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Hepatitis B Virus (HBV)

HBV infection is becoming a significant health problem in Alaska, especially in the highly susceptible Alaska Native community and, in particular, the Yupik Eskimo.

Hepatitis B infection is usually caused by prolonged close and intimate contact with a carrier and/or infected blood or blood products or serous discharges.

Complications of HBV infection can be many e.g. polyarteritis nodosa (serious inflammatory condition of the arteries) with a 30% mortality rate; primary hepatocellular carcinoma (PHC), has the highest incidence in the U.S.A. Estimated 10% of HBV chronic carriers will develop HPC; chronic active hepatitis with cirrhosis (CAH) will develop in 20 to 25% of chronic HBV carriers.

People at high risk include:

- Yupik Eskimos and to a lesser variable extent
other Alaskan Natives
- Health and hospital care providers
- Hemodialysis patients
- Recipients of blood products
- Laboratory workers
- Dentists and allied dental personnel
- Gay communities
- Illicit injectable drug users
- Staff and patients of mentally retarded institutions
- Sexual and household contacts of known carriers
- Newborn infants of mothers who are HBV carriers
- Southeast Asian groups

In late November 1981 a request for a supplemental appropriation of about 800,000 dollars to initiate a HBV program was sent to the Governor's Office. It never reached the legislature.

Normally the State provides and totally runs immunization programs for all State residents. Due to shortage of funds, high cost of HBV program and availability of some funds to ANHS in their budget ANHS (Alaska Native Health Service) and the State (Division of Public Health) are coordinating a joint effort. A Memorandum of Understanding has been jointly developed by both agencies covering many issues e.g.

- (a) Public Health Nurses will assist ANHS personnel where possible in screening initial vaccination and particularly follow-up vaccination.
- (b) If ANHS cannot hire people because of locale of fund allocation of last \$500,000, they will contract with us to provide all the necessary program people and activities.

- (c) In predominantly Native communities their screening teams will screen all citizens. We will be responsible for the lab testing of non-natives and will make arrangements for vaccination or replacement of vaccine if they do it.
- (d) ANHS and the State will use common forms e.g. info sheet, indications for blood-testing, vaccination, refusal-for-vaccination form. These forms are being edited for both parties.

The attached report gives necessary funding for a control program.

Because of the economics, a control program rather than an eradication program is proposed at this time. The purpose of such a program is to identify foci of infection and wall it off (break the chain of infection) by vaccinating the appropriate susceptibles.

Enclosed also is a document in which the population for an urban non-military, non-native program will go hand in glove with the rural predominantly native program.

We cannot estimate the cost of vaccine down the road but guess it will drop fairly precipitously within five years.

REPORT ON HEPATITIS B

The following action program outline is of two parts; an HBV program to control non-native population, one to coordinate a joint AMHS/State program and a total for a State-wide program conducted by the State.

Personnel required to handle project for the non-native, non-military Alaska population:

Project supervisor	21A	41.7
Clerk IV	9B	19.5
Microbiologist II	16A	34.0
2 Nurse Practitioners or equiv.	18A (34 x 2)	68.0
		163.2
Computer Programmer		32.0
		195.2

4 Months Program (March thru June, 83) FY 84 Program

Personnel	48.8	195.2
PCIS	25.0	10.0
Lab	50.0	90.0
Travel	38.0	91.0
Vaccine	80.0	112.0
Equipment, Misc.	8.2	1.8
	250.0	500.0

Much of the vaccinations would be handled by PHN's, health centers and by staffs of institutions. Screening i.e. blood collection, likewise would be done by health care facilities and private practitioners to a great extent. Much of the non-native possible high risk populations may be clustered around the various cities.

These program logistics are in addition to the program proposed by the AMHS. They anticipate expenditure of one million dollars a year for three years.

The total cost of a State-wide program is about 5 3/4 million dollars through June, 1987. It is based on State funding of \$250.0 balance of present fiscal year, \$500.0 FY 84, \$600.0 FY 85, \$700.0 FY 86, \$700.0 FY 87 along with the AMHS expenditure of 3 1/4 million over first three years of above activity. It is anticipated that these dollars would be turned over to the State through contract to get Alaskan Natives to a maintenance level. If, for any reason, the Federal monies were not appropriated, it would require additional State funding. AMHS received \$500,000 FY 82 year end monies and they purchased vaccine sufficient for the first year of the program. They received \$500.0 in their FY 83 appropriation which is \$265.0 less than their indicated program need. They envision 60,000 patients screened and 19,000 vaccine recipients over the three years. They plan for a staff of 10 persons - we would reduce this to 8 persons if we do (hopefully) the program.

The following table summarizes their proposed Hepatitis B Detection Surveillance and Control Program for Alaska Natives.

3 Year Proposed Budget

<u>Item</u>	<u>Year One</u>	<u>Year Two</u>	<u>Year Three</u>	<u>Total</u>
Personnel	385.0	300.0	316.0	901.0
Travel	294.0	147.0	294.0	735.0
Supplies	172.0	172.0	172.0	516.0
Equipment	15.0	-0-	-0-	15.0
Vaccine	-0-	405.0	518.0	923.0
	already bought (with year-end FY 82 monies)			
Total	765.0	1024.0	1300.0	3090.0

Population at High Risk for HBV
(excludes Military and Native Populations)

The assumptions are made that the Native population, as well as the military, will be handled by the ANHS (Alaska Native Health Service) and the military health system respectively.

Various population groups are at high risk; they may be so for a variety of reasons, ranging from geographic location, occupation, sexual practices to life style.

The following chart illustrates the types, numbers and rationales. This is followed by summary tables elaborating on numbers to be screened and numbers for potential vaccination. (numbers rounded off to nearest twenty-five for ease)

1)	EMS workers (non-native, non-military)	1500
2)	Health Care Workers (long term care)	1400
3)	Hospital staff (exc. Federal Hospitals)	3500
4)	Harborview, already screened, vacc. on 1/26/83	0
5)	Developmentally disabled (500 staff, 200 clients)	700
6)	Hemodialysis and hemophiliacs (patients & family)	200
7)	Gay community, est. 9600 (Anch., Fairbanks, Juneau)	7800
8)	Illicit injectable drug users (600-700)	650
9)	Household and sexual contacts of known carriers 2000-3000 (allowing for double reporting)	2500
10)	Corrections inmates (first study shows not at high risk)	0
11)	To identify newborn infants of mothers who are carriers	8000

EMT's	1500 x 90% =	1350
L.T. Care Workers	1400 x 90% =	1250
Hospital Workers	3500 x 90% =	3150
Dev. disabled staff & patients	700 x 80% =	550
Hemodialysis, hemophiliacs & staff	200 x 90% =	175
Gay community est. 9600 (Anch., Fairbanks, Juneau)	7800 x 20% =	1550
Illicit injectable drug users	650 x 20% =	125
Household and sexual contacts, carriers	2500 x 85% =	2125
Correction inmates	0	
Newborns of carriers	8000 x 0.3% =	25
	<u>26,250</u>	<u>10,300</u>
	(rounded-off figures)	

26,250 estimated to be screened (exclusive of IHS program). This will not include other people not included above who will ask for test.

