

ALASKA LEGISLATURE COMMITTEES

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SB 747 (#2)

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In addition to the formal educational requirements, the program seeks to employ persons who have a sensitivity for the realities of adoption from the perspective of the parent.

Although not depicted on the organization chart, three adoptive parents are being currently trained to co-lead adoption study sessions for prospective adoptive parents.

3. Budget and funding. Figure 2, below, is a presentation of the Adoption-Program budget for FY 1980:

FIGURE 2

INCOME

Fee Income:

<i>Consultation</i>	\$ 500
<i>Adoption Study Fees *</i>	42,500
<i>Education</i>	300
<i>Workshop</i>	4,000
<i>Third Party Reimbursement</i>	12,000
<i>Other Fees</i>	1,000
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<i>Total Fee Income:</i>	60,300

Grants:

<i>Tressler-Lutheran Home for Children</i>	95,659
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<i>Total Grants:</i>	95,659

Contributions:

<i>General Contributions</i>	1,000
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<i>Total Contributions:</i>	1,000

Non-Operating Income:

<i>Books (re-sale to clients)</i>	330
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<i>Total Non-Operating Income:</i>	330

Total Income: \$157,289

EXPENSES

Salaries:

<i>Administrators</i>	21,293
<i>Professional</i>	47,241
<i>Clerical</i>	15,783
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<i>Total Salaries:</i>	84,317

Benefits & Taxes:

Group Medical Insurance 1,968

Group Life Insurance	552
Pension	6,746
Worker's Compensation	784
FICA Agency Expense	5,168
State Unemployment Tax	828
Total Benefits & Taxes	<u>16,046</u>

Staff Support:

Mileage	7,300
Other Travel Costs	1,800
Meetings/Conferences	1,200
Memberships & Dues	150
Books/subscriptions	270
In-Service Training	500
Miscellaneous Staff Costs	100
Total Staff Support:	<u>11,320</u>

Physical Plant Operations:

Rent-Facility	4,376
Insurance	400
Maintenance & Repairs-Building	240
Maintenance & Repairs-Equipment	640
Lease-Equipment	1,800
Total Physical Plant Operations:	<u>7,456</u>

Purchased Services:

Legal	1,000
Consultant	300
Clerical	400
Counselor	1,600
Psychiatrist	200
Total Purchased Services:	<u>3,500</u>

Service Operations:

Telephone	10,050
Postage	4,500
Printing	3,850
Promotional Material	150
Miscellaneous Services	150
Total Service Operations:	<u>18,700</u>

Supplies:

Office Supplies	3,500
Books for Re-Sale to Clients	330
Non-Capitalized Equipment	100
Custodial Supplies	60
Program Supplies	110

<i>Food Supplies</i>	170
<i>Kitchen Supplies</i>	60
<i>Other Supplies</i>	50
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<i>Total Supplies:</i>	4,380

Capital Purchases:

<i>Capital Purchases</i>	2,395
<i>Funded Depreciation</i>	550
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<i>Total Capital Purchases:</i>	2,945

Costs Transferred IN:

<i>Allocated General & Administrative Costs</i>	6,623
<i>Allocated Church & Community Services Costs</i>	3,036
<i>Other Allocated Costs</i>	9,651
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<i>Total Costs Transferred IN:</i>	19,310

<i>Total Expenditures:</i>	\$157,289
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*Fees for services.

The agency charges an application fee and an adoption study fee.

The fee schedules are flexible and revised on a regular basis in regard to the cost of adoption services. Specific fees for adoptive applicants are determined through discussion with the applicants in conjunction with the current fee schedule and their financial circumstances. Other costs, such as transportation of children, or fees of cooperating agencies, may also be incurred.

Whenever possible, agencies having custody of children placed by the Adoption Program are asked to pay a placement fee based upon the actual cost of services provided. These may include: recruitment, study, supervision, and post-placement services. T-LSA believes that no child should be denied placement because of a prospective family's inability to pay a fee, or the lack of a placement fee from another agency.

C. Program Operations (Services)

1. Intake. The Adoption Program's intake process consists of those mechanisms used to contact prospective adoptive parents (Outreach and the Provision of Information) and to determine the interest of prospective adoptive parents in adopting a special needs child (Screening).

a. Outreach (Recruitment). During the early stages of the Adoption Program, radio announcements, newspaper advertisements, television interviews, and presentations to church groups and other interested organizations were used to publicize the need for adoptive parents.

However, since 1972 no formalized recruitment effort has been necessary. The primary recruitment technique has been adoptive families' demonstration of the workability of adoption in their own communities. These families prove the potential of adoption in their daily lives, leading other families to be encouraged to adopt by observing these successful examples. People who have been turned away by more traditional agencies tell others of their success through T-LSA, and a snowball effect occurs. The agency's acceptance of different life styles encourages some people to apply who may have feared rejection.

The agency and P.A.C.O., the Adoptive Parent Organization (See page A-25), work together to provide informational meetings in different geographic areas. These sessions provide opportunities for potential applicants to learn more about the realities of the adoption of children with special needs and to interact with experienced adoptive parents.

There have also been a number of newspaper articles, feature stories, and special local programs which have dealt with adoption and the services of T-LSA in recent years, but these were not initiated by the agency.

b. Information. Staff respond to all written and telephone inquiries about the program. A newsletter called "The Adoption Scene" is mailed to everyone who inquires about adoption. It contains information on the current availability of children and a description of agency services. An Interest Registration Form is attached to each of these newsletters. (See Exhibit A)

c. Screening. The initial means of screening prospective applicants is provided through use of the Interest Registration Form (Exhibit B). This form provides a statement of the applicant's interests in adopting a special needs child and serves as the basic information source for selecting applicants to be processed for the adoption of available children. Some of the items on the form are discussed below.

(1) Age. There are no set criteria for chronological age.

However, the following factors are considered:

Minimum: The age of the applicant should be sufficient to establish reasonable maturity and ability to accept the responsibilities of parenthood. It is considered in conjunction with emotional stability and any legal requirements.

Maximum: The importance of an applicant's physical health, comparative age with the potential adoptee, and his/her flexibility of ideas and attitudes related to parenting are considered, rather than chronological age.

(2) Marital Status. Single applicants, as well as married couples, may apply for adoption. The program accepts a wide variety of life styles as potentially providing appropriate families for children. Verification of marital status is required, and previous marriages ending in divorce are evaluated in light of subsequent adjustments.

- (3) Family Composition. Potential adoptive families are not categorically excluded because of the number of children already in the family. In fact, the staff has found that large families often provide good homes for children simply because the adopted child doesn't have to "be everything" and will not have to be the center of attention. The number of children placed in a family is determined primarily by the interest of the applicants based on their own assessment of financial capability, general health, stamina, and capacity for parenting.
- (4) Health. General physical and mental health should be such that it enables the applicants to meet the challenge of parenthood.
- (5) Income. No set level of financial assets or resources is required. T-LSA does not use the criteria of income or occupation as screening devices (e.g., a family with a yearly income of \$4,000 has had children successfully placed). However, there should be a reasonable relationship between a family's earning power and its financial stability: the level of income should be adequate to cover basic family needs.
- (6) Housing. Housing may be owned or rented as long as living space and sanitation can provide a clean and comfortable home for children.

2. Assessment and planning. The assessment and planning processes are combined. Assessments and planning of cases consist of Adoption Rap Sessions and the Study Process.

a. Adoption rap sessions. These meetings are held periodically in various parts of the service territory. People who are waiting for a group study session are invited to attend, and agency staff and adoptive parents lead the discussions. Interaction with "successful" adoptive parents enables

applicants to more realistically evaluate their own motivations, awareness, strengths, and commitment. T-LSA has found that applicants often become more flexible in the types of children they feel they can parent through adoption after participating in these sessions. The Interest Registration Forms are available at these meetings, and applicants have the opportunity to make necessary changes in stating the types of children they want to adopt.

Seven of these sessions were held during 1978 and one was televised by Maryland Public Broadcasting. It was shown on a nationwide syndicated program called "Consumer Survival Kit."

b. Study process. A realistic preparation for adoptive parenthood is developed through the use of various concepts such as parent effectiveness training, values clarification, and transactional analysis. Participants in each of the study group series are chosen on the basis of their interests outlined on the Interest Registration Form and the needs of available children. Approximately one hundred adoptive applicant families participate in the process each year.

Five to seven couples and/or single applicants meet for a series of nine sessions. This group method was initiated so that adoptive parents would not feel isolated during the adoption process, and to allow applicants to challenge, support, and encourage each other. Interaction within a group setting has been shown to reveal greater insight into parenting capacities and attitudes than individual sessions. In addition, applicants can be processed more quickly in groups, resulting in more homes for the waiting children.

Throughout the sessions, the emphasis is on educating parents to meet the needs of the children. T-LSA encourages the development of an honest relationship between the adoption worker and the client; therefore the process is conducted in a nonjudgmental atmosphere. The philosophy is that as the adoption workers become acquainted with the adoptive families, the applicants get to know themselves better. They

become aware of the children available for adoption and come to terms with their coping capacity, their strengths and their weaknesses. The prospective parents are assisted in questioning their capabilities and limitations, and, if necessary, removing themselves from the adoption process. Adoptive applicants who complete the study process have the responsibility and opportunity to select the children they want to adopt, instead of the worker making the choice for them.

The components of the study process are:

(1) Informational meeting. Prospective parents, selected to attend the study process based on their interests and the needs of the available children, meet to discuss basic information about adoption and agency policies. Application forms (See Exhibit C) are distributed, and the series of study sessions begins when these forms are returned with the application fees.

(2) Panel presentations. Two sessions, entitled "Parenting the Child Who is a Challenge," feature panel presentations by parents who have already adopted special needs children. The purpose of the panels is to present the realities of adopting challenging children. The panel discusses problems encountered before and after placement and topics such as stealing, running away, foul language, and bed-wetting. The presentations provide the applicants with an opportunity to discuss their own feelings about these realities before the actual adoption of a special needs child. The panel also discusses issues such as: What do prospective adoptive parents need to know about themselves before adopting an older child? How much experience should they have had with children? How committed are they to making the placement work?

(3) Group sessions. A six-session parent-child communication course focuses on values clarification, transactional analysis, and parent effectiveness training. During these meetings the social worker can get to know the applicants individually, and the applicants can gain self-awareness and insight. Tools and skills which they might need in meeting the challenges of adopting special needs children are also presented. The emphasis is on the social worker and applicants working together to increase the opportunity for a successful placement.

Part of the study process involves the completion of a number of assignments such as writing autobiographies, completing health forms, and providing "thought sheets." The "feeling autobiographies" provide answers to questions about attitudes and expectations. Thought sheets have questions such as "How would you handle a child who couldn't trust you or couldn't establish a close bond?" and "What would you do if this child became a disruptive influence on your marriage?" Basically the applicants write their own life studies instead of the social worker doing it for them.

The parent-child communication course is based on discussions about the individuals themselves and includes selected transactional analysis concepts which are explained and practiced in the non-threatening group atmosphere. The group is encouraged to evaluate the concepts presented and to provide examples of them in the daily conduct of their own lives. This approach to the study process provides a learning and growing experience for all involved. Through this open, informal approach the social worker can gain a feeling for the applicant's ability to parent or to improve his/her parenting techniques.

(4) Visit to an adoptive family. The prospective parent is linked with a family that has adopted a child of approximately the same age and characteristics that the applicant is requesting. The applicant visits the family and has the opportunity to obtain an even more realistic view of the adoption experience. The experienced adoptive family advises the agency staff on their impressions of the applicant's capabilities. This visit often results in a long-term linkage between the prospective parents and the host adoptive family.

(5) Individual interviews. The social worker also conducts an individual session with each applicant to further obtain an accurate picture of the prospective parent's background, philosophies, interests, self-image, etc. This is also an opportunity to discuss further any concerns the applicant or worker may have.

(6) Situational groups. Upon completion of the study process, new applicants are assigned to one or more "situational" or "special interest" groups depending on the age, variety, and number of children for which they have applied. These groups are composed of both adoptive families and people waiting to adopt. Attendance is voluntary, but participants have found that the groups provide an excellent atmosphere for "reality testing." Social, cultural, and educational sessions allow prospective parents to help determine whether they will be comfortable parenting those children for which they have applied. The situational groups at present include Korean, Vietnamese, Single Parent, Older Children and Siblings, Large Families (over 5 children), Inter-racial Adoption, Mexican-American, North American Indian, and Children with Medical Problems. Many people participate in several groups concurrently.

3. Services. The primary services of the T-LSA Adoption Program are the situation groups, placement, the operation of a twenty-four hour hotline, the conduct of a teen therapy group, and the provision of counseling services to adoptive families, when needed.

a. Situational groups. These groups (described in 2. b. (6) above) enable families to discuss similar challenges in a group setting. They also relate to issues of their children's heritage and culture and sponsor family activities. Additionally, they provide an opportunity for prospective adoptive parents to get a "feel" for the experience of adopting a special needs child.

b. Placement procedures. During the study process, the applicants have the opportunity to review information on available children provided by adoption exchange books and other agencies and to identify children they are interested in adopting. If an applicant expresses serious interest in a particular child or children, the staff requests complete background information from the agency having custody. The applicant studies it, discusses it with the staff, and consults doctors and community resources regarding the child's problem areas. By having the prospective parent do the groundwork instead of the social worker, T-LSA believes that the applicant develops an increased commitment, thereby increasing the potential for a successful adoption. At the same time the family study is sent to the referral agency. The study includes the autobiography, health form, references, "thought sheets," and a summary and recommendations from the social worker.

The placement decision is a tri-level one made by the applicant, T-LSA, and the referral agency. The agency with custody makes the final determination.

If all parties decide to proceed with the placement, specific arrangements are made. This may include a pre-placement visit to the child's home. This is not always a prerequisite and is usually determined according to the needs of the child and/or the agency having custody. T-LSA believes that it is difficult to determine in a short visit whether the placement will be successful. Through its experiences over the years, the agency has found that preadoptive visitations are of minimal value in determining the appropriateness or success of adoptive placements. In fact, many of the placements accomplished during the program's existence have been made without preplacement visits. It is believed that the most essential element to successful adoptive placements is not the visitation, but rather the adequate preparation of the child and of the potential parents.

If there is a placement that must be expedited because of a child's needs, the staff does not necessarily wait until the completion of the group study process before placing the child. The staff will work with the adoptive parents independently of the group sessions to facilitate the completion of the study. However, the family participates concurrently in the group study sessions.

As cited above, the primary responsibility for preparing a child for adoption rests with the agency having custody. However, one element of this preparation is provided by the adoptive parents through T-LSA. Each family is advised to develop a scrapbook reflecting family composition, their home, community, pets, hobbies, family activities, and other interests. These scrapbooks are shared with the child through his/her foster care worker to enable him/her to begin to identify with the family in advance of a visitation or direct placement. T-LSA provides these scrapbooks to the agency with custody for their preparation work with the child.

T-LSA also encourages the agencies with custody to have adoptive children maintain personal scrapbooks throughout their time in foster care and to carry them into adoptive placement. The staff believes that this aids children in maintaining their identification and strengthening their self concept.

c. PACO listening ear. A twenty-four hour hotline provides a crisis intervention function. This service is provided by trained adoptive parent volunteers in various locations throughout the twenty-six county area served. These volunteers give parent-to-parent support and also make reports and referrals to the professional staff. T-LSA has found that many adoptive families of special needs children do not have relatives and friends who support their decision to adopt these children. The Listening Ear provides this support as well as an emergency linkage with professional services.

d. Teen group. A therapy group composed of adopted teenagers enables these youth to deal with present conflicts as well as with years of repressed problems. T-LSA provides staff for these sessions.

e. Counseling. The staff provides counseling for the families and adoptive children as needed. Referrals are also made to other community resources and to other adoptive families for support.

4. Monitoring. Placements are monitored through follow-up visits, and the submission of "sharing sheets" by the adoptive family.

a. Follow-up visits. The agency staff is available to assist the family during the period between placement and the finalization of adoption (at least six months), as well as after finalization. A worker is assigned to have a minimum of three visits during this supervisory period prior to finalization. The staff encourages and expects the adoptive family to let them know when problems occur. Preventive and/or crisis therapy is suggested and provided when applicable.

b. Sharing Sheets. Families who have not finalized their adoptions send the agency monthly "sharing sheets" which let the staff know how the placements are progressing and the areas of success or difficulty they are experiencing. If staff are needed for guidance or if counseling is required, the family is contacted immediately. (See Exhibit D)

5. Case evaluation. By state law, program staff are required to make a minimum of three contacts with the family after the adoptive placement is made. Staff use these visits, as well as other supportive services provided, to evaluate whether the placement is proceeding.

