand why this will cause a great expense to school districts. She also noted she does not want this bill to apply to teachers only because too many children have been placed in special education and put on medication because they have behavioral problems. She added that nurses have estimated that 800 students in the Anchorage School District are given psychotropic drugs.

MR. MALONEY said, in regard to his statement that a referral to a physician could require an additional expense, if a teacher believes a student should have a medical evaluation independent of this larger, more informed process, it could mean the district would have to pay for it even though the special education team may not have recommended one.

SENATOR DAVIS noted that IEPs are done for all special education students but other students are put on medication yet do not go through that process. She wants to make sure they do not slip between the cracks. She pointed out that some children have been denied the right to come to school. SB 230 prohibits a school district from keeping a child out of school because the parent does not want the child to take psychotropic drugs.

CHAIRWOMAN GREEN took public testimony.

MR. RICHARD WARNER, President of the Citizens Commission on Human Rights of Seattle, said SB 230 represents an important first step toward establishing some clear limitations on the ability of state agencies to force parents to give normal children psychotropic drugs. By way of background, one reason some states are addressing this issue right now is that the use of psychiatric drugs by children is skyrocketing. These drugs, with the exception of Paxil and Ritalin, have never been approved for use on children by the FDA. Paxil and Ritalin are not approved for use by children under the age of six. The findings of a February 2000 study in the Journal of the American Medical Association warned that the use of stimulants on preschoolers tripled during the 1990s. Another survey by INS Health, which tracks pharmaceutical usage for the pharmaceutical industry, found the use of newer anti-depressants, like Prozac and Zoloft, on children older than six increased 580 percent between 1995 and 1999.

MR. WARNER indicated DOEED includes these children in a category entitled, "Other Health Impaired." He was able to determine a 200 percent increase in the number of children in that category between December of 1995 and December of 2000. During that same

time period, total school enrollment increased by 7 percent. Legislation recently passed the Utah House of Representatives that prohibits teachers from recommending or requiring psychotropic drugs for a child or recommending psychiatric treatment or evaluation. It also provides that the Division of Family and Youth Services may not remove a child from the home because the parents refuse to drug their child. Mr. Warner said the state should not intervene in parental decisions regarding medical treatment for their children when there is no clear consensus regarding the effectiveness of the treatment or the risk of the proposed treatment. In the case of ADD and ADHD, the drugs have been proven to have serious side effects and the diagnosis itself is in question, so it is more important to state the limits of state intervention. Adverse reactions to some of these drugs include anorexia, nausea, rapid heart beat, cardiac arrhythmia, weight loss, psychological problems, and physiological problems, such as liver disorders, blood disorders, convulsions, gran mal seizures, agitation, hostility, abnormal thinking, and 20 to 30 percent decrease in blood flow to all parts of the brain.

MR. WARNER stated support for SB 230 and agreed that a letter home should only state what a teacher has expertise in, for example, the observation of specific behaviors or emotional problems in a child. Sending a letter home requiring a medical evaluation is tantamount to suggesting the child has a medical disorder. He pointed out that a national consensus conference was held on this issue in 1998. Participants concluded there was no independent valid test for ADHD, and there is no data to indicate these children have any brain malfunction whatsoever. There are literally hundreds of conditions that can produce similar symptoms so it is dangerous to use a blanket diagnosis of ADHD for children who could have one of hundreds of things going on.

MR. JOHN BREEDING, Director of Texans for Safe Education and a psychologist, asked committee members to consider the statistics provided by previous speakers. He sees this issue as one of informed consent regarding accurate information and free choice. SB 230 is, to some extent, an anti-coercion bill. He recommended expanding Section 9 to say that school personnel not recommend, suggest, or pressure. He agreed with Mr. Warner that language be included in the bill to restrict schools from requiring the use of psychiatric drugs as a condition of school attendance because parents are being threatened with expulsion of their children in many places. Regarding Section 3, he recommends including language to prevent children from being removed from their homes if parents refuse to medicate them, because that has been occurring in other states.

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MR. BREEDING commented that not only is it proper for school personnel to provide a comprehensive evaluation for children who are selected out, he believes it is illegal not to do so. He said it is proper for the school to do a full behavioral evaluation.

MS. DEBBIE OSSIANDER, legislative chair of the Anchorage School Board, stated support for the intent of the bill. The board believes school personnel should not be recommending medications as that is not their area of expertise or their work. Anchorage already employs severe prohibitions against doing so. The board is concerned about the letter recommending a medical or behavioral health evaluation because of implications for requiring districts to pay for that evaluation. However, the board is generally supportive of providing information.

MR. RICHARD RAINERY, Executive Director of the Alaska Mental Health Board, stated support for the intent of SB 230 but expressed concern that recommending evaluations by physicians may impact smaller communities as they may not have the appropriate personnel. He referred to SB 302 and suggested broadening the pool of people who can do evaluations.