39% (est. 8,700) susceptibles to be vaccinated.

The above needs to be done within the next 16 months, (FY 1984, plus last 4 months of FY 83).

APPENDIX

Methodologies Used

- 1) EMS population figures from Section of EMS, DPH, reduced by eliminating Natives.

Health care workers population (long term care) taken from State Health Plan Data Appendix.
- 2) Hospital staffs (exclusive ANHS and Military) taken from State Health Plan Data Appendix.
- 3) Developmentally disabled patients and staff members given by Division of Mental Health.

Harborview staff and clientele already done by Division of Public Health.
- 4) Hemodialysis patients and staff, hemophiliacs numbers supplied by Section of Family Health, DPH.
- 5) Gay community numbers arrived at by figuring male population (non-native and non-military) between ages of 15 and 65; taking 10% of that number. Number used was calculating numbers for Anchorage, Fairbanks and Juneau. 1980 census for numbers of sex, racial and age characteristics was used.
- 6) Numbers of illicit injectable drug users was furnished by Office of Alcoholism and Drug Abuse.
- 7) Contacts of household and sexual contacts was estimated trying to eliminate double reporting of ones that would be counted under any of the above categories.
- 8) Numbers of corrections' inmates is counted as zero because study we did shows them not to be at high risk at this time. We screened over 350 long term males. Many of new ones will have been screened under one of the aforementioned programs.
- 9) There are about 10,000 births in the State annually; 2000 of them are Native and can be excluded from this listing.

Assumptions are many --

- a) It is difficult to accurately predict numbers that will accept screening and/or vaccination. Probably the screening numbers may be as much as 10-20% under our figures.
- b) For vaccination the percentages used were to allow for varying numbers of susceptibles and also refusal to accept vaccine.
- c) The percentage used for calculating male homosexual population was received from homosexual physician in Anchorage plus articles in medical journals.

- d) This program is considerably different than any other immunization program. The cost of the test and the exorbitant cost of the vaccine makes it necessary to screen rather than to vaccinate carte blanche.
- e) In addition, it is necessary to test to identify carriers (HBV surface antigen bearers) in order that testing for liver cancer can be done.

I. Statement of Introduction

The State of Alaska, Department of Health and Social Services, Division of Public Health and the United States Public Health Service, Indian Health Service, Alaska Area Native Health Service intend to enter into a memorandum of understanding to cooperatively develop and deliver a preventive program of Hepatitis B Virus infection control in Alaska.

Hepatitis B Virus (HBV) infection is a significant health problem in Alaska, especially in the highly susceptible Alaska Native Community. The recently available hepatitis B vaccine is an effective tool to control this important infection and to prevent the HBV related complications of liver cirrhosis, primary hepatic cancer and vasculitis.

A Hepatitis B Immunization and Control Program is a complicated one, and multifaceted activities are required at all organizational levels by several agencies to make it successful. Therefore, it is the desire of the Alaska Native Health Service and the Division of Public Health to coordinate available financial resources, personnel, laboratory services and professional expertise for implementation of a quality Hepatitis B Immunization and Control Program in an expeditious and cost-effective manner and to designate major administrative priority to the Program.

Implementation and accomplishment of the Hepatitis B Control Program depends upon the availability of continued State of Alaska funding and USPHS funding. Lack of funding would invalidate or necessitate modification of this understanding.

II. Areas of Agreement

A. Needs

1. At risk individuals need to be identified through expert analysis of appropriately obtained blood sera.
 - a. adequate laboratory facilities and technical capabilities are necessary to perform a large number of serologic determinations.
 - b. specialized personnel are necessary to obtain blood specimens from all individuals in entire rural Alaska Communities and who can separate serum, accurately identify specimens and ensure arrival at the laboratory expeditiously and intact.
2. Data systems need to be accessible and able to provide:
 - a. census data
 - b. demographic identification of all specimens
 - c. integration of individual serological and immunization data into the medical record.

- d. lists of susceptible individuals
 - e. lists of susceptible individuals by risk category
 - f. lists of individuals who are HBs Ag carriers.
 - g. the established data system would provide the above data on an ongoing basis.
3. As much as possible, the immunization phase of the Hepatitis B Immunization and Control Program needs to be integrated into existing vaccine delivery programs.
- a. Initially, the immunization phase needs coordinated efforts from public health nurses, specifically employed supplemental personnel, Community Health Aides and Alaska Native Health and Native Health Corporation health care providers.
 - b. Specialized care provided to newborns and infants of HBs Ag positive mothers needs to be provided in the hospitals at the time of delivery and the times when routine care coincides with established hepatitis B immunization protocols.
4. Sera aliquots from specimens needed by CDC need to be provided with demographic and serologic data to the CDC, Alaska Investigations Division.
- a. to establish a ser bank
 - b. to provide cancer screening with alpha-fetoprotein determinations on all HBs Ag positive individuals.

B. Risk Priorities

- 1. Infants born to HBs Ag positive carriers.
- 2. Household contacts of HBs Ag carriers.
- 3. Rural Alaska communities with a HBs Ag carrier rate of 5 percent or greater.
- 4. Individuals and staff in institutions for the mentally retarded.
- 5. Renal hemodialysis patients and hemophiliacs.
- 6. Active male homosexuals.
- 7. Health care providers having frequent blood contact.
- 8. Identified high risk prison groups.
- 9. Illicit injectable drug users.

C. Agency Interactions

1. To meet the high risk needs in the Alaska Native Community, the Alaska Native Health Service intends to enter into a contract with the State of Alaska.
 - a. to develop and maintain a Hepatitis B Control Program in cooperation with the AANHS Project Officer and the CDC-AID Director.
 - b. to identify and vaccinate high risk Alaska Natives.
 - (1) household contacts of known HBs Ag+ carriers
 - (2) village residents of known villages with 5 percent or greater HBs Ag+ carriers.
 - (3) high risk villages in Western Alaska with first priority to the Yukon-Kuskokwim Delta Area.
 - c. the contract will be written immediately and implementation start as soon as possible.
2. Coordination of the Hepatitis B Immunization and Control Program will be cooperatively directed by the Chief, Communicable Disease Control Section and the Chief, Community Health Services.
 - a. Monthly meetings involving key persons will occur
 - b. Records of discussion and decision made in the monthly meetings will be appropriately distributed.
 - c. A periodic information circulation will be published.
3. Free access and exchange of Hepatitis B epidemiologic information will be shared between the State of Alaska, Alaska Native Health Service and the Centers for Disease Control.

D. Specific Responsibilities

1. The State of Alaska Division of Public Health will be responsible for the administration of Hepatitis B vaccine. The vaccine will be administered by public health nurses, supplemental personnel, and other health care providers as needed.
2. Initial hepatitis preventive care and care that coincides with routine preventive care of newborns and infants will be provided by the Alaska Native Service or contract physicians.
3. Sera aliquots with demographic and serologic data will be sent to CDC, Alaska Investigation division by the State Laboratory.
4. Alpha Fetoprotein determinations will be performed by the CDC, Alaska Investigations Division.
5. Serologic determinations for the clinical needs of the Alaska Native Health Service and for the prenatal screening of Alaska Native Service beneficiaries will be provided by the Clinical laboratory of the ANMC.