6. Case termination. In effect there are no formalized termination of service procedures, as the program maintains ongoing contact with adoptive parents as long as necessary after the finalization of the adoption.

7. Follow-up. The follow-up services provided after the finalization of the adoption consist of visits to the home, the operation of an adoptive parents organization, the provision of counseling services, the operation of a 24 hour hotline, and the publication of the newsletters.

a. Follow-up visits. The follow-up visits as described in C.4.a. above continue after the finalization of the adoption.

b. Adoptive parents organization. Parents of Adoptive Children Organization (P.A.C.O.) provides a structure for the supportive relationships which adoptive parents need. T-LSA believes that adoptive parent organizations can make a significant contribution to programs involving the placement of available children through recruitment, education, and mutual support, and that agencies and adoptive parent groups should work cooperatively for these purposes. PACO is an integral part of the T-LSA Adoption Program.

The Adoption Program provides staff resources in development, coordination, and program planning for parent groups affiliated with the organization. Examples of the programs conducted by the group are seminars on sex education, child development and childrearing; legal information about adoption, wills, and insurance policies; and a session on voluntary and involuntary termination of parental rights. Family events in which children participate are also held. In addition to attending social and educational meetings, the members receive a bimonthly newsletter (See Exhibit F) which contains information about upcoming events, agendas for meetings, current legislation, reports from national conferences, information on current issues, letters from readers, a list of recent placements, and descriptions of adoption resources.

PACO groups are organized in specific geographic areas, and there are also subgroups composed of parents who have adopted children with similar special needs. Current subgroups are available for those who have adopted older children, siblings, Korean and Vietnamese children, children of Black and Black-White parentage, Mexican American and Native American children, and children with medical and physical disabilities. These groups meet periodically for programs related to their respective needs and interests. Some families may belong to several of the subgroups depending upon the types of children they have adopted.

PACO also provides interest free financial support to adoptive families for such needs as transportation costs, dental care, etc. The organization does not charge dues but instead conducts moneymaking activities such as parties, dances, and fairs.

PACO chats are small group sessions held in people's homes at which information on available children is shared and concerns of adoptive parents are addressed. T-LSA staff are present at these meetings. Prospective adoptive parents are also invited to attend these meetings if they have an Interest Registration Form on file with T-LSA.

c. Counseling services. The counseling services described in subsection C.3.e. are also provided as a follow-up service.

d. Twenty-four hour hotline. See subsection C.3.c.

e. Publications. Several newsletters are provided on a regular basis to keep families advised of social and educational programs, to inform them of available children, and to share current adoption issues.

- "Because We Care So Much" is a bi-monthly newsletter for families who have adopted five or more children. This is currently mailed to more than 850 adoptive families throughout the United States and in several other countries. This newsletter serves as a linkage for sharing concerns, challenges and the joys of large families.
- Every family, approved and waiting for a child, receives a monthly newsletter, "We Wait Too," which focuses on available children. (See Appendix F).
- "Children and Adoptive Parents" is a bi-monthly publication with a circulation of approximately 1,800 adoptive families and agencies. (See Appendix E).

SECTION IV. RESULTS AND EVALUATION

In the less than nine years that the Adoption Program has been in operation, more than 1,000 children with special needs have been placed in permanent homes. The annual placement statistics since the development of the specialized program are as follows:

<u>Year</u>	<u>Placements</u>
1972	98
1973	94
1974	99
1975	299*
1976	119
1977	121
1978	146
1979	<u>80</u> (through July, 1979)
Total	1,056

*Included over 200 children placed during the emergency airlift after the fall of South Vietnam; of this number, 96 were placed through other agencies with T-LSA having custody.

From January 1972 through December 1978, the number of children with handicaps who have been placed is 217. Other special needs children were members of sibling groups and those over the age of twelve. The following chart indicates the number of children placed by characteristic for 1976, 1977, and 1978.

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u> (through July 1979)
Over age twelve	12	22	18	11
Members of sibling groups	18	44	32	16
Mentally retarded	2	5	4	3
Emotionally disturbed	8	22	20	14
Slow learner	11	--	12	12
Auditory difficulty	1	--	1	2
Visual impairment	3	1	5	7
Cerebral palsy	3	2	5	1
Downs syndrome	--	4	5	--
Heart defect	--	1	--	--
Drug baby	--	1	--	--
Cleft palate	--	1	--	--
Gerodoma Osteodipplastica	--	1	--	--

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u> (through July 1979)
Hydrocephalic	--	--	3	--
High medical risk	--	--	3	--
Severe speech problem	--	--	1	--
Incest child	--	--	1	--
Deformities	--	--	1	--
Spinobifida	--	--	1	--
Epileptic	--	--	2	--
Sexually active	--	--	2	--
Severe skin problems	--	--	1	--
Orthopedic problems	--	--	1	5
Other medical problems	--	--	--	9

For these same years the following chart depicts the number of children placed according to race or native country:

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u> (through July 1979)
White (USA)	63	39	59	34
Black (USA)	12	12	5	6
Black/White (USA)	13	14	9	11
Korean	20	23	24	12
Vietnamese	--	8	2	--
Native American	18	13	35	11
Puerto Rico	4	2	--	--
Philippines	4	--	2	--
Indian/Black	1	1	--	--
Chinese	1	--	--	--
Dominican Republic	2	1	--	--
Mexican/American	--	2	--	1
India	--	2	--	--
Cambodian	--	2	--	--
East Indian	--	1	4	1
Columbia	--	--	--	3
Peru	--	--	--	1

The greatest number of children (847) were placed when the program had only two full-time adoption workers conducting the family studies. The disruption rate has been very low (5% overall) and most of these children were replaced with T-LSA families. The staff credits the client-centered approach for the low disruption rate and for the agency being able to meet the needs of many waiting children and adoptive parents. The self-assessment of strengths and weaknesses, the educational process of building on already existing parental skills, and the ability of prospective parents to be the primary decision-makers, all contribute to making adoption realistic for adoptive parents. The provision of multi-faceted post-adoption support services also adds to successful placements.

The success of the program can also be attested to by the fact that many other agencies are now incorporating the techniques employed by T-LSA. At the inception of the program in 1972, the exclusive placement of special needs children and the non-traditional T-LSA approach were unique to the field of adoption. However, due to the decrease in the number of healthy, white infants available for adoption, agencies have had to change their attitudes and redesign their programs.

To help these agencies adjust to the recent trend toward placing special needs children, the Director of the Adoption Program has made numerous presentations on client-centered adoption, the group study process, and supportive services. (See Exhibit G for letters from agencies attending presentations and workshops). Children Unlimited, an adoption agency in Columbia, South Carolina which places special needs children, has modeled its program of education and post-placement services on the T-LSA program.

T-LSA has also been selected as an exemplary agency in the successful placement of developmentally disabled children by the North American Center on Adoption, Inc.



the adoption scene at T-LSA



A REPORT ON ADOPTION FROM TRESSLER-LUTHERAN SERVICE ASSOCIATES

There are children everywhere. Some are eating cotton candy, others are being given rides throughout the grove of trees in a tractor-drawn wagon, and still others are being costumed as Indians.

The scene looks very much like a huge family reunion or perhaps a Sunday School picnic, except that, upon closer observation, one might note that many of the children are handicapped or biracial or of Indo-Chinese or Canadian-Indian descent.

But there's something even more special about this September Sunday gathering in Jacobus, York County: Practically all of the children are adopted.

The get-together is the annual York-area PACO (Parents of Adopted Children Organization) picnic, and that first, tentative description of the affair as a family reunion is not an inappropriate one.

Because of organizations like PACO and events like its yearly picnic, many adoptive parents say they feel as though they're part of a large, widely scattered family.

That feeling is one of the many unique aspects of Tressler-Lutheran Service Associates' adoption program.

At the very heart of that uniqueness is the fact that in 1972 the program was reorganized exclusively to place "special needs" children, those formerly (and unfortunately) labeled "hard to place." Discontinued completely was the placement of healthy, young white children and white infants.

What produces the special needs of the children T-LSA places is that they are black, biracial, or from a foreign country; or they are between the ages of eight and 18; or they have physical, emotional, or mental disabilities; or they are to be placed along with a varying number of their brothers and sisters. (T-LSA has placed with one family a "sibling group" of seven children!)

The program, operating in 26 Pennsylvania counties (the territory of the LCA's Central Pennsylvania Synod), has the function of preparing and then representing prospective adoptive parents to agencies in whose

care children are placed prior to being adopted.

Rather than providing care to these children awaiting adoption, T-LSA instead serves as an "adoption broker," bringing together special needs children and loving families.

Immediately apparent to anyone who has conceived of adoption as the fulfillment of a childless couple's needs by providing them with a healthy white infant is the fact that the nature of adoption has changed markedly: While the core of T-LSA's program is its work with adoptive parents, and while the adoption procedure is oriented toward these parents, the entire focus of adoption is on ministering to the needs of children.

As the nature of adoption has changed, so too has the manner in which children are adopted. And T-LSA has had a lot to do with that change.

The entire transition began in the late 1960s when fewer healthy white infants were becoming available for adoption. For some time prior to that Tressler staff had been doing some adoption work with special needs kids.

As a result of that work the program was redesigned entirely toward the placement of special needs children.

The traditional approach to adoption had been to have a social worker interview a prospective adoptive couple three or four times in an office. The social worker obtained information on the couple's background and usually made a home visit. Then, if they were "approved," a child was selected for them.

The group approach utilized by T-LSA is much better, say both adoption staff workers and adoptive parents.

"You feel a lot more at ease and are able to learn more," relates one York County adoptive parent. And the group sessions allow people to "reveal more of themselves than they ever would in an office interview with a social worker." They also are able to gauge their strengths and weaknesses and to work on

overcoming the weaknesses.

Typically, six to eight couples or single parents meet for eight or nine weeks, usually in the home of a staff member or a church parlor or other informal setting.

At those sessions, they share feelings, experiences, expectations, and fears. And they get a chance to talk with families who already have children similar to those they are contemplating adopting. The adoptive parents are as frank and open as possible, both to acknowledge the challenges of adoption and to aid group participants in learning if adoption is for them.

At the sessions prospective adopters also study information about children available for adoption, helping them and staff members to identify the type of child they would like and feel capable of rearing.

To reach this stage in the adoption process, prospective parents first file an "interest registration form" with the agency. Then, when periodic "adoption rap sessions" are scheduled in various areas, those people are invited to attend.

In accordance with the availability of children and staff resources, applicants — about 100 of them each year — are selected to participate in the adoption study process, which consists largely of the group sessions.

In addition, participants must complete "feeling" autobiographies.

These autobiographies are an additional way in which applicants can sort out their feelings on adoption, children, parenthood, and related topics.

During the study process an adoption unit staff member visits with the applicants, and, following completion of the group sessions, the prospective adoptive parents must visit the home of an adoptive family, usually with children similar to those they want to adopt. The family then files a report on the visit so that any problems can be worked out between the applicants and staff members.

Finally, if the prospective parents and staff members believe that the family is ready to adopt a child, the applicants are registered with adoption exchanges.

Sometimes, a child is placed with them relatively quickly; however, most placements take at least several months and some longer.

As part of its service to children, T-LSA carries the major cost of the program. This money represents a significant portion of the interest from the endowment fund of the Tressler Lutheran Home for Children.

Prospective adoptive parents pay an application fee and an adoption study fee, based on the actual cost of service and levied on a sliding scale in accordance with the applicants' ability to pay. These fees, however, seldom cover the cost of service provided by the agency.

T-LSA adoption services do not stop with the placement of the child. For the first six months following placement, staff maintain contact with the family, visiting them and providing whatever support is necessary.

But support comes from other sources as well. First, the adoptive families themselves provide support to one another.

Second, organizations like PACO - one of the largest adoptive parents organizations in North America -- and its various "subgroups" (for example, groups for families with Korean children) can be a help to adoptive parents.

And, third, there are the T-LSA

adoption newsletters, one of them designed just for families with five or more children, another for families waiting for a child.

What lies ahead for the adoption program?

Staff members cite the continuous evolution of adoption study guidelines, parent-training skills, and increased participation in support groups like PACO as part of the program's future.

But whatever is ahead, you can be sure of one thing, its origin: As the bumper sticker pasted on the rear of many adoptive families' cars proclaims, Adoption Starts in Loving Hearts.

Tressler-Lutheran Service Associates (T-LSA) provides a program of specialized adoption services including: the processing of applications for the adoption of children with special needs; community education regarding the needs of children available for adoption; and a variety of group and supportive services for adoptive families.

Applications for adoption may be received from potential adoptive parents residing in a twenty-six county area in Central Pennsylvania, which coincides with the territory of the Central Pennsylvania Synod of the Lutheran Church in America. These counties include:

Adams	Clearfield	Franklin	Lebanon	Perry
Bedford	Clinton	Fulton	Lycoming	Snyder
Blair	Columbia	Huntingdon	Mifflin	Somerset
Cambria	Cumberland	Juniata	Montour	Tioga
Centre	Dauphin	Lancaster	Northumberland	Union
				York

The Adoption Program is based in the York office and staff persons assigned to the program operate from the Williamsport and Altoona offices.

While the adoption scene is constantly changing, there have been several constant and significant trends in the past few years.

- more people have become interested in adoption as a means of having or expanding their families.
- fewer white infants and very young white children have become available for adoption because of more effective birth control measures, abortion, and many more unwed mothers raising their children.
- agencies and courts have increased their efforts to place the thousands of children with special needs, who had previously been considered hard-to-place.
- many children with special needs who are considered to be the "available children" are being placed in permanent adoptive homes.

INTEREST REGISTRATION FORM

The Interest Registration Form is designed to provide the agency with a concise statement of the applicants' interests in adoption. Applicants complete and return the form. This form serves as a basic information source for selecting applicants to be processed for the adoption of available children. Completion of the form does not imply any obligation on the part of the applicant or the agency. Changes on Interest Registration Forms may be made by writing or phoning the office with which you are registered.

Applicants are accepted for an adoption study according to the availability of children. T-LSA is constantly in touch with other adoption and child-serving agencies, with adoption exchanges in various states, and the Adoption Resource Exchange of North America (ARENA). Consequently, we learn of the types of children in greatest need at that particular time. Because we gear our service primarily to the needs of the available children, some potential adoptive parents may be registered for many months. Others may be processed within a short period of time. There is a greater possibility of studying and placing with those who have sincerely expressed a broad range of interest and flexibility on their Interest Registration forms.

CAUCASIAN INFANTS

The T-LSA Adoption Program does not place healthy, white infants. There is a "shortage" of such children for adoption and other agencies have long waiting lists. In fact, today it is almost impossible to locate any healthy, white children under the age of eight for adoption. We feel that these are not the children most in need of our services.

AVAILABLE CHILDREN

The following summaries present a concise reflection of the availability of children in the descriptive categories we generally use in the program.

OLDER CHILDREN (ages 8 to 18)

Many children are available for adoption in these age ranges. They come from a wide variety of backgrounds and experiences. All need the love and security of permanent homes.

MEXICAN-AMERICAN

Several years ago, we placed many Mexican American infants. In the past few years, we have placed no Mexican-American infants because the agencies in the Southwest have discovered that these children can be placed for adoption in their local communities. However, we have placed older Mexican American children and sibling groups.

SIBLING GROUPS (any family group of two or more brothers and/or sisters)

This is one of the most available categories of children. Generally, they are over the age of eight. The larger groups (more than two) are in the greatest need of adoptive families.

AMERICAN INDIAN (Native American)

Tribal laws now strictly limit adoption except by Indian families. The only exceptions likely to occur are for sibling groups of two over the age of ten or for sibling groups of three or more of all ages, also teenagers and children with medical limitations. Most of these children are from Canada.

BLACK & BI-RACIAL (Black-White)

Many children are available from within this broad grouping. Black and bi-racial infants are not as available as older children and sibling groups.

While T-LSA makes inter-racial placements, we strongly encourage black applicants. Thousands of children wait for black or white homes. We suggest that black applicants indicate this on their Interest Registration Forms because the need is so great for black families to adopt waiting children.

KOREAN

T-LSA has worked cooperatively with the Holt Adoption Program in placing youngsters from Korea, Thailand, and the Philippines. The availability of young Korean children is not limited to families who have previously submitted an application to Holt.