MR. FRANK TURNEY, testifying via teleconference from Fairbanks, informed committee members that the North Star Borough School District has brought in psychiatrists from other states on two different occasions to give teachers a pep talk on how to identify children with ADHD in the classroom. During the seminar, the psychiatrist supported the use of Ritalin and another drug as part of the treatment plan. Also the school district has had a long time relationship with Dr. Ferguson (ph) who is a leader in prescribing Ritalin in Fairbanks. He asked the school board to have Dr. Ferguson to come in and give an opinion on evaluating a child for ADHD and psychotropic drugs but they declined. In addition, he has requested data from the school district three times to determine how much Ritalin is being dispensed by the school nurse but the district has not provided that information. He informed members that the Colorado School Board was the first in the nation to pass a resolution warning parents about the use of Ritalin in schools. He stated support for SB 230 and said he will send proposed amendments to the committee.

MS. BETTY ROLLINS stated support for SB 230 and said it is important to not send a mixed message to students about drug use.

MR. CHARLES ROLLINS stated support for SB 230 and suggested checking children in state custody to see what medication they are taking.

MR. BROCK EIDSNESS, and 8th grader from Dzantik'i Heeni Middle School in Juneau, read the following testimony.

Imagine a society where children are all on psychotropic drugs. Imagine it is the teachers' fault because they referred all of the kids - a society where the drugs are doing more bad than good. That could happen if someone doesn't take the power away from teachers to put kids on psychotropic drugs. This could be a serious problem in the near future. I think you should pass SB 230 and save our society's children.

SB 230 is trying to limit teachers' influence on putting kids on psychotropic drugs. Psychotropic drugs are drugs to calm children down, like Ritalin, or to treat mental disabilities like depression. Teachers sometimes recommend these drugs to parents of disobedient kids for behavioral problems. According to the Journal of the American Medical Association, from 1991 to 1995 the number of preschoolers on anti-depressants increased 200 percent and the number of children ages 2 to 4 taking stimulants more than doubled. Chemically treating our children at the rate we are now may lead to problems in our society that [indisc.] emotional and financial costs to correct. These medications are being prescribed to children at increasingly younger ages and I believe this is because of the school influence.

Ritalin is a commonly used psychotropic drug. There are some children for whom Ritalin may be their best option. However there are countless others that are being drugged unnecessarily. There are some downsides to Ritalin, like Ritalin is derived from the same family as cocaine; Ritalin lasts only four hours, Ritalin treats only some of the symptoms of ADD; Ritalin provides superficial healing – it does not treat the root of the problem; Ritalin can cause side effects such as appetite loss, anxiety, insomnia, ticks, headaches and stomach aches; Ritalin use is responsible for causing children to begin a habit of taking drugs; Ritalin may need to be taken over an entire life span.

Stimulant drugs were found to have short-term effectiveness of 60 to 80 percent in reducing the hyperactivity, distractibility, and impulsiveness of school age children. Studies began in the 1960s show that children who took stimulants for hyperactivity over several years did just as poorly in later life as

a group of hyperactive children who took no medication. Doctors sharply criticized the lack of a uniform system for diagnosing and treating ADHD, saying the health department had largely ignored national health and medical research recommendations published in 1997. Dr. Florence Levy from the Sydney Children's Hospital has expressed concern at the frequency of incorrect diagnoses before.

The facts are straight: the number of kids on psychotropic drugs is rising. School influence is forcing parents to put their kids on psychotropic drugs by threatening to take them to social services and even reporting them. Most teachers probably have never been to medical school and can't diagnose that kind of disorder. If there is, I'd like to meet them but for now we need to limit what schools can do.

SENATOR DAVIS stated her intent in bringing SB 230 forward was not to address what many people have referred to as teachers making these recommendations. She said if a teacher was making such recommendations, the teacher would not be the one writing the letter. Teachers might say something informally during a parent-teacher conference, but anything official would not come from a teacher. She said her concern is about how these drugs are being introduced to children in general, regardless of who is doing it.

CHAIRWOMAN GREEN asked those participants who have raised questions to work with Senator Davis and her staff to find solutions.

SENATOR WARD asked if there is any way to find out the number of children on Ritalin.

MR. BENAVIDES said there would be no record if a parent administers the drug before school or if a child takes the medication on his or her own, however the number of medications administered by school personnel should be recorded.

SENATOR DAVIS corrected a previous statement she made and said in the Anchorage School District 480 students were identified by the school nurse, not 800.

MR. BENAVIDES said it should be possible to get the number of students receiving medications from school personnel.
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There being no further business to come before the committee, CHAIRWOMAN GREEN adjourned the meeting at 3:27 p.m.