6. In consultation with appropriate experienced CDC persons, the Laboratory Section, Division of Public Health, State of Alaska will develop the capability and quality assurances to assume responsibility for all the serologic screening necessary to conduct the Hepatitis B Immunization and Control Program.
7. In consultation with the appropriate CDC and PCIS persons the State of Alaska will develop an accessible and acceptable computer service to conduct the Hepatitis B Immunization and Control Program in the State Northern Regional Laboratory in Fairbanks.
8. The administration of the Hepatitis B Infection and Control Program will be the responsibility of the State of Alaska.
9. Evaluation of the impact of the Hepatitis B Infection and Control Program on the beneficiaries of the Alaska Native Health Service will be a responsibility of appropriate Alaska Native Health Service personnel. The State of Alaska Division of Public Health will evaluate the effect of the Program on the overall state population.

III. Renewal/Modification Clause

This Memorandum of Understanding is in effect for three (3) years unless modification or termination is issued with thirty (30) days advance notice by the offices of the original signers.

IV. Conclusion

Although the need to begin Hepatitis B Infection prevention and control is urgent, actions in program development and delivery must hold to the following principles;

1. Cooperation and trust
2. Open communication
3. Quality assurance
4. Rational planning.

Signatures:

B. A. Riley
Director, Alaska Area Native Health Services

January 27, 1983

E. S. Roberson
Director, Division of Public Health, State of Alaska

Jan. 28, 1983

Robert London Smith
Commissioner, State of Alaska Department of Health & Social Services

January 28, 1983

IMPORTANT INFORMATION
ABOUT HEPATITIS B AND HEPATITIS B VACCINE

Please read this carefully

WHAT IS HEPATITIS B?

Although Hepatitis B is an unpredictable disease with a variety of presentations and outcomes, most patients recover. Persistence of viral infection (the chronic carrier state) occurs in 5 to 10% of persons who become infected with hepatitis B virus. Acute Hepatitis B infection may be symptomatic and can incapacitate a person for weeks to months or lead to complications or chronic sequelae. However, 50 to 60% of all Hepatitis B infections are subclinical, asymptomatic, and usually undetected. These cases have a greater risk of progression to chronic sequelae. Chronic sequelae of Hepatitis B infection include:

- Chronic carrier state - develops in 6-10% of adult patients who have Hepatitis B.
- Chronic persistent hepatitis - generally benign.
- Chronic active hepatitis - major late complication; occurs in 3-5% of cases; often progresses to cirrhosis.
- Cirrhosis - an estimated 11% of deaths due to cirrhosis are associated with Hepatitis B. (4000/year)
- Liver Cancer - the relative risk for carriers is 273 times greater than for non-carriers (800 die/year from Hepatitis B related liver cancer)

There is no specific treatment and no known cure for Hepatitis B. The new vaccine can help prevent Hepatitis B.

HEPATITIS B VACCINE

The Immunization Practices Advisory Committee (ACIP) USPHS, has identified certain populations at risk of HBV infection and has recommended vaccination for appropriate members of the following groups:

ACIP recommendations for vaccination against Hepatitis B infection

- | | |
|--|---|
| .health-care workers | .classroom contacts of deinstitutionalized mentally retarded |
| .hospital staff | HBV carriers who behave aggressively. |
| .clients and staff of institutions for the mentally retarded | .special high-risk populations from areas where Hepatitis B is highly endemic |
| .hemodialysis patients | Indochinese and Haitian refugees |
| .homosexually active males | Alaskan Eskimos |
| .illicit injectable drug users | .inmates of long-term correctional facilities |
| .recipients of certain blood products | |
| .household and sexual contacts of HBV carriers | |

Persons at substantial risk of Hepatitis B infection who are demonstrated or judged likely to be susceptible should be vaccinated.

VACCINATION: Vaccination consists of 3 intramuscular doses of vaccine. The second and third doses should be given 1 and 6 months, respectively, after the first. Vaccine doses administered at longer intervals than those stipulated provide equally satisfactory protection, but optimal protection is not conferred until after the third dose. The duration of protection and the need for booster doses have not yet been determined.

Vaccination of individuals who possess antibodies against HBV from a previous infection is not necessary but will not cause adverse effects. The vaccine produces neither therapeutic nor adverse effects in Hepatitis virus carriers.

POSSIBLE SIDE EFFECTS FROM THE VACCINES:

Adverse Reactions: Hepatitis B vaccine is generally well tolerated. No serious adverse reactions attributable to vaccination have been reported during the course of clinical trials involving administration of Hepatitis B vaccine to over 6,000 individuals. Approximately half of all reported reactions were injection-site soreness. Other less common local reactions have included erythema, swelling, warmth, or induration. These signs and symptoms of local inflammation are generally well tolerated and usually subside within 2 days of vaccination.

Low-grade fever (less than 101°F) occurs occasionally and is usually confined to the 48-hour period following vaccination. Although uncommon, fever over 102°F has been reported. Systemic complaints, including malaise, fatigue, headache, nausea, dizziness, myalgia, and arthralgia, are infrequent and have been limited to the first few days following vaccination. Rash has been reported rarely.

As with any vaccine, there is the possibility that broad use of the vaccine could reveal rare adverse reactions not observed in clinical trials.

WARNING - SOME PERSONS SHOULD NOT TAKE THIS VACCINE WITHOUT CHECKING WITH A DOCTOR:

.Hepatitis B vaccine is not known to cause special problems for pregnant women or their unborn babies. However, doctors usually avoid giving any drugs or vaccines to pregnant women unless there is a specific need. Pregnant women should check with a doctor before taking Hepatitis B vaccine.

.Those who are sick right now with something more serious with a cold.

QUESTIONS: If you have any questions about Hepatitis B vaccination, please ask us now or call your doctor or health department before taking the vaccine.

REACTIONS: Anyone receiving vaccine who gets sick and seeks medical help in the 4 weeks after vaccination should report this to the facility which provided the vaccine.

Division of Public Health
State of Alaska
January 7, 1983

STANDING ORDERS
Hepatitis B Vaccine

Type of Vaccine

Age

Dosage

Hepatitis B

3 months through
life

3 doses i.m.; given on days 0, 1
month later and 6 months after 1st
dose.

	Initial	1 mo.	6 mo.
3 months to 10 yrs.	0.5ml	0.5ml	0.5ml
> - 10 yrs.	1.0ml	1.0ml	1.0ml
Dialysis and Immuno- compromised	2.0ml*	2.0ml*	2.0ml*

* Two 1.0 ml doses given at
different sites, i.m.

1. Store vials at 2-8°C. (35.6 - 46.4°F)
2. Shake well before using.
3. DO NOT FREEZE
4. Provide Hepatitis B Vaccine information sheet to each person before vaccination.

Contraindications: Hypersensitivity to any component of the vaccine.

- Precautions:
1. Not recommended for use in pregnant women. Ask if woman is pregnant. If answer is no, vaccine may be administered.
 2. Not recommended at present for use in children below the age of 3 months.