INTERCOUNTRY ADOPTION

Many children in other countries, particularly the developing countries, are in need of permanent adoptive families. However, the complexity of adoption requirements in some countries and difficulty in achieving international agreements on adoption make it very difficult, if not impossible, to obtain those children for adoption. When, and if, such arrangements are made, we expect to be able to work cooperatively with international agencies for this purpose. Persons interested in intercountry adoption should attach a separate note to the Interest Registration Form, stating their interests.

MEDICAL, EMOTIONAL AND PHYSICAL LIMITATIONS

Children with a wide range of medical and emotional needs are available. Some children may be retarded or only moderately limited in their potential. Their need for love and permanence is critical.

ADOPTION RAP SESSIONS

Adoption Rap Sessions are scheduled periodically. Everyone who has an Interest Registration Form on file at our office will receive an invitation to sessions as appropriate. Agency representatives and panels of adoptive parents are available at each of the sessions to discuss the current "Adoption Scene".

THE ADOPTION PROCEDURE

The procedure for adopting a child through T-LSA involves the following major steps:

1. Initial inquiry and completion of an Interest Registration Form.
2. Selection of applicants for the adoption study process according to the availability of children and staff resources. As the agency is made aware of available children, applicants are selected for study on the basis of their interests outlined on the Interest Registration Form and the greatest needs of waiting children. Invitations to enter the study process are then extended to the applicants who can be processed in a group (approximately six couples). (We generally have about 300 applications on file and are able to study approximately 100 applicants per year.)
3. Attendance at an informational meeting for those selected for the study group. At that time, basic information is discussed about adoption and the agency policies. Application forms are distributed at this meeting.
4. Remittance of the application form to the agency with the application fee (for those who wish to proceed with the adoption study.)
5. Attendance at a series of group meetings scheduled with the applicants. The primary purpose of these meetings is to enable the social worker to get to know the applicants as potential adoptive parents. This is also a time for increased self-awareness and insight on the part of the applicants. Individual interviews may be arranged as appropriate. Approximately ten sessions are involved.
6. Completion of the study process. The social worker and applicants make a decision regarding the readiness of the applicants for adoption and the study is then written. Material contained in the study is treated in a confidential manner and records are maintained in accordance with requirements of the Pennsylvania Department of Public Welfare.
7. Registration of processed applicants with appropriate adoption exchanges. Other efforts are also taken to make these potential adoptive homes available for waiting children.
8. Completion of initial home visit. The worker visits the home prior to placement to complete a descriptive summary.
9. Placement of a child with the family. (Timing cannot be accurately predicted). There is a period of at least six

months before the adoption can be finalized in court. This may be a period of adjustment for the whole family.

10. Follow up visits. The agency staff is available to assist the family during this time as well as after finalization.

THE COST OF ADOPTION

An application fee and an adoption study fee are charged by the agency. As a voluntary, non-profit, social service organization, the agency has established a fee schedule to enable the adoptive family to share in the costs of service. The actual fee is determined with the applicants according to a sliding fee scale and their respective financial circumstances. These fees are based on the actual cost of adoption services to the agency. However, as already noted, the agency has traditionally carried the major costs of the program.

Attorney fees and court costs are handled between the adoptive parents and their attorney.

Other costs, such as transportation of children or fees of cooperating agencies may be incurred. These costs vary with each situation and are worked out on an individual basis.

P.A.C.O.

An organization for adoptive families, P.A.C.O. (Parents and Adopted Children Organization) provides services and advocacy for children in partnership with the T-LSA Adoption Program. This organization holds educational and social programs and functions throughout the T-LSA service territory. Local PACO groups are organized in specific geographic area.

Special groups are available for those who have adopted older children; siblings; Korean and Vietnamese children; children of black and black-white parentage; Mexican-American and Native American children; and children with medical and physical disabilities.

T-LSA ADOPTION OFFICES:

- 25 W. Springettsbury Ave. - York, PA 17403 - (717) 845-9113
- 221 W. Fourth St. - Williamsport, PA 17701 - (717) 322-7873
- 1200 - 11th. / - Altoona, PA 16601 - (814) 944-5355

For other helpful information on adoption including books and subscriptions to "Adoptalk", contact: The North American Council on Adoptable Children, Inc., 250 E. Blaine, Riverside, CA 92507 Phone. 714-682-5364.

When T-LSA receives your completed Interest Registration Form this will be acknowledged by letter. You will receive an invitation to attend one of a series of Adoption Rap Sessions when they are scheduled. Because of the heavy work load and the very large list of registered applicants, you will not be contacted by the agency until your application may be accepted for further processing or to be notified of the Rap Sessions or PACO Chats.

INTEREST REGISTRATION FORM

Name: (Please Print) _____ Date: _____

Street Address: _____ Phone & Area Code: _____

City: _____ County: _____ State: _____ Zip: _____

We are interested in the adoption of children with special needs as indicated below. Please be aware of this interest and notify us when you can process our application or help us in any other way.

1. Number of children we would like to adopt now: _____

2. Ages or age range we are interested in: _____

3. We feel we could adopt the following special needs children:

- Children of Black parentage
 Older Caucasian (white) children (age 7 to 18)
 Mexican-American children (older than 5 years)
 Family group - more than one child
 Children of mixed Black-White parentage
 Native American children
 Caucasian children (age 0 to 7 or 8) with limitations
 Intercountry children (as available)

Physical, Mental and Emotional Limitations:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Heart defect | <input type="checkbox"/> Brain damage |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Missing arm or leg |
| <input type="checkbox"/> Speech impairment | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Sight loss |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Hydrocephalus |

 Other disability (please specify):

* Other types of special needs we could accept: _____

Our family currently consists of: Man (age) _____ Woman (age) _____

Children (list age and sex) _____

Other members of immediate family: _____

- Adoption study group sessions are generally scheduled in the evening. If you could not possibly attend evening sessions, please check here.
 I am unmarried and would like to adopt.
 If you are Black, kindly indicate this, since there is such a need for Black homes.

T-LSA encourages your registration with other agencies wherever possible. For those interested in Intercountry Adoption, it is necessary to register with resource programs. (A listing will be sent upon request). If you are registered with another agency, please identify that agency. _____

Signatures of applicants: _____

Please return to the designated area office: _____ York _____ Williamsport _____ Altoona

Note: Your registration may be changed at any time by notifying this office.

* Use reverse side for additional comments.

ADOPTION SERVICES UNIT
Division of Family and Child Services
Tressler-Lutheran Service Associates

APPLICATION FORM

1. IDENTIFICATION

Last name of applicant: _____ Date _____

Address: _____ / _____ / _____ / _____ / _____
Street City County State Zip

Telephone: (Area Code & Number) _____

MALE

FEMALE

First, Middle & Maiden Name	_____	_____
Birthdate/Birthplace	_____	_____
Education:	_____	_____
Religious Denomination:	_____	_____
Name of Clergyman:	_____	_____
Address of Clergyman:	_____	_____

2. EMPLOYMENT

Occupation:	_____	_____
Present Employer:	_____	_____
How long with this employer?	_____	_____
Approximate yearly salary:	_____	_____

3. MARITAL STATUS

Married (), Never Married (), Divorced (), Widowed ()

Date & Place of Marriage: _____

Previous Marriage? (Dates & names of previous spouse, how and when terminated and, if divorced, who initiated) _____

4. FAMILY STATUS:

<u>Names of Children</u>	<u>Birthdates</u>	<u>"Homemade" or Adopted</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Names of others in home</u>	<u>Ages</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____

5. Have you ever had any professional counseling for an emotional problem?
_____ If so, please explain. _____

6. Have you ever been convicted of any charge other than a minor traffic violation? _____ If so, please explain: _____

7. Have you ever made application for adoption to another agency? _____
If so, please indicate: Name of agency, location, results of your contact.

Is that application still active? _____

8. Have you previously applied for adoption through this agency? _____
If so, please indicate: when, location agency office, results of that application.

9. Your attorney for the adoption procedure (It is not necessary to select an attorney until after a child is placed in your home).

Name: _____
Address: _____ Zip: _____
Telephone: _____

10. Your physicians (or physicians)

Name: _____
Address: _____
Telephone: _____

11. References (List three references, not related to you, who have known you for at least several years)

<u>NAMES</u>	<u>ADDRESSES</u>	<u>PHONE NO.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. Reason for adoption (Please state briefly your reasons for wanting to adopt child.) _____

If you are unable to have children born to you, are there medical reasons?
_____. Have you been given a medical opinion on this? _____ By whom?
_____ When? _____ What was the diagnosis? _____

13. Child desired to adopt (Please specify the type of child you are desiring to adopt at this time: age; number of children; ethnic background; handicaps; etc.) _____

14. How long have you lived at your present address? _____
Previous Addresses (List previous addresses if you have resided at your present address for less than five years)

ADDRESSES

DATES

_____	From: _____	To: _____
_____	From: _____	To: _____

15. Directions for reaching your home (Clearly describe the easiest way to reach your home by car from the office where your application is being processed) _____

Signature of applicants: _____

Note:

Information contained in this application is held in confidence by the agency. Kindly return this application to the agency representative noted below:

() Mrs. Barbara Tremitiere
Adoption Services Unit
Tressler-Lutheran Service Assoc.
25 W. Springettsbury Ave.
York, Pennsylvania 17403

() Miss Lois Eckels
Adoption Services Unit
Tressler-Lutheran Service Assoc.
221 W. Fourth St.
Williamsport, Pennsylvania 17701

() Ms. Winnie Goings
Lutheran Children & Family Service
2900 Queen Lane
Philadelphia, Pennsylvania 19129

TRESSLER-LUTHERAN SERVICE ASSOCIATES

For Work With Older Children in Placement

"Sharing Sheet"

CHILD'S NAME: _____

DATE: _____

FAMILY NAME: _____

GENERAL ADJUSTMENT: (Give examples)

SCHOOL ADJUSTMENT: (Give examples)

ADJUSTMENT TO FAMILY MEMBERS:

AREAS OF SUCCESS:

AREAS THAT NEED IMPROVEMENT:

FEELINGS OF ADOPTIVE PARENTS:

AREAS WHERE EITHER CHILD OR ADOPTIVE PARENT NEED PROFESSIONAL HELP:

PLEASE CONTACT US BEFORE NEXT REPORT IS DUE: YES _____ NO _____

EXHIBIT D (cont.)SESSION VI

CONTENT: PET - PROBLEM SOLVING FAMILY COUNCIL - also INDIAN FAMILY FANTASY

ENCLOSURE: (For use later) Sharing Sheets

OBJECTIVES:

To summarize PET and see how it all fits together.

To help people "feel as an adopted child might feel and work through those feelings.

To evaluate, and set up future contact through PACO and T-LSA.

After Placement

- "Sharing Sheets"
- Supervisory Visits
- Staff Counseling and Support
- Referral to Other Resources
- Preventive and Crisis Therapy
- Special Interest Groups
- "Listening Ear"
- "PACO Chat"

T-LSA views adoption services as a continuum - from inquiry through and beyond the formal adoption process - for as long as a family may need identifiable service.

"How can we say we've done our share,

When everywhere we look, the children are there!"

BTT



A NEWSLETTER FOR ADOPTIVE FAMILIES

SEPTEMBER - OCTOBER 1978

Finally, all the kids are back in school....time to take a breather from a hectic summer! Placements continue to happen at a rapid rate. We are so thankful to all of you, our adoptive families, for opening your homes and hearts so readily to these little ones!

Placements:

From our Williamsport Office:

The Lynn family of Northumberland County received their bi-racial daughter. She joins her 7-year-old Vietnamese brother and 10-year-old biological brother.

The Foster family of Clearfield County recently received their 3-month-old Caucasian Downs Syndrome son. He joins his 9-year-old Canadian Indian sister, his 2-year-old Downs Syndrome brother and his 6-year-old biological brother.

The Anderson family of Lycoming County received their 9-year-old Caucasian daughter. She and her 5 sisters will sure keep their Mom and Dad busy!

The Williams family of Lycoming County received their 8-year-old Caucasian son.

The Bryan family of Lycoming County received their infant son. Mr. Bryan is busy decorating and making rugs for the nursery.

The Sorens family of Bucks County received their 14-month-old son from India.

The Evans family of Lycoming County received their 14-month-old son from India. Both boys (Sorens and Evans) were thought to have heart problems, but upon arrival it was good news to learn that both boys only have heart murmurs.

The Bilger family of Snyder County received their 3-year-old Caucasian daughter. She joins her 3 siblings including a Vietnamese brother, Song.



Parents of Adopted Children Organization

A COMMUNITY SERVICE OF TRESSLER LUTHERAN SERVICE ASSOCIATES

ADOPTION WEEK 1978 IS THANKSGIVING WEEK!!!! While we all "meditate" on the year gone by, and all the children who now have homes, let us also think ahead to 1979. If each of our families, through news media, personal contact, etc., could help one waiting child to find a home in 1979, what a wonderful year it would be! (Let's put special concentration on the teens, the handicapped, and the BOYS!)

Nov. 20 - PACO members on Lou Doolittle Show, WSBA-TV, York, 1:00-1:30

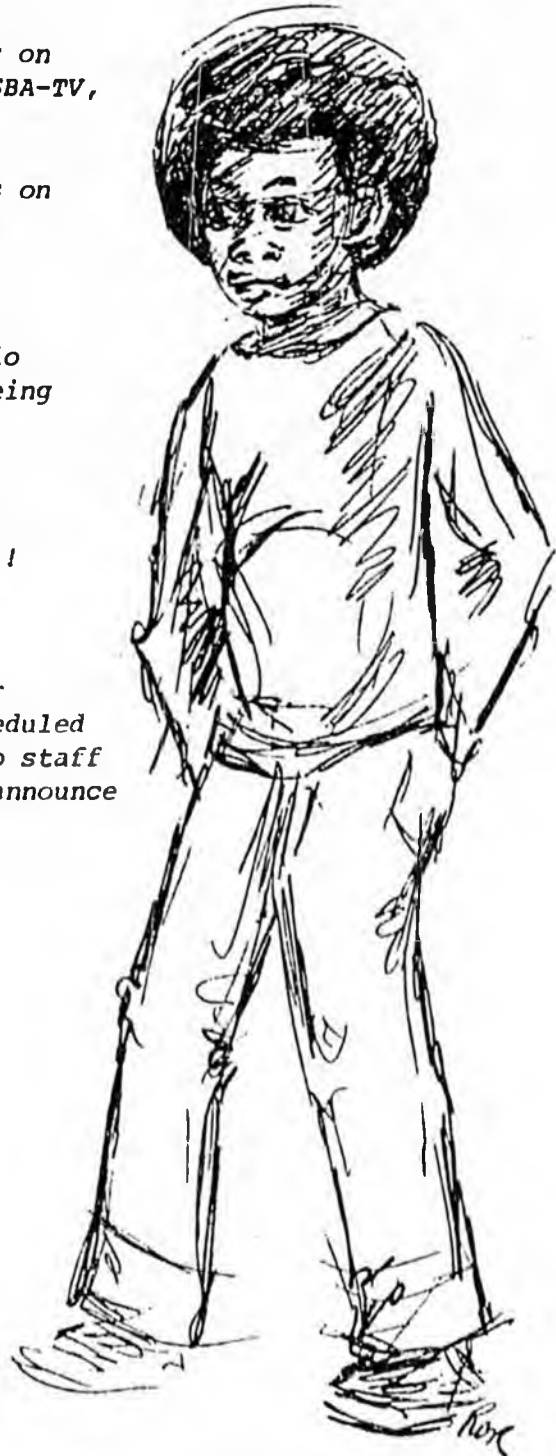
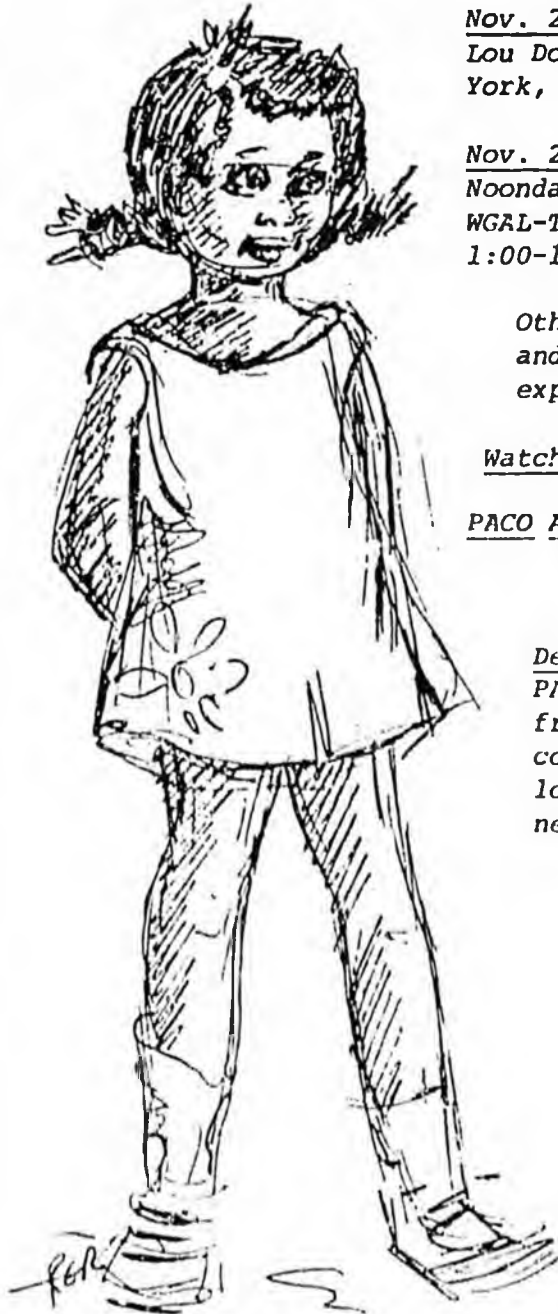
Nov. 21 - PACO members on Noonday On Eight Show, WGAL-TV, Lancaster, 1:00-1:30

Other possible Radio and TV spots are being explored!