- Indications:
1. Indicated for immunization against infection caused by all known subtypes of Hepatitis B virus.
 2. Vaccination is recommended in persons 3 months of age or older who are at substantial risk of infection with Hepatitis B virus.
 3. Groups and individuals to be vaccinated are designated by the Medical Epidemiologist, Division of Public Health or his designee.

STATE OF ALASKA

JAY S. HAMMOHD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF COMMUNICABLE DISEASE CONTROL

ROOM 222, MACKAY BUILDING
335 DENALI STREET - ANCHORAGE 99501

January, 1983

HEPATITIS B AND HEPATITIS B VACCINE

I certify that I have been provided information about Hepatitis B. I am aware that I may be at increased risk of contracting Hepatitis B infection because of my work or my residence. I have had an opportunity to ask questions about Hepatitis B and to discuss Hepatitis B with staff at this facility. I understand that I can have my blood tested free of charge to see if I have been infected with Hepatitis B in the past or whether I could become infected with Hepatitis B in the future. I understand that I can also be vaccinated against Hepatitis B free of charge and that vaccination can protect me from becoming infected with Hepatitis B in the future. I understand that this program is entirely voluntary but that the Division of Public Health strongly recommends that I have my blood tested and, if I have not been infected with Hepatitis B in the past, that I receive Hepatitis B vaccine.

I do not wish to have my blood tested for Hepatitis B.

I do not wish to be vaccinated against Hepatitis B.

(Signature)

(Date)

(Witness)

THE LEGISLATURE OF THE STATE OF ALASKA
THIRTEENTH LEGISLATURE

FISCAL NOTE

21 Hear

I. REQUEST
 Bill/Resolution No. Senate Bill No. 96
 Title "An Act making a special appropriation for inoculations for hepatitis B."
 Requested by _____ Date 2/1/83

II. FISCAL DETAIL
 Agency Affected Health and Social Services
 Program Category Affected Health
 BRU, Program, Or Subprogram(s) Affected Communicable Disease Control
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	250.0					

FUNDING (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
GENERAL FUND	250.0					
FEDERAL FUNDS						
OTHER (Specify Source)						
	250.0					

POSITIONS

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

This Bill provides a special appropriation for a hepatitis B inoculation program and providing for an effective date.

RECEIVED

FEB 9 1983

LEGISLATIVE FINANCE

IV. DATE 2/1/83 PREPARED BY Dean F. Tirador, M.D.
 AGENCY Health & Social Services, Public Health
 Original: Legislative Finance PHONE 465-3150
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)
 33-001 (Rev. 12/82) OMB Reviewed by: Nancy Dunn

Health, Education and
Social Services Committee



Official Business

Alaska State Legislature
Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-1907
465-4908

February 9, 1983

Bonnie L. Gabaldon
Interim Executive Director
Alaska Native Health Board
1689 C. Street, Suite 230
Anchorage, Alaska 99501

Dear Ms. Gabaldon:

I thank you for your letter of January 27. The Senate Committee on Health, Education and Social Services has given its approval for appropriations to combat Hepatitis B. As chairman of the committee, I am recommending that the legislature fund \$250,000, the figure recommended by Senator John Sackett, as a supplemental appropriation to the current FY 1983 budget in order to undertake this important effort.

I appreciate your letter of January 27 and want you to know that I share the concerns of the Alaska Native Health Board and support the resolution you enclose.

With best wishes,

Sincerely,

Joe P. Josephson
Joe P. Josephson

JPJ/rmc

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501

PHONE (907) 276-8989

Reference #A83-0139

January 27, 1983

RECEIVED

JAN 31 1983

Josephson,

Senator Joseph Josephson
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Josephson:

During its regular quarterly meeting in December 1982, the Alaska Native Health Board unanimously passed the enclosed resolution imploring the State of Alaska to respond immediately to the "geographic epidemic" of Hepatitis B in Alaska.

Studies conducted by the Indian Health Service and Centers for Disease Control have found the infection rate in some Alaska villages is as high as 27.9%. This is over 50 times higher than the rates found in other USA populations. Alaskan Eskimos have the highest reported incidence of primary liver cancer in the U.S. and the highest reported incidence of Hepatitis B associated polyarteritis nodosa in the world.

The above facts are both deplorable and astounding. However, we firmly believe the potential for a health hazard of even more devastating proportions exists. If left unchecked, Hepatitis B will continue to spread into what are now considered to be low prevalence areas. Hepatitis B has already shown that it knows no racial boundaries. Young children are most susceptible to the often fatal complications that can result from Hepatitis B (i.e., liver cancer, polyarteritis nodosa, and chronic active hepatitis with cirrhosis).

Hepatitis B is a communicable disease. It is now preventable. As such, Hepatitis B falls within the parameters of the State's existing commitment to prevention and immunization programs. Again, we ask that the State honor its commitment to the people and take immediate action to insure that adequate funds are made available to the Division of Public Health to implement the necessary testing and immunization programs.

If you have any questions or desire further information, please do not hesitate to contact our offices.

Sincerely,



Bonnie L. Gabaldon
Interim Executive Director

blg

ALEUTIAN/PRIIBILOF ISLAND ASSOC., INC.
BRISTOL BAY AREA HEALTH CORPORATION
COOK INLET NATIVE ASSOCIATION
COPPER RIVER NATIVE ASSOCIATION

KODIAK AREA NATIVE ASSOCIATION
MAUNELUK ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH CORP.

NORTON SOUND HEALTH CORPORATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

RESOLUTION #82-11

- WHEREAS: The Alaska Native Health Board is a legally established organization of Alaska Natives, as defined in the Alaska Native Claims Settlement Act (85 Statute 688); and
- WHEREAS: The Alaska Federation of Natives, Inc. is a legally established organization of Alaska Natives which is democratically elected by the adult members of the Alaska Native community and which includes the maximum participation of Alaska Natives in all phases of its activities, has unanimously designated, by formal resolution on January 11, 1979 of its Full Board, "That the Alaska Federation of Natives, Inc. formally recognizes the Alaska Native Health Board as the Health Committee of AFN, Inc. and thereby conveys full authority to articulate policy and to act on health issues;" and
- WHEREAS: Hepatitis B has been identified by the Alaska Native Health Board as the number one preventable health threat to the people of the State of Alaska; and
- WHEREAS: This highly infectious, often fatal disease, affecting children and elderly alike, is increasing statewide; and
- WHEREAS: Statewide testing and immunization is imperative to the welfare of Alaska residents;
- THEREFORE: BE IT RESOLVED that the Alaska Native Health Board hereby directs the State of Alaska to cooperate with the Indian Health Service and Center for Disease Control in their proposal to ameliorate impacts of the epidemic in Alaska; and
- BE IT FURTHER RESOLVED that the State mobilize additional resources necessary to immunize those at risk throughout the State; and
- BE IT FURTHER RESOLVED that the State incorporate this vaccine in their ongoing immunization program; and
- BE IT FURTHER RESOLVED that the State of Alaska respond immediately to this crisis.

Passed and approved this 16th day of December, 1982 by the Alaska Native Health Board.

CERTIFICATION: Passed by unanimous vote; 10 for, 0 against.

S

B

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7



Bethel Social Services, Inc.

• A PRIVATE NON-PROFIT CORPORATION •

November 5, 1982

Senator John Sackett
P. O. Box 29
Ruby, Alaska 99678

Dear Senator Sackett:

This letter is to follow-up on our recent conversation regarding the cost of care dilemma that the Bethel Receiving Home is now in.

Bethel Social Services, Inc., opened the original Receiving Home in 1969 in an old B.I.A. building. This project was closed on 1976 as the building was simply not licensable. At the request of many State agencies, especially the Department of Corrections, Bethel Social Services, Inc., built a new receiving home with a combination of borrowed funds and Criminal Justice monies. This facility was constructed at great financial risk to the Corporation with assurances from the State that it would be fully utilized.

Our cost of care was set at \$55.63 based on the proposed budget divided by 75% of the number of licensed beds. Thus began the cost of care rate of having to lose money to get the cost of care rate up to make money. The following circumstances have prevailed at the Bethel Receiving Home in regard to the cost of care:

1. When the new home was opened in 1980, the cost of care rate was set too low because the anticipated usage AS ESTIMATED BY THE STATE fell below the actual usage.
2. With the exception of one facility which has donated labor, the Bethel Receiving Home has had the lowest cost of care rate throughout the State.
3. The Bethel Receiving Home has lost money each year. It failed to lose enough money, however, to raise the cost of care rate substantially to make money.
4. We have always been opposed to the cost of care method of setting rates. It rewards the inefficient. However, the interim method of freezing the rates will cause the Bethel Receiving Home to close. Our rate has been frozen

at the lowest receiving home rate in the State with the exception of the Sitka Home which has donated labor, we understand.

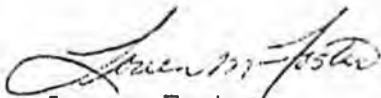
5. We were not aware that there had even been a change in the process until three months after it went into effect.
6. We are requesting the legislature set a cost of care rate for the Bethel Receiving Home at \$115.00 per day. Our current rate is \$75.52 per day. The \$115.00 is the average rate taken from averaging the rates from the receiving homes in Anchorage, Juneau, Nome and the North Slope. In essence we are saying that it should cost us an average of what the other facilities are providing care for. With sound management, this rate will allow the Bethel Receiving Home to provide care and reduce it's indebtedness.

Just to clarify the relationship between Bethel Social Services, Inc. and the Bethel Receiving Home, Inc. --- Bethel Social Services, Inc. operated the old receiving home. The building was owned by the Bureau of Indian Affairs. Bethel Social Services, Inc. built and owns the new receiving home and is the parent corporation and registered agent for Bethel Receiving Home, Inc., which operates the Bethel Receiving Home. (Without the two separate entities, there is no provision for paying the lease on the building under cost of care regulations.)

We are also enclosing a copy of the current rates for facilities throughout the State and a table of information pertinent to the Bethel Receiving Home's operations during the past three fiscal years. We have been in contact with John Pugh, Division of Youth & Family Services, and are trying to keep him abreast of our request through the legislature.

Please let us know if we can provide you with any additional information.

Sincerely,



Loreen Foster
Administrative Director

cc: John Pugh, Director, Div. of Youth & Family Services
Chet Adkins, President, Board of Directors

Encl: (2)

SUMMARY OF OPERATIONS
 BETHEL RECEIVING HOME
 FEBRUARY, 1980—JUNE, 1982

PERIOD	TOTAL EXPENDITURES	EXCESS OF EXPENDITURES OVER REVENUES	TOTAL KID DAYS	COST OF RATE	ACTUAL COST OF CARE
Feb - June, 1980	\$39,728.	(\$8,883.) (Losses covered by Crimi- nal Justice Start-up Funds)	695 (audited)	\$53.63	\$57.16
July, 1980- June, 1981	\$126,061.	(\$3,520.)	1,903	\$64.02	\$66.24
July, 1981- June, 1982	\$131,768.	(\$28,121.)	1,350	\$75.52	\$97.61

IN-STATE INSTITUTIONAL CARE RATES

PROVIDER	NAME	FY83 RATE	EFFECTIVE DATE	PROVISIONAL FY82 RATE	FY82 AUDITED
004996	ALASKA BAPTIST FAM SVS. CTR	\$117.02	7/1/82	\$117.02	
232007	ACS RECEIVING HOME	149.85	7/1/82	149.85	\$189.44
001455	ACS AQUARIUS HOUSE	107.60	7/1/82	107.60	106.61
002122	ACS COLLETTI HOUSE	117.51	7/1/82	117.51	118.79
001394	ACS JESSE LEE	165.46	7/1/82	165.46	134.70
001398	ACS RABBIT CREEK	166.40	7/1/82	166.40	168.84
001098	ACS NORTH STAR	103.55	7/1/82	103.55	102.61
004227	BETHEL GROUP HOME	59.06	7/1/82	59.06	57.72
231001	BETHEL RECEIVING HOME	75.52	7/1/82	75.52	
003339	BOOTH MEMORIAL	146.90	7/1/82	146.90	
001404	COVENANT HIGH SCHOOL	51.16	7/1/82	43.26	
004287	HILLTOP HOME	85.53	7/1/82	85.53	
001409	JUNEAU RECEIVING HOME	106.17	7/1/82	106.17	
004404	KENAI COMM CARE CTR	91.74	7/1/82	91.74	
236007	KETCH. INTENSIVE CARE UNIT	152.56	7/1/82	152.56	
004594	KETCHIKAN TEEN HOME I	74.26	7/1/82	74.26	69.59
236001	KETCHIKAN TEEN HOME II	81.61	7/1/82	81.61	69.59
001843	KODIAK BAPTIST MISSION	61.61	7/1/82	61.61	61.43
001037	KODIAK BAPTIST MISSION	61.61	7/1/82	61.61	61.43
005412	NOME RECEIVING HOME	116.97	7/1/82	116.97	109.20
233001	NORTH SLOPE BOROUGH REC HME	168.35	7/1/82	170.80	170.80
001004	NORTH STAR CHILDRENS HOME	62.25	7/1/82	62.25	
004247	PRESBYTERIAN HOSPITALITY HSE	111.98	7/1/82	111.98	
232005	"R" HOUSE			111.98	
001414	ST. MARYS MISSION			8.33	
005398	ST. JUDE CENTER, INC.	72.33	7/1/82	72.33	
005556	SITKA RECEIVING HOME	40.66	7/1/82	40.66	
001918	TURNING POINT BOYS RANCH	105.37	7/1/82	105.37	