Watch and Listen for

PACO ADOPTION WEEK!!!!

Dec. 5 - Lancaster PACO Chat (Re-scheduled from Oct. 3 due to staff conflicts) Will announce location in next newsletter.



Feb. 1979

PACO VALENTINE PARTY !!

A special super event for the whole family, to be held for the second year at the York YWCA. We will have the swimming pool, etc. for a great party! Mark your calendar now! Details coming soon!

Mar. 24, 1979

PACO DANCE !!!!

This annual event will be held in March instead of May this year so more of you will be able to attend! Mark your calendar now...details coming soon!

PACO Board of York, the Parent Group of all of our PACO chapters, shares the following important announcement:

Anyone wishing to serve on the PACO Board of Directors and anyone wishing to nominate anyone on the PACO Board of Directors (individual or couples) should submit their name to:

PACO
Tressler-Lutheran Service Associates
25 West Springettsbury Ave.
York, PA 17403

as soon as possible. The ballots will be going out in November to all PACO members to vote on board members according to our by-laws for the next two-year term. Duties will start January 1, 1979.

One-half of the Board will be elected every year. This way we will have experienced people working with those who do not have experience.

PACO Board President - Ron Lentz

By-laws are now being sent out to all of our PACO Presidents, and will be run for all of you in our next PACO newsletter. We want to thank the present PACO Board, who, under the leadership of the Wileys and the Lentzes, finally got us some by-laws! It has been a long, hard pull!

CHILDREN OF THE MONTH:

Jimmy is one year old. He is a hydrocephalic child who spent his first four months in the hospital with a shunt. He has none now. Jimmy comes from a family with superior intelligence. He is a "risk" child, as his intelligence is unknown. Subsidy is possible. Jimmy is Caucasian. Would he fit into your home?

Tommy, also Caucasian, is 6. He is considered to be a disturbed child, although he is not a problem in school. His intelligence is at least average, and he is described as a "beautiful child". Problems include a high sexual awareness, possible exploration with other children, and "urinating anywhere". Could your family help and include him?

Sandy, Caucasian, age 12, is an attractive girl with mild CP. She also has had to have some plastic surgery and orthodontic work done. She prefers men to women, and is able to manipulate adults. Does your family have the strengths to meet her challenges? She needs a home very soon.

Todd and Tim, Caucasian brothers, aged 12 and 13, are behind in school due to frequent moves and early deprivation. It is thought that they are of average intelligence. They have some behavior difficulties, but nothing major. These beautiful, blonde boys badly need a family - before Christmas, they hope.

If you are interested, let me know! Barb Tremitiere
(717-845-9113)

AREA GROUP NEWS:

York Area: Many thanks to all who helped so much with our great PACO Fair. Special thanks to the Hambergers and Johnsons who put in so many hours of organizational work!

WE WAIT TOO !!!

February Issue 1979

In the midst of winter, snow, etc., let's give some thought to more of the children who wait.

Sandy, a Black child born in 1975, is a beautiful child with an outgoing personality. Could she fit into your home?

Jessie, Caucasian girl born in 1966, has had too many placements for any young girl. Could you help her to grow up and achieve her full potential?

Debbie, Caucasian, born in 1962. Paralyzed from waist down due to abuse or fall, but gets around with braces and crutches and can care for herself. Wants so much to have a family of her own. A beautiful girl.

Warren (born 1969) and Wade (born 1967) are brothers, Caucasian, who need a loving home with a family who will "hang in there" with them. Is it yours? These boys are in Canada.

John Jairo, in South America, was born 9/76. He has had some problem areas, but it is felt that he is doing well now.
Cost - about \$2000.

We also have several more children from South America, aged 3 - 10 on referral. Most have some physical problems. Cost about \$2000 per child.

We have some Korean children available also, including siblings (girl 12, boy 10), and a five-year-old boy with a slight hunch-back due to the after-effects of having had TB of the spine. Cost is about \$1600 per child.

Looks like we will also be getting some children on referral from India. They will be young with some medical problems. Cost will be about \$2000.

Let us know of your interest in any of the above, and we will send more information.

So much to do; so many to place; so short a time before they grow up! If you want to be a part of their growing-up years, let us know!



Tressler-Lutheran Service Associates

York Office
Barb Tremitiere (717) 845-9113

Williamsport Office
Lois Eckels (717) 322-7873

EXHIBIT G**SPAULDING
FOR CHILDREN**

P.O. Box 337 • Phone: 714.475.2500 • Chester, Mo. 63018

February 10, 1978

Ms. Barbara Tremitiere
Tressler -- Lutheran Service Association
25 W. Springettsburg Ave.
York, PA 17403

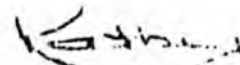
Dear Barb,

I just finished reading your newsletter and want to thank you for sending it along.

Also, I would like to extend my personal thanks to you for the workshop in Ann Arbor. It was a most enlightening and stimulating experience. You are doing a remarkable job and you had a most positive influence on us.

Keep up the good work.

Sincerely,



Kathleen M. Cavannah
Director of Agency Development

KMC:kp



ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1717 WEST JEFFERSON • PHOENIX, ARIZONA • P.O. BOX 6123 85005

Bruce E. Babbitt
GOVERNORE.D. CROWLEY
ACTING DIRECTOR

May 15, 1978

Mr. William Tremitiere
Program Director
Tressler-Lutheran Services Association
25 West Springeptsbury Street
York, Pennsylvania 17403

Dear Bill:

Thank you for taking time from your busy schedule to participate in the Adopt Co-op/DES Conference on Adoption. Those who attended your sessions found them stimulating and thought-provoking. As we have active adoptive parents' organizations in Tucson and Phoenix; which have not been utilized by the public, I am hoping that your workshop will provide the impetus for these groups to be better utilized. I am also hopeful that the Bureau of Social Services will be able to secure funds to bring you and Barbara back to Arizona for more training in adoption, as training in this area is greatly needed.

I enjoyed the opportunity to get to know you and hear about the many creative approaches your agency has taken.

Sincerely,

A handwritten signature in cursive script, appearing to read "Anna".

Ms. Anna Arnold, M.S.W.
Special Assistant
to the Director

EXHIBIT G (cont.)

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF SOCIAL WORK
UNIVERSITY PARK
LOS ANGELES, CALIFORNIA 90007

April 17, 1978

Mr. William Tremitiere
Tressler-Lutheran Assoc., Inc.
York, Pennsylvania 17403

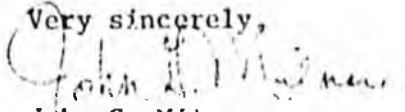
Dear Mr. Tremitiere:

Carol Williams and I wish to express our thanks to you for the excellent presentation you made to our North American Adoption Seminar members. Our group members continued their discussion of your program on the days that followed your being here and all agreed that you had contributed many new ideas and methods of practice. They too asked to have their appreciation expressed to you.

Payment from our university is somewhat slow and we regret this. The necessary request for payment has been sent to our payroll department.

I shall look forward to seeing you at the Arizona meeting.

Very sincerely,


John G. Milner
Project Director

JGM:ed

10 June 1981

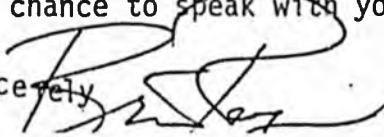
Dear Dr. Worrall,

Thank you for your letter of June 4th regarding lay midwives and House Bill 11.

My purpose in introducing this bill is simply to allow patients the ability to know more about the person or persons whom they choose as a birth attendant. I do not intend to limit in any way the right of a patient to choose their health care provider. Many states allow the practice of licensed lay-midwives and statistics show that even home births, when attended by a trained midwife (not necessarily a nurse) compare favorably with hospital births. Because of this, many doctors are willing to work with lay midwives and are supportive of this bill.

In any case, I appreciate your comments and hope to have the chance to speak with you about this bill in the future.

Sincerely,

A handwritten signature in dark ink, appearing to be 'P. S. Worrall', written over the word 'Sincerely'.

Fairbanks Clinic

1867 Airport Road • P.O. Box 1330 • Fairbanks, Alaska 99707 • (907) 452-1761

June 4, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers,

This is a word against lay midwives and Sponsor Substitute House Bill #11.

I am 56 years old, a physician, a certified and recertified obstetrician-gynecologist, a fellow of the American College of Surgeons, etc., etc. I have been practicing obstetrics-gynecology in Fairbanks since 1966. I no longer do much obstetrics.

Lay midwives (please do not use the term midwife without the qualifying words "lay" or "nurse". In qualifications they are worlds apart) do not have sufficient training to deliver babies, and the State of Alaska should not suggest they are qualified by recognizing them. The law should prohibit lay midwifery for a fee or remuneration of any kind.

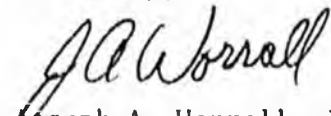
Practicing obstetrics is like flying an airplane. Things can go wrong at anytime, and when things go wrong, you want the best available talent at the controls to prevent disaster if at all possible. I have been out of medical school for 33 years, and I firmly believe this about delivering babies: To have a baby at home or in the bush is foolhardy and a form of child abuse.

Physicians will not cooperate with lay midwives, and patients who through ignorance go to a lay midwife will receive substandard care and will be at risk of unnecessary complications.

If you wish to promote nurse midwifery, this is a different matter, and I endorse encouragement of nurse midwifery in the State of Alaska.

You should beware of people who tell you that "obstetricians are not trained to handle normal birth". This is nonsense.

Sincerely,



Joseph A. Worrall, Jr., M.D.
Obstetrician/Gynecologist

JAW:jme



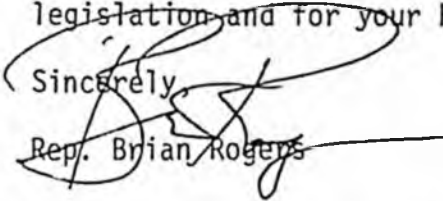
9 June 1981

Dear Dr. Brown,

Thank you very much for the information you sent regarding the practice of lay midwifery and information regarding home births in North Carolina. What you suggest is, indeed, a reasonable compromise and I hope to incorporate many of these ideas in House Bill 11 when we continue work on it next year. The bill is currently in the House Finance Committee where it will stay until we convene in 1982. I will be in contact with you again as soon as there is new information to pass on.

Thank you for your continuing attention to this legislation and for your help.

Sincerely,


Rep. Brian Rogers

Women and Children's Health Associates



Box 2101 Palmer, Alaska 99645

Wasilla Phone: (907) 376-3237

Palmer Phone: (907) 745-4711

OBSTETRICS / GYNECOLOGY

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June 4, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

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Receptionist

Dear Representative Rogers:

As a follow-up to my recent letter of May 26, 1981, I have attached a recent article which reviews some important work done on the home birth movement and neonatal mortality in North Carolina. The full text of the article in the Journal of the American Medical Association may be one which you might wish to review.

Most sincerely,

Carolyn V. Brown, M.D.

cVB/dd

Home Birth and Neonatal Mortality

A basic difficulty in assessing the safety of out-of-hospital compared with in-hospital births is that summary reports of state vital statistics seldom give details regarding the circumstances. Planned and attended home births are combined with those for which little or no care was provided, along with sudden births that occurred at home or en route to the hospital. Fetal and neonatal deaths are also reported using the same two general categories.

In a recent report in *JAMA*, *The Journal of the American Medical Association*, Dr. Claude A. Burnett and other researchers in North Carolina and Georgia point out that this summary information "has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery." With the growing interest in home births, however, "the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them."

Shift to Hospital Delivery

In 1940, they note, 76 percent of infants were born at home in North Carolina; the proportion had fallen to less than 1 percent as of 1975. "With this shift to hospital delivery, maternal mortality fell from 50 per 10,000 live births in 1940 to 3 per 10,000 live births in 1975, a decline of 94 percent. Neonatal mortality also declined 61 percent, from 33 per 1,000 live births in 1940 to 13 per 1,000 live births in 1975. Neonatal mortality remained more than 40 times that of maternal mortality in 1975, despite nearly universal hospitalization for childbirth."

Against this background of declining mortality, "Most of the medical profession advocates hospital delivery and views home delivery as a regressive step that would reverse the historical improvement in the safety of childbirth." At the same time, "an increasing number of women prefer delivery at home in order to be among familiar people and surroundings, to avoid the perceived risks of highly technical medical care, and to reduce cost."

In evaluating risk associated with the place and circumstances of birth, the authors used data from North Carolina's vital statistics for the years 1974 through 1976. Birth records were coded as occurring in a hospital, in a clinic or office, en route to a hospital, or at home. Since infant death records are routinely linked with their birth records in the state, it was possible to determine mortality by birth characteristics.

The 1,296 home deliveries occurring in North Carolina during the study period were classified by both planning status and the attendant present. "If a home delivery was chosen and a healthy infant anticipated, it was classified as planned." For those home deliveries that resulted in neonatal death, the cases were "individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery."

— appropriate supervision.

Home Births Must be Approved

In some North Carolina counties, lay midwives legally attend home births. Their practice is regulated by county health departments; no new lay midwives have been licensed since 1964, and those still practicing are "gradually being phased out." Every home birth by a midwife must be approved in advance as low risk, and the health department must provide prenatal care involving physician-supervised screening for risk factors.

The authors assumed that all home births attended by a lay midwife were planned (since a permit is required), and that home deliveries of infants with birth weights less than 2,000 g and not attended by a lay midwife were unplanned. Unclassified home deliveries were followed up with questionnaires to county health departments, and those remaining unclassified were listed as unknown.

Planning Status Alters Statistics

Of the 1,296 births that occurred at home, 934 (72 percent) were classified as planned, 250 (19 percent) were considered unplanned or precipitate, and the remainder unknown. Of the planned home births, 768 were attended by lay midwives and 166 were classified by questionnaire as "intended" and therefore assumed to be planned. There were 36 neonatal deaths associated with home delivery; of these, six followed planned home delivery. In three of the six deaths, a trained attendant was not present; in the remaining three, attended by lay midwives, death was attributed to congenital anomalies.

Without regard to their planning status, home births were associated with a neonatal death rate of 30 per 1,000 live births. However, when subdivided by their planning status, a different picture emerged. The neonatal mortality of planned home deliveries was 6 per 1,000, while that of unplanned home deliveries was 120 per 1,000. The relative risk of

unplanned home deliveries was 20 times that of planned home deliveries." Among prenatally screened home births attended by lay midwives, the rate was 4 per 1,000.

"Hospital deliveries, including high-risk pregnancies and low-birth-weight infants, were associated with a neonatal mortality rate of 12 per 1,000 live births. After excluding infants weighing 2,000 g or less at birth, the neonatal mortality rate for hospital deliveries was 7 per 1,000 while that for lay midwife home deliveries remained 4 per 1,000. This difference was not statistically significant."

Considering maternal characteristics, the women attended by lay midwives were "more likely to be young, black, unmarried, and less educated than the average woman who delivered in the state. Despite their high-risk demographic profile, these women had a relatively low-risk medical profile. None of their infants weighed 2,000 g or less, and their neonatal mortality rate was one third that for all deliveries."