Clay Row

ACS

ANCH/WILLOW

BETHEL

ACS Receiving Home
C/O AK Childrens Services
1200 E. 27th
Anchorage, AK 99504

Booth Memorial Home
C/O Salvation Army
Box 3-063
Anchorage, AK 99504

Bethel Receiving Home
Box 271
Bethel, AK 99559

#232007 X
\$149.85/day
07-01-82

#003330
\$146.90/day
07-01-82

#231001
\$75.52/day
07-01-82

ACS Aquarius House
C/O AK Childrens Services
1200 E. 27th
Anchorage, AK 99504

Hilltop Home Inc
P.O. Box 10-2223
Anchorage, AK 99511

Bethel Group Home
P.O. Box 385
Bethel, AK 99559

#001455
\$149.85/day
07-01-82

#004287
\$85.53/day
07-01-82

#004227
\$59.06/day
07-01-82

ACS Colletti House
C/O AK Childrens Services
1200 E. 27th
Anchorage, AK 99504

Turning Point Boy Ranch
Mile 68 Parks Highway
Willow, AK 99688

NOME
Nome Receiving Home
Box 1033
Nome, AK 99762

#002122
\$117.51/day
07-01-82

#001918
\$105.37/day
07-01-82

#005412 X
\$109.20/day
07-01-82

FAIRBANKS

OUT OF STATE

ACS Jesse Lee
C/O AK Childrens Services
1200 E. 27th
Anchorage, AK 99504

PHH-Receiving Home
C/O Pres. Hospitality House
1401 Kellum Street
Fairbanks, AK 99701

Excelsior Youth Center
15151 E. Quincy Avenue
Denver, CO 80015

#001394
\$165.46/day
07-01-82

#232005 X
\$111.98/day
07-01-82

#247011
\$64.77/day
07-01-81

ACS North Star

DDU Treatment Unit

Child Center

Anticipated supplemental
- based on 1600 total
kid days between
July 1, 1982 - June 30, 1983

$1600 \times \$40^{00}$ (approx
diff.
between existing rate - $\$15^{52}$
and req. rate - 115^{00})

Total Supp. \$ 64,000.



Superior Court
State of Alaska

FOURTH JUDICIAL DISTRICT

P.O. BOX 130

BETHEL, ALASKA

99559

CHAMBERS OF
CHRISTOPHER R. COOKE, PRESIDING JUDGE

PHONE: (907) 543-2298

November 1, 1982

Mr. John Pugh, Director
Division of Family and
Youth Services
Pouch H-05
Juneau, Alaska 99811

Re: Bethel Receiving Home

Dear Mr. Pugh:

It has come to my attention that the Bethel Receiving Home is in serious financial trouble. The home is operating at a substantial loss and will soon be forced to close unless additional revenue can be secured.

The Receiving Home provides temporary shelter for juveniles detained in delinquency proceedings and emergency foster care for children in need of aid. Loss of the Receiving Home would have a great adverse impact upon the Alaska Court System and this region since it is the only facility of its type in this area.

Without the Receiving Home, juveniles detained in delinquency proceedings would have to be housed in the substandard Bethel City Jail and, at great expense and inconvenience, McLaughlin Youth Center in Anchorage. Emergency foster homes for neglected or abused children would have to be found on a case-by-case basis. This would constitute a giant step backward for the juvenile justice system in this region and for the local and regional operations of your department.

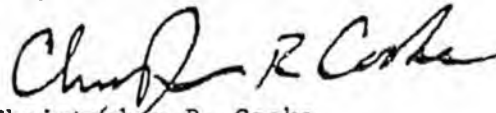
One reason for the Receiving Home's financial plight is the cost of care rate paid by your department. Currently that rate is \$75.52 per day while comparable facilities in Nome, Juneau and Anchorage receive

Mr. John Pugh
Page Two
November 1, 1982

\$116.97, \$106.17 and \$149.85, respectively. The Receiving Home would be financially viable if their daily rate were in the vicinity of \$100.00 or if bed space could be provided to your agency on a monthly retainer basis.

I would appreciate your prompt attention to this situation. If the Bethel Receiving Home is forced to close, this community, the 56 villages of our region, and both our agencies will suffer. With your cooperation I hope that such a drastic result can be avoided.

Very truly yours,



Christopher R. Cooke
Superior Court Judge

CRC/bn

cc: ✓ Senator John Sackett
Representative Tony Vaska
David E. Arnold
Gloria Hawkins
Bob Buttane
Loreen Foster
Don Constantine
Jim Shanks
Laurie Otto

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE CS FOR SENATE BILL NO. 97

PAGE 1

"An Act making a supplemental appropriation to the Department of Health and Social Services for payment as a grant to Bethel Social Services, Inc.; and providing for an effective date."

House Committee Substitute for Senate Bill No. 97 makes an appropriation of \$65,000 to the Department in the form of a grant designated for Bethel Social Services, Inc. to operate the Bethel Receiving Home during the remainder of the current fiscal year.

There are a variety of problems inherent in operating such facilities in Bush communities which are either unique to those facilities or exaggerated because of their location. For example, initial start-up and ongoing operating costs of such facilities are usually greater than for urban facilities.

In addition, smaller facilities located in rural areas generally have less predictable resident populations and suffer from cash flow problems.

The number of emergency placements has declined in the Bethel area as it has statewide. This decline has resulted from changing needs of children and more effective efforts to comply with the Indian Child Welfare Act, which mandates preferential placement of Native children in the homes of relatives or in Native foster homes. This has proven particularly problematic, however, to those facilities, such as the Bethel Receiving Home, operating in areas in which the majority or a very large percentage of the population is Native. Thus, while staffing is generally maintained at levels adequate to provide for the average population of the facility and for emergency circumstances the actual number of residents is often below the level required to provide fiscal support for the facility's operation. Since contracting for a number of beds is not allowable under existing purchase of services law, the facility cannot be assured of income necessary for operation during those periods when few or no placements are made.

In summary, the Department is supportive of maintaining facilities such as the Bethel Receiving Home which serve as necessary placement resources for abused or neglected children and for delinquent youth who do not require detention. Maintenance of such facilities in rural areas is critical due to

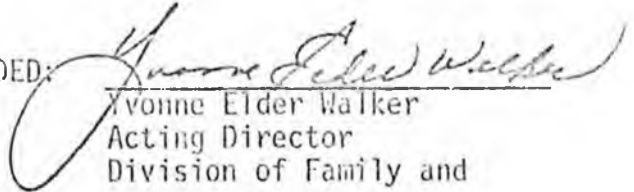
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MAY 27 1983

Josephson,

the general paucity of alternative resources. Without such resources many children and youth would necessarily be placed in urban facilities far from the systems of support provided in their communities and separated from their families. Such separation at times nullifies efforts to resolve the precipitating social or family problems and may prevent reunification of the child and family or rehabilitation of delinquent youth.

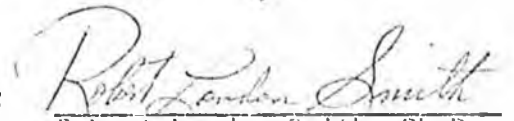
RECOMMENDED:


Yvonne Elder Walker
Acting Director
Division of Family and
Youth Services

DATE:

May 23, 1983

APPROVED BY:


Robert London Smith, Ph.D.
Commissioner

DATE:

5/24/83

MINUTES OF THE RCCF
PAYMENT RATE STUDY COMMITTEE

November 8, 1982

BACKGROUND:

CCSHB 357, which was passed by the Twelfth Legislature in 1982, suspended operation of AS 47.05.010(14), AS 47.40.010, 47.40.040, and 47.40.050 from July 1, 1982 through June 30, 1984 and established a five member committee to study alternatives to the method of establishing payment rates under AS 47.40. Under CCSHB 357, the committee is to be composed of five members appointed by the Commissioner of the Department of Health and Social Services, three of whom are to be employees of the Department of Health and Social Services (DHSS), and two are to be providers of residential child care services. The following persons were appointed by Commissioner Helen D. Beirne to serve on the committee: John Garvin, Executive Director of Alaska Children's Services and President of the Alaska Association of Children's Homes; Linden Staciokas, Director of Presbyterian Hospitality House; Joe Betit, Deputy Director of the Division of Administrative Services (DHSS); Marsha Hubbard, Director of the Division of Management and Budget (DHSS); and John Pugh, Director of the Division of Family and Youth Services (DHSS). Dale Voltz, Director of the Juneau Receiving Home, and Bill Webb, Director of the Nome Receiving Home, were appointed as non-voting members of the committee to service as alternates in the case of the absence of a voting residential child care provider, as well as to provide comments from the perspective of smaller and rural facilities.

FIRST MEETING:

The first meeting of the committee was held in Juneau on the morning of November 8, 1982, the purpose of which was to delineate the scope and plan the work of the committee. Present were Joe Betit, John Pugh, Marsha Hubbard, John Garvin, and Dale Voltz. Linden Staciokas was absent due to illness. Bill Webb was not present since the travel costs for the short meeting did not appear to be justified. Ted Sponsel, Presbyterian Hospitality House, attended the meeting, and two staff members of the Division of Family and Youth Services (Jackie Damon and Nina Kinney) were present to provide staff support for the committee.

John Pugh was chosen chairman of the committee.

ISSUES:

After reviewing CCSHB 357, the committee members identified the following issues to be addressed by the committee:

1. Rate Setting Mechanism: Consideration will be given to the full cost of care method, contracts, grants, and any other methods identified by the committee or DFYS staff.
2. Methods of reimbursement for capital costs, including lease-back depreciation.

3. Sources of Funding: The availability and use of other sources of money to finance residential child care services and to finance the construction of residential child care facilities.
4. Allowable Expenses
5. Who shall be the service providers? John Garvin suggested consideration of this topic to include consideration of the types of organizations the Department should purchase from (profit, non-profit, municipalities, etc.) and whether the Department should require accreditation by an independent body.
6. Purchase of Service Regulations: Once the rate setting approach and other major issues are decided on, the final committee report will include a preliminary draft of regulations which would be needed to implement the committee's recommendations. There was agreement that it would not be feasible to have a finished set of regulations, but that at least the broad categories and approaches would be addressed by the committee and the Division would complete a first draft.

TIME FRAMES:

CCSHB 357 requires a report to the Legislature by the 30th day of the second session of the 13th Legislature (approximately mid-February, 1984). However, the committee decided it would be preferable to complete the work by November 15, 1983.

INFORMATION GATHERING:

There was a discussion regarding sources and methods of gathering information with the following decisions made:

1. The Division will review information on purchase of residential child care services from other states, and provide an analysis to committee members, and copies of any particularly useful documents.
2. John Garvin has compiled material from the Child Welfare League Library and offered to share an analysis and copies of relevant information.
3. John Pugh stated that the Region X Resource Center for Children, Youth, and Families at the University of Washington is planning a workshop on purchase of residential child care services. As soon as he receives the dates and agenda, John will notify committee members.
4. If outside consultants are available free of charge to the committee, they will be requested to provide information. Mention was made of Jim Mann, Western Regional Representative of the Child Welfare League of America, and the possibility of ORPSCA sharing the information they compiled two years ago from all the states.

COMMUNICATION WITH RCCF PROVIDERS:

There was discussion regarding the ways in which the committee could solicit and receive comments from providers. It was decided that everyone receiving full cost of care should receive a summary of the minutes of each meeting, and that they would be asked to share any concerns, comments, and reactions with

the Chairman of the Committee, John Pugh. Providers would thus receive ongoing communication as issues are addressed and would have the opportunity to provide comments.

There was also a suggestion made that teleconferencing could be utilized by the committee, especially when consultants are available.

DECISION-MAKING:

Plans are for the committee to meet in work sessions, primarily in Juneau to minimize the number of people who need to travel, and to be able to provide staff support to the committee. Meetings are open to the public, and prior to any votes on recommendations, the Department will give written public notice.

The Committee adopted Robert's Rules of Order, requiring a simple majority for any votes taken. If the Committee does not reach consensus on issues, the final report will include minority reports indicating the minority views and identifying the committee member votes.

COMMUNICATION WITH THE LEGISLATURE:

It was decided that it would be useful to keep the Chairmen of Health, Education, and Social Services Committees in the House and Senate apprised of the work of the committee. Therefore, once the chairmen are appointed, the Division will send them copies of the preceding minutes and provide other information as requested.

NEXT MEETING:

The next meeting, and first full committee meeting will be held on Monday, December 20, 1982, at 8:30 a.m. The topic for this meeting will be the rate-setting mechanism.

The following meeting will focus on capital costs (Issue #2) and the subsequent meeting will address allowable costs (Issue #4).

Minutes Taken By:

Nina Kinney
Nina Kinney
Social Services Program
Coordinator
Division of Family and
Youth Services

Approved By:

John R. Pugh
John R. Pugh, Director
Division of Family and Youth Services
Chairman of Committee

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF FAMILY AND YOUTH SERVICES

POUCH H-05
JUNEAU, ALASKA 99811
PHONE: (907) 465-3170

DOCUMENT NO. 83-36

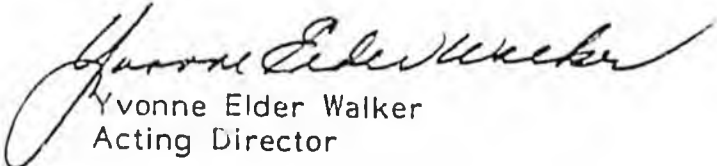
February 3, 1983

Honorable Joe Josephson
Chairperson, Senate HESS
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

This is in follow-up to my letter of January 31, 1983 in which the minutes of the Payment Rate Study Committee were inadvertently omitted. They are now enclosed.

Sincerely,



Yvonne Elder Walker
Acting Director

Enclosures

YEW:NK:kk

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Josephson

Minutes of the RCCF Payment Rate Study Committee

December 20, 1982

The second meeting of this Committee was held on December 20, 1982 in Juneau. Present were: John Garvin, Linden Staciokas, Joe Betit, Joann Clark (for Marsha Hubbard), John Pugh, Dale Voltz, and Bill Webb. The Division of Family and Youth Services staff members present were: Jackie Damon and Nina Keeler.

John Pugh convened the meeting and asked for feedback on the minutes of the previous meeting. There being none, John Garvin reported on the meeting of the Alaska Child Care Providers Assn. which occurred subsequent to the first meeting of this Committee. Mr. Garvin stated that the members of the Assn. want to try to preserve the basic components of the current reimbursement system for cost of care. They feel that controls can be instituted by developing purchase of service regulations which address other income plus a mechanism for reimbursement of capital expenses.