Low Risk No Guarantee

In contrast, women who gave birth without a trained attendant had a "low-risk demographic profile: 5 percent were younger than 20 years, 78 percent were white, 90 percent were married, and 48 percent were educated beyond high school." Additionally, their deliveries were at low risk with respect to infant birth weight. "Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay midwife home deliveries."

The present study, say the authors, "showed that the outcome of delivery varied importantly by both the place and circumstances of delivery. In-hospital vs out-of-hospital classification does not adequately group births by risk of neonatal mortality. Even more specific designation of the place of birth does not suffice to describe risk. Deliveries occurring at home ranged from lowest to highest risk of neonatal mortality depending on planning and the attendant present."

Thus the screening program carried out through physician-supervised prenatal care for those women who planned on home birth with a lay midwife was "apparently effective." On the other hand, planned home births without medical screening and without a trained attendant resulted in high neonatal mortality despite the low-risk demographic profile. "Adequate prenatal care and provision of care appropriate to medical risk repeatedly has been associated with lower neonatal mortality."

continued on back cover

a reasonable compromise
→

define

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HOME BIRTH AND NEONATAL MORTALITY

(continued from page 62)

As limiting factors, the authors note that the number of neonatal deaths was small; classification errors may have occurred, and births and neonatal deaths may have been underreported. Moreover, home delivery practices in North Carolina during the study period "were not necessarily representative" of those elsewhere. Home and hospital births attended by nurse-midwives were not represented, although they are "an increasing proportion of deliveries in other states." Finally, since the lay midwives were initially certified in 1964 or earlier, they had at least ten years of home birth experience at the time of the study. For all these reasons, "inferences regarding the safety of home births should await prospective controlled studies."

In conclusion, there has been a "dramatic shift" from hospital to home birth in the last 40 years in North Carolina. Nevertheless, "some women prefer or economically need an alternative to a high cost physician-hospital delivery." To extend adequate prenatal and birth services to poor women in rural areas, "economically realistic alternatives should be developed before existing traditional services are phased out." Whatever alternative program a community develops, "monitoring the quality of prenatal care, adequately identifying high-risk pregnancies, and training competent birth attendants all require the knowledge, expertise, and support of the medical community."

Source

Claude A. Burnett III, MD; James A. Jones, MPH; Judith Rooks, CNM; Chong Hwa Chen, MS; Carl W. Tyler, Jr, MD; and C. Arden Miller, MD, "Home Delivery and Neonatal Mortality in North Carolina," *JAMA*, Dec 19, 1980 (Vol 244, No 24), p 2741



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Executive Director
Earl S. Mackey

June 19, 1981

Nancy Deitrick
Senate Health & Social Services Committee
Pouch V, State Capitol
Juneau, AK 99811

Dear Ms. Deitrick,

In response to your request for information on licensing requirements for lay midwives in the states, I have enclosed a survey of state legislation pertaining to nurse-midwifery that includes some information on lay midwifery. The report, first published in 1976, has been updated to January 1980 in some areas. I also tried to contact the National Midwives Association, which should have additional information on lay midwifery, but have been unable to reach them by telephone. I will let you know about any relevant information that the Association is able to provide. Meanwhile, I hope that the enclosed survey will be useful. I also have copies of state legislation that I will be glad to send to you at your request.

If you have further questions or need additional information, please be sure to write or call. I will be happy to assist you.

Sincerely yours,

Bonnie Dolan

Senior Research Associate



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 463-3991

April 21, 1981

MEMORANDUM

TO: Representative Tony N. Vaska

FROM: Peter B. Froehlich *PF*
Issues Analyst

RE: Oregon Attorney General Opinion on Lay Midwives
Research Request 81-98

Your staff has asked us to analyze a June 17, 1977 Oregon Attorney General's opinion concerning the practice of lay midwifery. This opinion was discussed in two memoranda to you, dated March 27 and March 31, 1981, from Leslie Longenbaugh of this office. The opinion itself was forwarded to you several days later.

In summary, our analysis of the opinion indicates that it is based on Oregon statutory language which is similar to Alaska statutory and regulatory language. A strong argument can be made, therefore, that an Alaska Attorney General opinion would be likely to reach the same conclusion as does the Oregon opinion.

The Oregon opinion addresses two questions: 1) whether a person in Oregon, other than a licensed physician or nurse, can legally be a midwife and assist at a normal childbirth; and 2) if so, whether the person (lay midwife) can legally administer medicine or perform an episiotomy. The first question was answered affirmatively and the second negatively by the Oregon Attorney General's office.

Permissibility of Lay Midwifery

The basis for the first answer that one could legally serve as a midwife without licensure as a physician or nurse hinges upon the explicit use of the word "midwife" in the Oregon statutes requiring the filing of birth certificates.

The Oregon statutes provide in pertinent part:

432.205 (1) a certificate of birth shall be filed with the local registrar or the registration district in which the birth occurred within the time prescribed by the division, by either the physician or midwife in attendance at the birth, or if not so attended, by one of the parents;.... (Emphasis added)

432.210 If neither of the parents of the newborn child, unattended by either physician or midwife, is able to prepare a birth certificate, the local registrar shall secure the necessary information for the preparation of a birth certificate from any person having knowledge of the birth. (Emphasis added)

A predecessor Oregon statute, adopted in 1905, also referred specifically to "midwives." The Oregon Board of Examination and Registration of Graduate Nurses was established six years later, in 1911, to license people who engage in the practice of nursing, without any mention of midwives or the functions they performed.

However, like the Alaska legislature, the Oregon legislature never defined the practice of nursing to specifically include midwifery and never required licensure of midwives. Thus, the Oregon opinion concludes that the Oregon legislature has recognized "midwifery as an occupation distinct from nursing" for which there has never been a licensing requirement imposed.

The Alaska statutes concerning birth certificates provide in part:

Section 18.50.160 Birth Registration...

(c) When a birth occurs outside an institution, the certificate shall be prepared and filed by one of the following in the indicated order of priority:

- (1) the physician in attendance at or immediately after the birth; or in his absence;
- (2) a person in attendance at or immediately after the birth; or in his absence;....

Section 18.50.240 Fetal Death Registration...

(b) The funeral director or person acting as the funeral director who first assumes custody of a fetus shall file the fetal death certificate. In his absence, the physician or other person in attendance at or after the delivery shall file the certificate of fetal death....

Although the word "midwife" is not currently used in either of these sections, nor indeed, in any other Alaska statute, the word is used in a 1960 regulation, 7AAC 05.370, adopted under AS 18.50.150.

7AAC 05.370 PERSON RESPONSIBLE FOR FILING... When a birth occurs outside an institution, the following shall be the order of responsibility for preparing and filing the certificate:

- (1) physician in attendance;
- (2) nurse in attendance;
- (3) sub-registrar of village, if any;
- (4) midwife or any other person in attendance (Emphasis added)

The broad language of the statutes (i.e., "person in attendance at the birth,") and the specific use of the word "midwife" in the regulations indicate that the practice of midwifery is recognized and permitted in Alaska, as in Oregon, as an occupation distinct from nursing. Likewise, just as in Oregon, there is no Alaska requirement that midwives be licensed. Furthermore, the word "midwife" was used in the Alaska statute requiring birth certificates from its first enactment in 1917 (§2 ch 35 SLA 1913) until it was rewritten more broadly in 1960 (§13 ch 18 SLA 1960) to include anyone attending a birth, and not only midwives. The Alaska Nurses Examining Board was not established until 1941 (ch 46 SLA 1941), and the practice of nursing was not defined until 1949 (§1 ch 28 SLA 1941). Neither enactment and none of the several subsequent amendments to the nurse licensing statutes has prohibited or mentioned midwifery directly or indirectly.

Scope of Lay Midwifery

The second part of the Oregon opinion concluded that lay midwives could not legally administer medication or perform episiotomies. This result was based on Oregon statutes and Attorney Generals' opinions which define the practice of medicine and of nursing to include performing surgery and administering medication respectively.

Alaska statutes clearly also include performing surgery such as episiotomies within the definition of the practice of medicine (AS 8.64.3802(e)) and therefore, a license to practice medicine is required by AS 08.64.170(a). Performing surgery has been included in the statutory definition of the "practice of medicine" since the first Alaska Medical board was created in 1917 (§14 ch 8 SLA 1917).

The Alaska definition of the "practice of professional nursing" includes:

...the administration of medications and treatments prescribed by a licensed physician or dentist which require substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science....
(Emphasis added) AS 8.68.410(5)

Thus, some medications can be legally administered only by licensed nurses, while other medications can be administered by anyone, including a lay midwife. Under the Alaska Administrative code, the

Representative Vaska
April 21, 1981
Page 4

prescription eyedrops which prevent infant blindness due to maternal gonorrhea, must be placed in the eyes of newborn infants by a "physician, nurse, or certified (nurse) midwife." (7AAC 27.111) It is not perfectly clear that the eyedrops are medication that requires the type of "substantial specialized judgment" which, under AS 8.68.410(5) would mean they must be administered by a licensed nurse (or physician). Nonetheless, the Department of Health and Social Services eliminated in 1980 any remnant of doubt by adopting 7AAC 27.111 which requires in no uncertain terms that the drops be administered by a doctor or nurse. Therefore, anyone other than a physician or dentist who administers these eyedrops or any other prescribed medication which requires "substantial specialized judgment and skill" must be licensed as a nurse under AS 8.68.160.

In conclusion, Alaska law is very similar to Oregon law on this subject, and we believe that an Alaska Attorney General opinion would probably reach a result very similar to that of the Oregon opinion. Informal discussion with an Assistant Alaska Attorney General further confirms this supposition.

Please contact us if we can provide any further information or assistance. You may also wish to contact the Legal Services Division of the Legislative Affairs Agency concerning this subject.

PF/bf

STATE HEALTH NOTES

As the debate over the efficacy of traditional birthing practices continues, the midwifery movement appears to be gaining momentum in a number of legislatures. A new bill in **WASHINGTON** State (SHB 316), which has already passed the Senate, may serve as the model for the nation. SHB 316 updates Washington's 1917 licensure act regulating the practice of midwifery. It includes *midwife* in the definition of a health care provider, and creates a midwifery advisory committee consisting of one obstetrician, one physician, one certified nurse-midwife, three licensed midwives, and one public member. In addition, SHB 316 specifies the qualifications candidates must meet in order to take the licensure examination. These include: a minimum of three years of midwifery training, unless the candidate meets certain requirements; education in obstetrics, neonatal pediatrics, basic sciences and other specified subjects; observing fifty women in each of the prenatal, intrapartum and postpartum

periods; and observing an additional fifty women in the intrapartum period.

The Health Policy Analysis Program at the University of Washington, Seattle, has published an extensive monograph on the state-of-the art of midwifery, nationwide and worldwide, covering such areas as the scope of the practice, education and training, credentialing, the question of independence, and other related issues and policy questions. The monograph's title is *Midwifery Outside of the Nursing Profession: The Current Debate in Washington*, (\$6.00, 156 pp) and it may be obtained by calling (206) 543-3522.

Other states are also examining the midwifery option. **UTAH**'s legislature, for example, passed a resolution to establish a study commission for a lay midwife program (SCR 8). A bill in the **NEW HAMPSHIRE** Legislature (HB 319) would establish an advisory committee to regulate lay midwives. **ARIZONA**'s SB 1336 would set procedures and requirements for the licensure of midwives.

Midwifery

While experts continue to argue over whether a nurse shortage actually exists, many states are convinced of its existence and are proposing a variety of legislative remedies. **NEW YORK**, for example, is considering legislation that would provide 600 additional scholarships annually for basic professional nursing education (A2220). **KANSAS** is considering legislation (SB 247) that would provide state financing of professional nursing education in public or private nonprofit hospital schools of nursing. Under this bill, each facility would receive up to \$1,000 for each nursing student in the second or third year of

a three-year program.

The **ARKANSAS** General Assembly has passed legislation (Act 54, SB 100) which authorizes the Board of Nursing to waive the educational requirements for licensure for practical nurse or psychiatric technician nurse, if the board determines the applicant is otherwise qualified. **MARYLAND**'s HD 1349 would establish a scholarship program for retaining nurses in that state.

In a related issue, **TEXAS** (SB 532), **MASSACHUSETTS** (H 3444) and **MINNESOTA** (SF 688) are considering legislation that would provide for the registration of temporary nursing pools. **MINNESOTA**'s

Nursing Legislation

SF 688 requires nursing pool agencies to register with the Commissioner of Health. Further, the commissioner would establish minimum standards for the registration and operation of tem-

porary nursing pools. A WISCONSIN bill (AB 16) would require the Department of Health and Social Services to set maximum rates nursing pools may charge for services reimbursable under Medicaid.

Abortion Legislation Increases

Restrictions on abortions have become a focus of legislative activity in a number of states. Many of the legislative proposals, while aimed at restricting or prohibiting abortions, make exceptions in instances where the life of the mother is in danger or in cases of rape, incest or fetal abnormality.

Several states, including OKLAHOMA, RHODE ISLAND and ILLINOIS, have introduced legislation that would make coverage for abortions available only as an optional rider to health insurance contracts, plans and policies. NEBRASKA has introduced a resolution (LR 27) to require that abortion coverage be an optional benefit under the state employee group health insurance plan, with coverage to be financed entirely by the employee.

The NEBRASKA legislature adopted an emergency act (A 125) which prohibits group insurance policies or HMOs paid for in part by public funds from including coverage of abortions. The act does not prohibit the insurer from providing special coverage for abortions so long as the costs are borne solely by the employee. IOWA is considering an approach (HF 650) similar to Nebraska's.

Other states, such as NEW YORK (AB 2162), ALABAMA (S 522) and MICHIGAN (HB 4179, SB 18), are considering legislation to eliminate coverage of abortions under their Medicaid programs. TEXAS and OKLAHOMA are debating bills (HB 1194 and HB 1257, respectively) which would restrict all public funds from paying for abortions.

Several recent court decisions have had a significant impact on the abortion issue. The MASSACHUSETTS Supreme Court, for example, ruled that the state must pay for all *medically necessary* abortions for welfare recipients. CALIFORNIA's Supreme Court went beyond the Massachusetts decision and ruled that the state must pay for abortions of welfare recipients if the state chooses to pay for the medical care of women desiring children.

The U.S. Supreme Court upheld INDIANA's law requiring that abortions in the second trimester of pregnancy be performed by physicians in hospitals. A few weeks earlier the Supreme Court declared state laws requiring parental consent for an abortion for an unmarried minor to be constitutional. In a similar action, the MASSACHUSETTS Supreme Court recently upheld a 1980 statute requiring parental consent for an abortion. While the statute requires the consent of both parents in the case of an unmarried minor, it does provide that if one or both parents do not consent, or if the minor refuses to seek her parents' consent, she can appeal to the supreme court of the state for a private hearing. The judge can approve an abortion on a finding that the minor is mature or that the abortion is in her best interest. Several states, including OHIO (H 92), VERMONT (S-123) and MINNESOTA (HF 399) have introduced legislation requiring parental approval before an abortion can be performed on an unmarried minor.

Protective Services for the Elderly

A number of states are debating potential solutions to the growing problem of elderly abuse. WEST VIRGINIA, for example, has introduced legislation that would provide protection for elderly persons, age 60 and older. SB 121 would require doctors, police officers, etc., to report to the State Department of Welfare suspected cases of abuse, neglect, exploitation, abandonment or cases in which elderly persons are in need of protective services. The department would subsequently be required to investigate the matter and when necessary,

with the consent of the elderly person or his conservator, to provide whatever protective services the person may need. The Commissioner of Welfare would be given broad general authority to take all actions necessary to protect the health, safety and welfare of an elderly person unable to care for himself.

The MASSACHUSETTS Legislature is considering similar legislation (H 4112, S 640). Under these bills, all suspected cases of abuse and all deaths which result from abuse must be reported to the Department of Elder Affairs. Any death

which occurred as a result of abuse or neglect must also be reported to the district attorney. In addition, the department would be required to conduct an assessment and evaluation, and develop a service plan which may include such services as: 1) homemaker; 2) transportation; 3) legal assistance; 4) counseling; 5) emergency housing; and 6) emergency financial assistance.

A new statute in **WYOMING** establishes an Adult Protective Services program (Chapter 155, Laws of 1981, HB 49-A). Under this law, the Department of Health and Social Services (Division of Public Assistance and Social Services) is required to coordinate a protective services program to ensure that all disabled persons, age 16 and older, will have easy access to these services. In addition, the department is required to adopt regula-

tions necessary to implement the program, as well as develop and maintain a statistical data system by type of referral and disposition.

Reports of crime and victimization of elderly persons have spurred **RHODE ISLAND** to consider legislation (H 5089) that requires housing authorities to provide 24-hour security guards to protect all older persons who reside in housing projects for the elderly.

To protect the rights of elderly persons in nursing homes, **MASSACHUSETTS** is debating legislation that would establish a nursing home ombudsman unit in the Department of Elder Affairs (H 617, H 3448). Under this proposal, the ombudsman would receive and investigate complaints against nursing homes and any agency that is responsible for regulating nursing home care.

States continue to demonstrate an interest in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). **NORTH DAKOTA** alone has introduced seven bills in this area. HB 1049, for example, would establish and appropriate funds for a revolving loan fund for the construction and renovation of ICFs/MR, while HCR 300 would direct the North Dakota Social Services Board to cover ICFs/MR services under Medicaid.

At least 25 states have introduced legislation this year aimed at regulating the sale of supplemental Medicare health insurance policies. Most of these so-called *Medigap* bills extend authority to the insurance commissioner in each state to issue new rules and regulations on minimum standards for policies and benefits, loss ratios, disclosure requirements, etc. **INDIANA**, for example, has passed legislation (HB 1878) which authorizes the insurance department to adopt rules to simplify terms and coverage of Medicare supplement policies. At least 15 bills introduced in legislatures across the country cite PL 96-265, which includes the Baucus Amendment, as one reason for the new

In **MAINE**, LD 299 would allow nonambulatory persons certified as being capable of following directions the option of residing in small normalized boarding care facilities without requiring these facilities to meet the requirements of the Institutional Occupancy Section of Maine's Life Safety Code.

A new study examining the experience of ICFs/MR throughout the country is available by calling or writing IHPP (\$5.00).

ICFs/MR

legislation, and indicate the intention to bring the state into compliance with the federal law. The Baucus Amendment establishes, among other things, a voluntary certification program for Medicare supplementary policies effective July 1, 1982. States with an approved Medigap program in place by the 1982 deadline will be unaffected by the federal statute.

Because of the large amount of legislative and regulatory activity over the past two years surrounding this issue, preliminary figures indicate that a solid majority of states should be in compliance with Baucus by next year's deadline. The IHPP will be compiling an up-to-date summary of all state activities in this area within the next two months.

Medigap Activity Continues

IHPP has completed a 50-state survey of Medicaid cost-containment proposals. The survey lists, state by state, all legislative and executive proposals which would affect services, eligibility and

reimbursement, as well as strategies for improving the administration and management of the program. The survey is current through May 1, 1981. Copies can be obtained by sending \$2.00 to IHPP.

Medicaid Survey

State Health Highlights

- A new statute in **ARKANSAS** (Act 380, laws 1981) directs all state agencies which administer funds for long-term care services to develop a coordinated and accessible network of long-term care and related community-based services by utilizing an interagency referral system.

- A new bill in the General Assembly of **NORTH CAROLINA** (HB 405) would direct the Secretary of the Department of Human Resources to consolidate all programs and services that serve the elderly into one unified program, emphasizing in-home care whenever possible. In addition, the bill would direct the Secretary to expand the Medicaid nursing home preadmission screening program.

- The **MINNESOTA** Legislature is considering a bill that would provide for a statewide program of subsidies to families who agree to provide home care and training to their minor dependants who are mentally retarded (HF 314, SF 408).

- **ALABAMA's** Legislature has directed the state Medicaid agency to exempt children, including newborns, who have had an EPSDT screening, from the state's 20-day annual limit on hospital days (Act 86, Laws 1981).

- A new report, *Better Health for Our Children: A National Strategy*, contains over 100 recommendations for improving the organization and financing of maternal and child health services. To obtain the four-volume report contact: Mimi Simms, Office of Maternal and Child Health, Public Health Service, (301) 443-2170.

- A bill now in the **WASHINGTON** Legislature legalizes the use of the drug DMSO (dimethyl sulfoxide). DMSO has not been approved by the federal Food and Drug Administration except for

bladder infections. There are claims, however, that it may provide relief from arthritis and a variety of other ailments. **WASHINGTON's** HB 88 authorizes licensed practitioners to prescribe DMSO to a state resident, and authorizes licensed pharmacists to dispense DMSO with a prescription. In addition, the bill makes it lawful for DMSO to be manufactured in the state of Washington by licensed pharmacists.

- A new statute in **MAINE** (LD 914, chapter 271) creates an Environmental Health Program within the Department of Human Services, Bureau of Health. The program is authorized to develop and monitor the health of Maine's citizens, identify significant problems, particularly those related to environmental factors, and conduct and contract for investigations to ascertain whether or not particular problems are related to environmental factors.

- The **FLORIDA** House adopted a bill (HB 90) prohibiting disability insurance carriers from discriminating against persons exposed to DES.

- According to a recent study released by the **GEORGIA** Department of Human Resources, 30 percent of the mentally retarded residents in Georgia's institutions could be better served in a community setting. A lack of statewide residential services was cited as a major obstacle in moving these persons into community residences. Furthermore, the study, Project P.R.O. (Preparing for Residential Options), identified 1,212 mentally retarded individuals now living in the community who are in critical need of other residences. The study recommends placing both groups of persons in a variety of residential settings over a three-year period -- costing the state about \$4 million for the first year and about \$3.7 million for the second and third years.

STATE
HEALTH
NOTES



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UTAH STATE SENATE

SOPHIA C. BUCKMILLER
SECRETARY OF THE SENATE

317 STATE CAPITOL
SALT LAKE CITY, UTAH 84114
PHONE 328-8473, 328-5701



May 21, 1981

Ms. Nancy Deitrick
Research Analyst Health, Education &
Social Services Committee
Alaska State Legislature
Pouch V - State Capitol
Juneau, Alaska 99811

Dear Ms. Deitrick:

In compliance with your request dated May 18, 1981,
I have enclosed a copy of S.C.R. No. 8, INTERIM
STUDY OF THE LAY MIDWIFE PROGRAM, by Senators Bangerter,
Ferry and Farley.

If at any time our office can be of further help, it
will be our pleasure to respond.

Respectfully,

Sophia C. Buckmiller
Secretary, Utah State Senate

Encl:

INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

GENERAL SESSION

Enrolled Copy

S. C. R. No. 8

By Jack M. Bangerter

Miles 'Cap' Ferry

Frances Farley

A CONCURRENT RESOLUTION OF THE GENERAL SESSION OF THE 44TH LEGISLATURE OF THE STATE OF UTAH, THE GOVERNOR CONCURRING THEREIN; DIRECTING THE LEGISLATIVE MANAGEMENT COMMITTEE TO ASSIGN TO AN APPROPRIATE INTERIM STUDY COMMITTEE THE DUTY OF STUDYING THE PRACTICE OF LAY MIDWIFERY IN THE STATE OF UTAH.

Be it resolved by the Legislature of the State of Utah, the Governor concurring therein:

WHEREAS, there has been an increase in the number of lay midwives in the State of Utah;

WHEREAS, there has been an increase in the number of children delivered by midwives in the State of Utah;

WHEREAS, there has been concern about the training and certification of lay midwives;

WHEREAS, the legality of the practice of lay midwifery in the State of Utah is uncertain;

WHEREAS, the State of Utah is interested in the promotion of health care services for protection of people of the state.

NOW, THEREFORE, BE IT RESOLVED, by the General Session of the 44th Legislature of the State of Utah, the Governor concurring therein, that the Legislative Management Committee be directed to assign to the appropriate interim study committee the duty to study the practice of lay midwifery in the State of Utah.

S. C. R. No. 8

BE IT FURTHER RESOLVED, that the existing program, during the interim, be supervised by the division of registration.

INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

GENERAL SESSION

Enrolled Copy

S. C. R. No. 8

By Jack M. Bangerter

Miles 'Cap' Ferry

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INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

GENERAL SESSION

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S. C. R. No. 8

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Rock History -

No cases involving mid-wives
Only case Dr. Rovey in Sitka
found innocent in court but
negligent in licensing hearing
and therefore elected to leave
State (Wash.) rather than
go with recommended charges

11:00 - Canceled
Callista 3132

MICA 274-9232 Anchorage

Mr. Peterson (?) Home delivery care.
Attitude of Dr. Newman is that it works
well in some parts of the world w/ mobile
units and readily available physicians.

Hasn't had any cases. Controversy
over Dr. Peter Rovey in Sitka - dropped
his insurance. Not a formal underwriting
position but on basis of his being
under investigation. No legal precedent.

Nancy - Message from Charlie
① - Check ^(court building) around to find out
how many cases (if any) ^{what} have been
prosecuted in last few years
(Re: Drs. delivering at home or
midwives - etc) -

Library 3808

Dr. Racey - Dept of Law

② - call M.I.C.A. Corp.
(this is an ^{INSUR} agency set up for
doctors) - Re: any mal-practice
liabilities (if any) ^{that} were brought
up - where doctors
gave pre-natal care (x-rays)
but the woman had
a home delivery with
a mid-wife - or doctor

Nancy

Rock 3620

Jan therapy - 3428

- ① Cathleen Horwitz
2601 Kona Lane
Anchorage, AK. 99503
- ② Kathy Lettinger
16208 ~~Mar~~ Market St.
ABX, AK. 99701
- ③ Theresa Rasin
8141 Country Woods
Anchorage, AK. 99502
- ④ Al Rushing
1403 E. 27th
Anchorage AK. 99504
- ⑤ Julie Ballard Sorham
S.R. 1552 Eagle River Road
Eagle River, AK. 99577
- ⑥ Barbara + Harold Parker (MR. + MRS.)
P.O. Box 605 A.
Chugiak, AK. 99657

March 25 Video T/C

Total Time: 2 hours + possible x-tra 10 min.
Segment Time (4 sites)

come up to video:

0 minutes

OPEN JNU



VIDEO TO ALL SITES
OF JNU COMMITTEE

Opening statements from the committee
chairman, Welcome, Intros.
[Brief statement of bill + positions]

count down and switch to:

5 minutes

FIRST SITE FBX



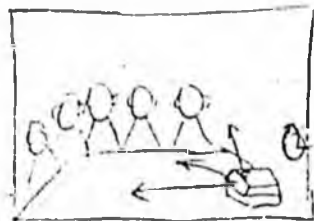
FBX VIDEO OUT TO
ALL VIDEO SITES
(FBX SEES JNU COMMITTEE)
(ALL OTHERS SEE FBX ADDRESS)

FAIRBANKS STATEMENTS TAKEN
WITNESSES:

switch to:

minutes

SECOND SITE SIT



ALL VIDEO SITES RECEIVE
SIT COMMITTEE LISTENING
(MAY BE SIT)

See Fairbanks FBX, move to SIT.
SITKA STATEMENTS TAKEN
WITNESSES:

See Fairbanks Sitka, move to Bet.

site change / same video



THIRD SITE

BET

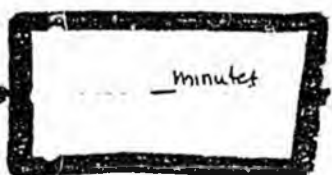


BETHEL STATEMENTS TAKEN

WITNESSES:

ALL VIDEO SITES RECEIVE JNU committee listing (AUDIO OF BETHEL WITNESSES)

sound down and switch source to:



Sen. Parr thanks Bet hel, on to Anchorage

FOURTH SITE

ANC.

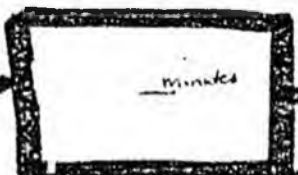


ANCHORAGE WITNESSES TESTIFY

WITNESSES:

(ANCHORAGE SEES COMMITTEE ON THEIR MONITOR)
ALL SITES RECEIVE VIDEO OF ANCHORAGE WITNESSES
- ANCHORAGE VIDEO CUT TO ALL SITES -

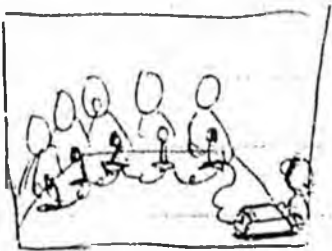
completion and switch source to:



Sen. Parr thanks Anc / Summaries

VIDEO CLOSE

JNU



TRANSITION STATEMENTS FROM COMMITTEE / VIDEO TO AUDIO ONLY

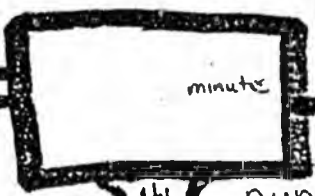
Sen. Parr wraps up, summarizes,

thanks participants & indicates future track of this bill in legislative process.

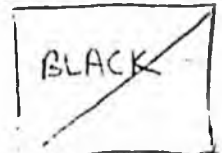
Sen. Parr reminds people that video portion is over and indicates continues for another 1 1/2 hours

Sen Parr + committee to all sites.

Video countdown to BLACK / LTR continues.



REGULAR TIC



VIDEO TRANSMISSION ENDS

AUDIO LTN/Teleconference until 7 pm PST.

Sen. Parr or Moderator begins teleconference round robin.

SENATE ENGROSSED COPY

State of Arizona
Senate
Thirty-fifth Legislature
First Regular Session
1981

SENATE BILL 1336

AN ACT

RELATING TO PUBLIC HEALTH AND SAFETY; EXEMPTING FROM LICENSURE AS MIDWIVES PERSONS ATTENDING WITHOUT COMPENSATION WOMEN IN CHILDBIRTH; PROVIDING FOR CERTAIN PROVISIONAL LICENSING, AND AMENDING SECTION 36-752, ARIZONA REVISED STATUTES.

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Section 36-752, Arizona Revised Statutes, is amended to
3 read:
4 36-752. Attendance at childbirth
5 A. A person attending women in childbirth, ~~habitually or~~ for hire,
6 shall, ~~on and after July 1, 1957,~~ be:
7 1. A qualified physician;
8 2. A registered nurse certified by the Arizona state board of
9 nursing as a qualified nurse-midwife;
10 3. Under the personal direction and supervision of a qualified
11 physician; or,
12 4. A licensed midwife.
13 B. NOTHING IN THIS CHAPTER SHALL BE CONSTRUED TO PROHIBIT A PERSON
14 NOT LICENSED UNDER THIS CHAPTER, WHO DOES NOT ACCEPT MONETARY
15 COMPENSATION, FROM ATTENDING WOMEN IN CHILDBIRTH.
16 Sec. 2. Provisional licensees to practice midwifery
17 For a period of six months from the effective date of this act, the
18 department of health services shall grant a provisional license to any
19 applicant who passes an examination established by the department pursuant
20 to title 36, chapter 6, article 7, Arizona Revised Statutes, and pays a fee
21 of twenty-five dollars. The provisional license is valid for a period of
22 one year from the date of issuance and is nonrenewable. Upon the
23 expiration of the provisional license, the department of health services
24 shall issue a license to the holder of a provisional license upon
25 documentation of successful assistance in a ~~minimum of~~ at least five births
26 and the payment of licensure fees pursuant to section 36-754, Arizona
27 Revised Statutes.

midwives' licenses
FISCAL NOTE INDICATED

COVER SHEET

S.B. 1336
(Reference to Senate engrossed bill)

Struck everything after the enacting clause

Amended title to conform

STATE OF ARIZONA
35th LEGISLATURE
FIRST REGULAR SESSION

REFERENCE TITLE: midwives' licenses
FISCAL NOTE INDICATED

SENATE

SB 1336

Introduced
February 10, 1981

Referred on February 12, 1981

Rules _____

HEALTH, WELFARE & AGING

Introduced by
Senator Hardt; Representative Cooper

AN ACT

RELATING TO PUBLIC HEALTH AND SAFETY; PRESCRIBING QUALIFICATIONS, EXAMINATION AND LICENSURE FOR MIDWIVES; PRESCRIBING FEES; PRESCRIBING CONTINUING EDUCATION AS CONDITION FOR RENEWAL OF LICENSE; ESTABLISHING MIDWIFERY ADVISORY BOARD; AMENDING SECTIONS 36-753 THROUGH 36-755, ARIZONA REVISED STATUTES, AND AMENDING TITLE 36, CHAPTER 6, ARTICLE 7, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-755.01.

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-753, Arizona Revised Statutes, is amended to
3 read:

4 36-753. Application for examination for license as midwife;
5 qualifications; examination fee

6 A. A person who desires to obtain a license to practice midwifery
7 shall make written application to the director of the department of health
8 services, upon a form to be supplied by the director, and shall furnish
9 such information as may be required by the director, AND SHALL PAY AN
10 EXAMINATION FEE OF SEVENTY-FIVE DOLLARS.

11 B. TO BE ELIGIBLE FOR THE EXAMINATION GIVEN BY THE DEPARTMENT OF
12 HEALTH SERVICES, THE APPLICANT MUST SHOW EVIDENCE OF:

13 1. COMPLETION OF HIGH SCHOOL, OR ITS EQUIVALENT.

14 2. COMPLETION OF A MIDWIFE EDUCATION PROGRAM APPROVED BY THE
15 DIRECTOR.

16 Sec. 2. Section 36-754, Arizona Revised Statutes, is amended to
17 read:

18 36-754. Licensing of midwives; renewal of license; continuing
19 education; fees

20 A. The department of health services shall grant a midwife's
21 license to ~~a person meeting the qualifications prescribed by this article~~
22 ~~and payment of a fee of one dollar.~~ AN APPLICANT WHO PASSES THE
3 EXAMINATION AND PAYS THE INITIAL LICENSE FEE OF TWENTY-FIVE DOLLARS.

1 B. The license shall expire ~~July 1~~ ON DECEMBER 31 of ~~the following~~
2 ~~calendar~~ EACH year, AND ~~A valid license~~ may be renewed ~~each succeeding~~
3 ~~year~~ upon ~~application to the director,~~ without payment of ~~a further~~ THE
4 ANNUAL RENEWAL fee OF TEN DOLLARS AND UPON EVIDENCE OF COMPLETION OF EIGHT
5 CREDIT HOURS OF CONTINUING EDUCATION APPROVED BY THE DIRECTOR OR HIS
6 DESIGNEE.

7 C. A LICENSEE WHO FAILS TO RENEW A LICENSE WITHIN SIX MONTHS OF ITS
8 EXPIRATION MUST APPLY AGAIN TO THE DEPARTMENT FOR AN ORIGINAL LICENSE AND
9 TAKE THE EXAMINATION.

10 D. THE DEPARTMENT SHALL GRANT A LICENSE WITHOUT EXAMINATION TO A
11 MIDWIFE HOLDING A CURRENT LICENSE GRANTED BY ANOTHER STATE WHICH HAS
12 LICENSING REQUIREMENTS SUBSTANTIALLY IDENTICAL TO THOSE OF THIS STATE.

13 E. THE DEPARTMENT SHALL GRANT A LICENSE TO AN APPLICANT WHO HAS
14 PRACTICED MIDWIFERY CONTINUOUSLY FOR THE FIVE YEARS PRECEDING THE
15 APPLICATION, IN ANOTHER STATE WHICH DOES NOT REQUIRE LICENSURE, IF THE
16 APPLICANT PASSES AN ORAL AND PRACTICAL EXAMINATION GIVEN BY THE DEPARTMENT
17 AND PAYS THE APPROPRIATE FEES.

18 Sec. 3. Section 36-755, Arizona Revised Statutes, is amended to
19 read:

20 36-755. Rule-making powers of director

21 A. The director may make such rules and amendments as may from time
22 to time be deemed necessary for the proper administration and enforcement
23 of this article.

24 B. The director shall, by regulation:

25 1. Provide reasonable regulations necessary to assure that any
26 person holding a midwife license is free from communicable disease or
27 diseases.

28 2. Define and describe, consistent with this article and the
29 medical practice act and the laws of the state, the duties and limitations
30 of the practice of midwifery.

31 3. Provide reasonable and necessary regulations to safeguard the
32 health and safety of the mother and child.

33 ~~4. Describe and define reasonable and necessary minimum~~
34 ~~qualifications for midwives, including:~~

35 ~~(a) The ability to read and write.~~

36 ~~(b) Knowledge of the fundamentals of hygiene.~~

37 ~~(c) The ability to recognize abnormal conditions during labor.~~

38 ~~(d) Knowledge of the laws of the state concerning reporting of~~
39 ~~births, prenatal blood tests, and of the regulations pertaining to~~
40 ~~midwifery.~~

41 4. PREPARE OR ADOPT AN EXAMINATION TESTING THE KNOWLEDGE OF
42 APPLICANTS FOR A LICENSE.

43 Sec. 4. Title 36, chapter 6, article 7, Arizona Revised Statutes,
44 is amended by adding section 36-755.01, to read:

45 36-755.01. Midwifery advisory board; membership; duties

46 A. THERE IS ESTABLISHED THE MIDWIFERY ADVISORY BOARD CONSISTING OF
47 SEVEN MEMBERS APPOINTED BY THE GOVERNOR FOR A TERM OF THREE YEARS PURSUANT
48 TO SECTION 38-211. MEMBERS ARE ELIGIBLE TO RECEIVE COMPENSATION PURSUANT
49 TO SECTION 38-611.
50

1 B. TWO MEMBERS SHALL BE DOCTORS OF MEDICINE PRACTICING OBSTETRICS
2 AND GYNECOLOGY, TWO SHALL BE LICENSED MIDWIVES, ONE SHALL BE A REGISTERED
3 NURSE CERTIFIED AS A NURSE-MIDWIFE AND TWO SHALL BE PUBLIC MEMBERS NOT
4 ENGAGED IN HEALTH CARE.

5 C. THE BOARD SHALL ADVISE THE DIRECTOR OF THE DEPARTMENT OF HEALTH
6 SERVICES ON MATTERS PERTAINING TO THE PRACTICE OF MIDWIFERY AND THE
7 LICENSING OF MIDWIVES.

8 Sec. 5. Initial terms of members

9 Notwithstanding section 36-755.01, Arizona Revised Statutes, as
10 added by section 4 of this act, the initial terms of members are:

- 11 1. Two terms ending on the third Monday in January, 1984.
- 12 2. Three terms ending on the third Monday in January, 1985.
- 13 3. Two terms ending on the third Monday in January, 1986.

14 The governor shall make all subsequent appointments as prescribed by
15 statute.

16 Sec. 6. Current licensees

17 The department of health services shall renew a license to practice
18 midwifery to any person who on the effective date of this act holds a valid
19 license to practice midwifery in this state and who upon the expiration of
20 such license pays the required fee and shows evidence of having completed
21 the required hours of continuing education.

22 Sec. 7. Intent regarding termination

23 Notwithstanding the provisions of this act, the legislature intends
24 that, if the provisions of title 41, chapter 20, Arizona Revised Statutes,
25 operate to terminate an agency, any provisions regarding powers, duties,
26 functions or personnel added or amended by this act terminate on the date
27 of termination of the particular agency.

28 Sec. 8. Effective date

29 This act shall become effective on December 31, 1982.

SUMMARY
PERINATAL ADVISORY COMMITTEE MEETING
October 27, 1981

Members Attending: Lynda Collier Elaine McKenzie
Jennifer Gleason Agnes Nichols
Sharon Gray Oliver Osborn
Jacqueline Greeman Joan Pelto
Jack Jacob David Spence
Ralph Wells Jeanne Wolf
Peggy Wilson Penny Chemilewski

Guests: Verneilia Randall, Maternal Child Health Nursing Coordinator,
State of Alaska, Juneau
David Ottoson, Board Member, Family Centered Birth Inc., Juneau
Liz Gollogly, Lay Midwife, Fairbanks
Portia Kauffman, Chief, Health Facilities Certification and
Licensure, State of Alaska, Anchorage
Erwin S. Rabeau, Director, Division of Public Health,
State of Alaska, Juneau

Staff: Liz Sappington, Health Educator
Carolyn Aoyama, Maternal Nurse Consultant
Dwayne Peebles, Project Coordinator

The Perinatal Advisory Committee met in the 5th Floor Conference Room of the Anchorage Department of Health and Environmental Protection Building to review the draft prenatal education curriculum and to discuss alternative birthing in Alaska.

Activity Update

The committee was presented with a summary of activity progress for the period May 1, 1981 thru September 30, 1981.
(Committee Meeting Materials pp. 12-15)

Prenatal Education:

A draft of the prenatal education curriculum was completed in September and is scheduled to be reviewed by the committee during the October 23, 1981 meeting. Based upon the committee's comments, the curriculum will be revised and available for public review during December. In addition, the appropriate audio-visual materials to accompany the curriculum were previewed and purchased during June, July and August.

Prenatal Risk Forms:

Drafts of the three prenatal care forms (Risk Assessment, Patient Care and Patient Care Continuation) were completed and an outcome/follow-up form was drafted. It is anticipated that this fourth form will be field tested this winter and be revised for distribution by spring.

Maternal Transport System:

The committee was updated by Jack Jacob as to the development of the maternal transport and consultation systems. The perinatal hotline will be operational in December with 24 hour access to obstetricians and neonatologists. The system will not be based at the Providence Hospital as originally planned, but will be routed through McCaw Communications, Inc. switchboard via radio telephones to the consulting physicians.

Fairbanks Improved Pregnancy Project:

The project has continued with an average enrolled case load of 90 clients per month. A preliminary assessment of the client profile for the months of July and August indicates an increase in utilization of the project and cost per client of those receiving financial assistance. The increased cost is associated with a stronger focus on high risk women and the associated medical care.

Professional Continuing Education:

The committee met via teleconference on September 3, 1981 to develop a final recommendation concerning the purchase of the Nursing Child Assessment Satellite Training materials from the University of Washington. After considering the costs and the benefits, the committee recommended purchase of materials utilizing FY '81 funds. The first NCAST class is scheduled for October in Anchorage.

The Nurse Preceptorship Program at Providence Hospital has continued to train hospital nurses in neonatal care skills. During this period nurses from Elmendorf and Cordova hospitals participated in the program.

Federal FY '82 Plan and Grant Application:

The grant application was prepared in May based upon the priorities identified by the committee during the April 22, 1981 meeting. Notification of Award was received during the last week of September and the project received an additional \$22,000 more than was originally anticipated. The additional funds were made available by the granting agency for the purposes of continuing the project coordinator's position full time and maintaining genetic counselling services through contract arrangements with the University of Washington.

(Committee Meeting Materials pp. 16-18).

Human Services Institutional Review Board:

Vernellia Randall, MCH Coordinator presented a request for volunteers to participate in a Human Services Review Board that would advise on a cervical cap study project. This study would be conducted at the Juneau Health Center Family Planning Clinic for a period of two years. The board's responsibility would be to assure that individuals using a cervical cap for contraception would have their rights protected and that the project was conducted in a safe manner.

(Committee Meeting Materials pp. 20-22)

Appendix I

ALTERNATIVE BIRTHING IN ALASKA

PREFACE

As follow-up to an expressed interest by the Perinatal Advisory Committee members concerning the issue of alternative birthing during the April 23, 1981 meeting, Carolyn Aoyama organized a presentation on the current birthing trends in Alaska. The presentation consisted of a general overview of the issue by Ms. Aoyama; a discussion of freestanding birthing centers by David Ottoson; and discription of lay midwife practice by Liz Gollogly.

INTRODUCTION

The debate over management of childbirth has intensified in recent years. Both professional and the lay public are increasingly scrutinizing traditional physician oriented and hospital based obstetrics. Serious questions as to the necessity, safety, dignity and cost of institutional maternity care are being asked. Critics charge that hospital obstetrics have become increasingly impersonal. They argue that many of the routine practices are more for the convenience of medical and hospital staffs than for the health and safety of mothers and their newborn. Many argue that these practices may even be harmful. At issue are such items as routine enemas, perineal shaving, IV's, restriction of food, fluids and mobility, separation of family members before and after birth, electronic fetal monitoring, multiple and often unsupporting attendants, the use of analgesics and the traditional lithotomy delivery position for birth. At issue also is the perceived attitude that pregnancy, labor and delivery are pathologically inclined events, that since birth is so inherently hazardous, it should only occur in the hospital.

Patients and professionals are also voicing serious concerns over aspects of medical obstetrical management of labor and delivery. The emphasis here is on aggressive management and excessive intervention. Many are particularly alarmed about the routine application of sophisticated technology in the absence of medical indication or in situations where its benefits have not been firmly established through rigorous scientific experimentation. Much of the controversy centers on the short and long term effects of obstetric medications, electronic fetal monitoring, elective induction, the routine or preventive use of forceps, and the cesarean section rate which doubled between 1971 and 1976.

A result of this controversy is that hospital based obstetrics has come to be viewed by many as insensitive to personal needs and obsessed with the use of sophisticated equipment. Since the early 1970's a small, but growing number of parents have sought and received maternity care outside of hospitals. This care has been obtained in the offices and clinics of practitioners, in free standing birth centers and in the home. After a steady decline over the past decades, the percentage of U.S. births occurring outside of hospitals has risen from a low of 0.6% in 1970 to 1.5% in 1977. The trend in Alaska according to the Bureau of Vital Statistics, shows that out of hospital rates have gradually increased from a 2.3% in 1977 to 3.3% in 1979. These rates

Review of the Draft Prenatal Education Materials:

Liz Sappington reviewed the prenatal education modules previously mailed to the committee. Each module was reviewed separately with verbal comment from the committee concerning the general content and philosophy of the curriculum. Written comments were also obtained that addressed specific points was requested to be forwarded to Ms. Sappington.

The committee's general comments on the draft modules are summarized as:

- include more graphics into the reading materials and simplify the vocabulary to reduce the reading level;
- utilize larger print and make the visual affect more attractive;
- utilize true-false questions in the workbook and condense the information;
- include a discussion of the effects of tobacco chewing;
- discussion of medical tests and procedures should be simplified;
- the reader should be referred to the health care provider for any questions concerning tests and procedures.

Alternative Birthing in Alaska:

Carolyn Aoyama presented a discussion of alternative birthing in Alaska as follow-up to an expressed interest of the committee members. The presentation focused on the three major types of alternative birthing; hospital based birthing rooms; free standing birthing centers; and home births. To provide input from those participating in alternative birthing, guest speakers where invited to discuss their activities. David Ottoson of Family Center Birthing Inc. of Juneau discussed free standing birthing centers and Liz Gollogly, a lay midwife discussed home births. A synopsis of the presentation is attached in the meeting summary appendix.

Proposed Birth Center Regulations:

Portia Kauffman, Chief, Certification and Licensure, requested that the Perinatal Committee review the draft proposed birth center regulations. A draft of the regulations was handed out to the committee and any comments the members may have could be forwarded to her office in Anchorage.

Public Comments

The floor was opened to allow for comments or questions from the audience. Several individuals had comments and questions concerning the alternative birthing presentation. Liz Gollogly and Carolyn Aoyama answered the comments concerning the type of practice experienced in lay midwifery and birthing center.

The committee decided to meet in the next three to four months, possibly in Juneau. Dwayne Peoples would be contacting committee members to determine the schedule depending upon prospective funding for next year's grant application.

must be interpreted with caution since many out of hospital births are not reported.

Hospital Birthing Rooms

To varying degrees, many hospitals have responded to consumer pressure for change by altering their policies and procedures. These modifications have ranged from simply permitting husbands into the delivery room to the creation of separate family centered maternity units staffed by nurse midwives or physicians where parents can have a substantial voice in their birth experience. It is still much too early to assess the impact that these changes in hospitals obstetrical practices will have on the prevalence of births outside the hospital.

Alaska's hospitals have responded to consumer's requests for family centered care with a variety of approaches. Fairbanks, Providence and Alaska hospitals have all initiated birthing rooms with policies directed at keeping the labor and delivery experience as safe, but as personally satisfying to the family as possible. Only low risk women can use these birthing rooms. Couples generally must take prenatal classes, a birthing room orientation class and have the written permission of the mother's and baby's physician. At the client's request, technology is kept to a minimum and the mother is encouraged to take oral fluids, and labor and deliver in her position of choice. Newborns are not separated from their families after birth unless it is in need of special care. Mothers remain in the birthing room for about 4-12 hours postpartum with a nurse. If there is no contraindication, they are discharged from the birthing room directly home. Home visits are made by either the labor and delivery nurses or the public nurses within 24 to 72 hours postpartum. At that time, the nurse does a thorough maternal and neonatal physical assessment including PKU and drawing blood for the bilirubin level if necessary. The newborn is generally seen by the pediatrician by the 5th day of postpartum. Families seem well satisfied with the birthing room at Alaska hospital where they have conducted their own survey.

Birthing Centers

A second type of facility that has developed in response to consumer demand is the free standing birthing center. A birthing center can be defined as both a setting and a concept. The woman's and family's involvement in childbearing is enhanced. Birthing centers screen out high risk clients and only accept low risk women who aren't likely to have complications. Medical technology and aggressive management is minimized. The birthing center is free standing, in e.g., located and owned independent of the hospital. The basic goal of the birthing center is to foster childbirth as an experience in which the woman feels physically safe and psychologically secure and in control of her labor, delivery and postpartum experience. The family is central to the experience and the free standing birthing center must be viewed, therefore, as an extension of the home rather than an extension of the hospital.

In the birthing center, the family usually makes the decisions (within safe limits) regarding the nature of the delivery. General anesthesia is never used and drugs for analgesia are used only upon request. Routine

Forceps-assisted delivery and cesarean section, pitocin induction, general or regional anesthesia beyond pudendal block are not used. Decisions regarding labor position, lighting, and who will be with the mother during delivery are family decisions. If a particular medical procedure is considered advisable such as episiotomy, the patient is consulted first and her approval is required. At all times, the staff informs her of what they are doing and why. Typically the mother and infant are discharged within 12 hours of birth. Because the FBC is usually a fairly small operation, more tailored, less routinized care can be offered.

Since the free standing birth center is not part of a hospital, (although it is usually located near a hospital) it can only provide minimal emergency care of the newborn and mother, including resuscitation of the newborn using oxygen intubation. IV's and plasma expanders are used for maternal hemorrhage. Because it does not have access to blood and is not capable of surgery, stringent criteria are used to screen against women likely to be at risk in labor and delivery. Typically less than 10% of their clients require transfer to a hospital.

The screening out of high risk women is the single most crucial element in assuring safety at birthing centers. The effectiveness of such screening techniques has been demonstrated by the fact that less than 10% of women who reach labor are transferred out of these centers. In the experiences reported to date there have been no postpartum emergency transfers. (MCA, New York, Oregon, McLamery).

There are four identifiable stages in pregnancy at which screening criteria must be developed and used. These correspond to Maternity Care Center Association's criteria. They are:

1. Early pregnancy screening criteria (e.g. BP or diabetes).
2. Antepartum referral criteria (problems discovered later in pregnancy but before labor, e.g., preclampsia).
3. Intrapartum transfer criteria (for problems discovered during labor prior to delivery e.g. prolapsed cord).
4. Postpartum transfer criteria (for problems with the mother or infant after delivery such as hemorrhage or respiratory distress).

Birthing Room /Free-standing Birth Center Charges

When compared to the charges for similar services in conventional OB units, birthing room and FBC charges range from 20% to 70% less.

A fiscal audit of Maternity Center Association (MCA) in New York for the years 1976 to 1977 by Blue Cross of Greater New York reported that charges for MCA were 37.6% of in hospital care barring complications. Also noted was the cost to the plan had the same family gone to the hospital, barring complications.

The primary reasons for the reduced charges are:

1. the elimination of charges for labor, deliver and recovery rooms
2. elimination of nursery charges
3. elimination of most drug and anesthesia charges
4. reduction in length of stay from 24 to 72 hours postpartum

In addition, birthing centers are oriented toward preventing costly complications through the use of careful screening criteria. Care during labor and delivery is constant and individualized with nearly 100% of that time spent in contact with professional staff. Traditional hospital oriented management cannot begin to provide such professional contact time.

Further economies are realized through utilization of non-hospital space as a setting for healthy normal childbearing while making reasonable allowances and arrangements for the safe care of clients with complications extensive, educational programs emphasizing nutrition, family relationships and self help. Self care responsible health habits are included in the charge. Unlimited telephone consultation is also available.

Family Centered Birth Inc.

David Ottoson

Family Centered Birth Inc. of Juneau is the only free standing birth center in Alaska. The center is governed by a board of directors and is not part of the hospital or physician practices in Juneau. It is a non-profit corporation which was organized by Juneau residents to develop an alternative to existing choices.

Members of the board obtained a grant from the Department of Health and Social Services for the purpose of assessing community need and support for a center; providing public education concerning the center's services; and obtaining consultation in developing the center. Presently, the corporation has obtained a facility and has hired a certified nurse midwife and expects to be open for business by midwinter of this year.

The birth center will offer a home-like environment for low risk women to obtain prenatal care, and education for labor and delivery. This care will be provided primarily by a certified nurse midwife with a physician on contract for back-up services. Transfer protocol will be arranged for urgent or emergency transport to the hospital which is less than 10 minutes away from the center.

The birth center is seeking no state or local governmental support, but will obtain it's funding from private loans and public contributions. The start-up cost of this type of service has been high. Although the board would like to purchase the building it is using, it will probably have to lease the space and medical equipment. It is anticipated that the center will be serving 75 families the first year and 166 the second year. Although there will be dependency on loans and contributions for the start-up cost, the center is projecting financial stability by the second year or operation.

Lay Midwifery

Lay midwives for my purpose here will be defined as individuals who attend women during childbirth outside of the hospital and outside of established medical obstetrics and nurse-midwifery. Those individuals vary widely in their training, experience and competence.

Unlike nurse midwives whose training standards and codes of professional practice are well established, lay midwifery does not yet have a strong professional or educational foundation. Few states have attempted to provide a regulatory framework for them and only a few states have taken steps to regulate the activities of lay midwives. Most states either have no statutes relating to midwives or have laws enacted in the early 1900's that have little relevance to modern standards of OB care.

In ongoing debate over the future of maternity services in the country, the most divisive issue is that of home birth. Despite a common perception that this occurred due to the activities of "counter culture types", religious sects and other "fringe groups", the available evidence indicates that the primary interest in birth at home is coming from certain middle class individuals who are seeking greater flexibility and control of their birth experiences than are allowed in hospitals or other institutional settings. In addition, another large segment of this group desires home birth for the family closeness and convenience of home. Care becomes centered on mother and child rather than the institution or physician.

Because home birth and lay midwifery represent such as a radical departure from the current norms of obstetrical practice, and since there has been little substantive research on these subjects, the controversy has been based as much on emotion and ideology as on objectivity.

My own assessment is that home birth and lay midwifery is neither safe or hazardous in and of themselves. Rather, it appears from the scientific literature that the outcome of childbirth at home with lay midwife attendants will be largely depended on the conditions under which the birth take place. While information is certainly limited, the study on Home Delivery and Neonatal Mortality in North Carolina, as well as Mehl's study of home birth in California, indicate that planned home birth utilizing trained midwives or other trained attendants could be a viable option in safe maternity care. There are several pre-requisites to a reasonable homebirth approach including: careful selection of cases to include only low risk pregnancies; a high level of parental responsibility and maturity; a suitable home environment; management of the pregnancy by skilled practitioner; and the ready availability of consultation and support services to handle complications and emergencies.

Lay midwives have experienced considerable difficulty in obtaining recognition and legitimacy. This is in large measure due to a lack of professional body which could set standards and accredit educational programs and determine the scope of midwifery practice. Although there are about ten training programs in the country, the limited information gathered suggests that, for the most part, they are loosely organized and vary widely in their

sponsorship, structure, teaching, orientation and stability. Moreover, none is accredited or otherwise endorsed by a public licensing body or private professional body. Therefore, quality of standards of instruction provided is impossible to measure. At present there are independent advocacy groups such as Washington State Midwifery Council that have formed to disseminate information and press for favorable legislation and regulatory policies.

The characteristics and practice patterns of midwives vary. Some are entirely self taught, having done little more than attending periodically and reading a book or two on the birth process. At the other end of the spectrum are those, like the European midwives, who have gone through several years of specialized training, including theoretical preparation and supervised clinical instruction. In between lies a variety of background and skills.

Practice patterns also differ. While some midwives conduct their activities completely separated from other established maternity care resources, others have developed working relationships with local providers that enable them to provide a higher standard of care.

The basic issue concerning lay midwives has to do with public safety and quality of care. A key argument used in the debate on where childbirth should occur and who can legally attend and care for the childbearing women involves the mortality rate. Proponents of hospital childbirth relate the decline of maternal and infant mortality rates to the medical technology and in-hospital delivery by highly trained and regulated practitioners. Many fear that a shift of childbearing from hospitals attended by physician back to the home and attended by unregulated personnel will result in increased morbidity and mortality.

Establishment of causal relationships using such observational data is fraught with difficulty. Interpreting and extrapolating trends without taking into account the improved health in population, decreased fertility rates, improvement of sanitation and housing as well as control of communicable diseases can only lead to confusing and erroneous conclusions.

The increased incidence of out-of-hospital births and the reporting of data on their safety has led home birth advocates to begin to conduct research into this area. Mehl et al. investigated the statistical outcomes of home delivery in California. The outcomes of birth attended by 6 groups consisting of combinations of lay midwives, nurse midwives and general practitioners were compared. The perinatal mortality rates for their study populations revealed significantly lower rates compared to the state as a whole.

For women who have been adequately screened for risk factors with reasonable consultation and referral, good outcomes are the rule. However, even in an apparently normal pregnancy, problems can and do occur so that a positive outcome can never be guaranteed. The interest, therefore, of public officials in the rising numbers of out-of-hospital births largely is due to the uncertain qualifications and competence of the lay attendants as well as the uncertain outcome of any birth.

Midwifery outside of nursing is beginning to gain legal status as a legitimate profession or trade. In Oregon, a recent opinion of the state's attorney general held that midwifery, independent of nursing, is within the scope of the law so long as it excludes the performance of episiotomies or use of medications. In some states, courts have recognized midwifery as separate from nursing and in others they have concluded that childbirth is a natural function and consequently midwifery does not constitute the practice of medicine (Oregon).

The majority of state midwifery provisions are remnants of the early 1900's. State governments have attempted to deal with the reality of midwifery outside the established maternity care system. In Arizona, Rhode Island, and New Mexico, action was initiated by their respective state health departments and state health agencies involves a qualifying exam, case reports by midwives and oversight by a professional advisory committee. Arizona's program was the first to be established in February of 1978, and state officials report a generally favorable experience in terms of safety factors and workability of the program.

The quality of obstetrical services is dependent upon competent clinical judgment, standards of care and integrated referral systems. While some states have taken initial steps to incorporate lay midwives into the medical system, Alaska presently has not followed this action. While the future of the lay midwife's role in Alaska's medical system is hard to predict, it can be assumed that the demand for their services and home births will continue.

In the State of Washington, a midwifery statute has passed in both the House and Senate and is now awaiting the Governor's signature to become law. Washington's Substitute House Bill No. 316 provides for a three-year training program and defines a specific subject area which must be included as basic. There are shorter training requirements for individuals with nursing backgrounds. Hospitals, clinics, birth centers or private residences are recognized as acceptable settings for clinical experience.

Lay Midwife and Homebirths in Alaska Liz Gollogly

There are various lay midwives actively delivering newborns in Alaska with various backgrounds and types of practice. Liz Gollogly, a lay midwife presently practicing in Fairbanks was trained in Europe. The services she provides are prenatal care, home deliveries and postpartum care. Prospective clients seeking her services are initially screened to determine their medical risks and are informed as to what would be required for a home delivery. Those who are accepted are required to attend childbirth education classes, develop a transport plan to the hospital for emergency and make adequate preparation for the delivery. They are also encouraged to communicate with their physician as to their plans.

During the prenatal period, the clients are continually monitored for potential medical problems. The risking is continued throughout the prenatal period and during delivery. At any time when conditions warrant the patient is referred and transferred to the hospital for delivery.

Those who deliver at home do not receive anesthesiology or episiotomies. The newborn is assessed for the 1 and 5 minute APGAR and blood drawn for testing. The parents are encouraged to see a physician with 24 to 48 hours for a complete medical check-up.

During the postpartum period, the clients are advised to the possible problems and are checked on during the first few days following birth. In addition, they are encouraged to call if any problems develop.

During a 20-month period, client outcome was monitored to evaluate practice. Of a total 62 requesting home births, 17 were screened out for medical or other reasons. Of the remaining 45, 9 were subsequently referred to the hospital for delivery. Of the 36 who began labor at home, 9 were transported to the hospital during the 1st, 2nd or 3rd stage of labor. Of the 9 who were transported to the hospital, 7 were primips. The total risk out during the prenatal and intrapartum period was 35, of which 24 were primips. As a result of these statistics, Liz Gollogly only accepts multiples as her clients.

It was Ms. Gollogly's general conclusion that lay midwives need to be integrated into the medical community and their referrals to physicians should be accepted. In addition, clients who do have homebirths should not be discriminated against by physicians and hospitals.

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Evaluation of Outcomes of Non-Nurse Midwives:
Matched Comparisons with Physicians^{1, 2}

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Introduction

The practice of midwifery and the attendance of home births by midwives are much discussed issues today. Equally discussed is the distinction between lay midwife and certified-nurse midwife. In this paper we shall attempt to evaluate the results of out-of-hospital practice by experienced non-nurse midwives.¹

Opponents of possible licensing of non-nurse midwives center on several specific concerns:

1. Midwives may provide inferior care to that currently available.
2. Lower socioeconomic status women may be shunted to midwives in an effort to save funds.
3. Licensing midwives will be *de facto* approval of out-of-hospital delivery, which is not safe.

Proponents of legislation to license midwives argue that:

1. Trained, experienced midwives provide as high (if not higher) standard of care than that which is generally available, calling upon physicians for consultation and intervention in situations exceeding the depth of their skills. (Two concomitant issues arise here: first, the level of judgment

- necessary to accomplish such a task and, second, the feasibility of creating risk groupings by screening.
2. The demand for midwives comes largely from middle- to upper-class women.
 3. Midwives may be the best primary care provider for rural areas, provided expert obstetrical consultation is available.
 4. Home birth and out-of-hospital birth can be safe alternatives for screened, selected women attended by trained, competent practitioners.

Summaries of the arguments of those opposed to the licensing of midwives can be found in Pearse (1976), Aubry (1976, 1977), Hibbard (1977), and International Medical News Service articles (1977a, 1977b). These arguments center on contentions that studies exist proving that home birth and midwives are unsafe (the two issues are usually considered concurrently). Aubry (1977a) presents birth certificate data from Oregon showing higher neonatal mortality rates among out-of-hospital deliveries from 1970 to 1975. Similar data are now available for Hawaii (Pearse, 1977) and California (Emrey, 1977). Without desiring to advocate for home delivery and midwives, we must point out that from a research methodology perspective these data merely obscure the basic issue. Two questions are not properly differentiated. The first is the more important: can screened, ..

selective women deliver at home with trained midwives without significant increases in risk? The second is less so: what are the overall incidences of complications for reported out-of-hospital deliveries? Currently, birth certificates do not differentiate between types of out-of-hospital delivery--home, taxicab, car, birth center, planned or unplanned. In addition, from the standpoint of cultural anthropology, home birth is a complex phenomenon. In conducting our initial study on home birth with midwives in Santa Cruz County, California (Mehl, Peterson, Shaw, & Creevy, 1975), we learned that only 25% of deliveries were reported to the State Health Department. Since then, we have found ranges of percentage reported from 20% to 100%, the least with unattended deliveries, the most with physician-attended deliveries. In one of our prospective experiences in Madison, Wisconsin, even with strong encouragement on the part of the birth attendants, only 60% of deliveries were reported within 6 months of delivery. The other sample-biasing effect is that abnormal deliveries or newborns needing medical attention or dying are all reported at the moment of contact with an established medical or legal institution. Emrey's (1977) contention that home-birth parents "bury their babies in the woods" is a non-scientific statement with no valid basis. It would be extremely difficult to conceal the outcome of a pregnancy in modern society. Thus, birth certificate data is not a

valid source of data on intentional home birth. In this regard, it is important to note that of Emrey's California out-of-hospital deaths, 65% were among infants weighing less than 2,500 grams. The planned home-delivery-population prematurity rate has been reported as 3.0% among several northern California home-birth services (Mehl, Peterson, Whitt, & Hawes, 1977). There were no neonatal deaths among these premature infants. Established home-birth services consistently report low neonatal mortality rates (Taylor, 1976; Epstein et al., 1977; Berman, 1977; Carson, Felton, Gloyd, Luehis, Mansfield, Mertz, Myers, & Rivard, 1977; White, 1976; Mehl et al., 1977; Estes, 1977).

While established services do report good outcomes, real problems exist in the practice of midwifery, which cannot be currently regulated. The California Department of Consumer Affairs estimates that 300 to 500 nonlicensed midwives are practicing in California (Krisman, 1977). Nancy Mills, a well-known lay midwife in Sonoma County, California, receives an average of 40 telephone calls weekly from women who want to be midwives. There are ample numbers of anecdotes about women who have seen one or two births and then called themselves midwives, only to encounter complications they were not prepared to handle or could have avoided through adequate screening. The important question seems to be how to provide legislation which would permit the rise of competent midwives while prohibiting the practice of