Review of Materials From Other States

The Division of Family and Youth Services presented copies of selected materials from other states (purchase statutes, regulations and cost manuals), and the Committee reviewed the packet. In addition, John Garvin added comments on some of the states systems based on his discussions with providers from other states. States which were discussed included:

- a. Michigan. Michigan uses a utilization rate of 85%, with a reimbursement rate range of \$45-\$100/day, which is based on the previous year's costs. There is no mandated cost of living increase factor, but cost of living is taken into account in rate-setting. A facility can spend donated funds on allowable costs and these costs will then be factored into the following year's rate. Significant programming changes must have approval of licensing and program staff of the State.

Each facility has a master contract which includes an average number of beds the agency will provide. The department's appropriation amount determines the maximum number of children who will be served. In last year's negotiations with the State the Michigan Association agreed that rates would not escalate more than 15%. This year's rates, however, are frozen. The material sent by the state of Michigan on interim rate setting will be useful to review in more depth.

- b. Pennsylvania. Pennsylvania is organized by county, and their system would not be workable for Alaska.
- c. Wisconsin. Wisconsin negotiates individual contracts with facilities, and has a prospective rate setting system with

partial cost setting. They require a surety bond for advances.

The providers at this meeting stated that cash advances for receiving homes would be very helpful, because providers of emergency shelter care have such a hard time with the current system.

- d. Alabama. Alabama also provides exceptions for emergency shelter care.

Two other issues arose in reviewing material from states. Cost of living adjustments if allowed must be used with discretion. For example, applied to fixed capital costs, COLA becomes very inflationary. Contracts or written agreements are not currently required under full cost-of-care; however, the Department of Administration is moving towards requiring RFP's and contracts with many more providers, and it may be that they will be required in the future.

The Committee then chose to compare rate setting methods by comparing the strengths and weaknesses in each method from the perspective of both the administration (State) and the providers. The following tables will provide comparisons, and will identify providers by a (P) and the State administration by (A).

STRENGTHS AND WEAKNESSES OF THE
FLAT RATE/SCHEDULED RATE METHOD

Description:

Under this method, a specified rate is paid to all facilities regardless of the actual costs involved in providing the necessary care. As a result, although the rates paid are often based on surveys of provider costs or on general governmental indices, some providers are underreimbursed for their expenses while others can realize a "profit". However, a scheduled rate method is the easiest and least costly method to administer.

(Discussion based on assumption that rates set prior to appropriation.)

Strengths

- A. Easy to administer
- P. Pre-determined knowledge of rate
- A. Uniformity and, with proper levels of care, could be fairness
- A. Costs for next FY established prior to budget

Weaknesses

- A. Profits and severe underfunding could affect quality of care
- P. Failure to take into account individual agencies' programming
- A. Difficulties in developing levels of care
- P. Negotiations take time, resources, etc.
- P. Rate is generally set historically, fails to keep pace with inflation and industry norms (COLA)

A = Administration
P = Provider

NEGOTIATED RATES

Description

This method relies on the supply/demand relationship between the number of institutions able to provide the required care and the amount of public funds available to pay for that care. Negotiated rate methods often start out as cost-based methods, but deviate from them if provider costs increase more quickly than government revenues.

(Based on contract - but could be a grant process also.)

<u>Strengths</u>	<u>Weaknesses</u>
A/P Individualized contracts for each agency	A/P Complexity and difficulty of administration (RFP)
A Creation of new programs where needed	A/P Possible lack of continuity
A Competition among providers	A Capital projects paid by the State decrease competition*
A Ability to live within appropriation	A Necessitates the development of levels of care
A Administration can set limits on costs, expenditures (based on appropriation)	A/P Adversarial process
P More "sophisticated" providers would have an advantage in RFP process	P Smaller/rural programs may have difficulty competing
	A/P More out-of-state bidders - 1. not knowledgeable about Alaska - 2. megabucks behind them and out-of-state bidders unaware of high ongoing salary costs

*Taking State funded buildings into account in negotiation would be very difficult.

A = Administration
P = Provider

FEE FOR COMPONENT SERVICE METHOD

Description:

This method is more sophisticated than the flat rate method in terms of relating the rate paid to the service provided. There are two basic approaches under a fee for component service method. The first is to set rates for various groups of institutions providing similar services. The other approach is to set rates for specific services to be provided to an individual child, such as certain types of therapy or tutoring.

Strengths

- A/P Allows for individual programming/child (cost-incentive) and allows for payment of those services
- A This type of system would be necessary to implement a goal oriented system (GOSS) which could allow for evaluation of services for each child
- A/P Truer picture of costs per type of child

A = Administration
P = Provider

Weaknesses

- A/P Staff resources
- A Administrative problems - fiscal, audit
- P Additional administrative A costs to the provider
- A/P Possibility for conflict between provider and administration over services needed

COST BASED METHOD

Description:

This method bases the rate paid on the costs incurred by the institution in providing care to the foster child. Determination of the costs may be accomplished either by taking historical costs and applying a cost-of-living adjustment to allow for the intervening time lag, or by using costs which have been projected by the provider for the period to be covered by the rate.

<u>Strengths</u>	<u>Weaknesses</u>
P Helps providers to keep up with increasing costs 1. Inflation factor 2. Upgrading of program	A/P Great fluctuation in percentage increases/decreases
P Program continuity	P Providers have major cash flow problems since it's retrospective rate setting
A/P Up-front administrative costs are minimal	A Difficulty in initiating new programs
A/P Detailed regs can provide a clearer understanding of allowables/unallowables, etc., (Preferred by providers)	A Provider competition
P Provides an opportunity for improved quality of care if resources are available	A No incentive for cost effectiveness
A/P Better Department/provider rapport	A Requires audit resources
	A Lack of control over program development and costs
	A Inability to adequately forecast rates for budget purposes
	A Lack of ability to influence programming
	P Severe problems with emergency shelter

A = Administration
P = Provider

ALASKA'S FULL COST-OF-CARE SYSTEM

Strengths

- P Help provider keep pace
 - inflation
 - development
- P Program continuity
- A/P Administrative costs are minimal
- A/P Opportunity for improved quality of care
- A/P Provider/State rapport is good
- A If programs stay full, there is an advantage to the State
- A Private dollars do supplement State dollars

Weaknesses

- A/P Lack of detailed regs
 - lack of specificity of allowable costs
 - lack of depreciation as allowable
- A Annual audit for rate-setting is required and audit staff are insufficient
- P High increases by one or few providers means decreasing dollars for others
- A/P Uncontrollable cost escalation (private dollars can escalate costs)
- A/P Inability to forecast rates for budgeting purposes
- A Leads to deficit spending
- A/P Extreme fluctuation in rates
- P Cash flow Problems
- P Funding problems for ES
- A Inability to control program development

A = Administration
P = Provider

IDEAL SYSTEM

Following the comparisons of the five methods, the Committee considered the elements that an "ideal system" might include. Providers and the state representatives were in agreement that an ideal system would be easy to administer, would improve quality of care for children, provide continuity of care and for a reasonable growth in the amount of beds. In addition, it would control cost escalation, provide for individualized programming for children, would address other income sources and depreciation, and would set program standards. There was also agreement that emergency shelter beds would be treated as a separate component, ideally.

Providers felt that their ideal system would allow for program development autonomy. They would like to see a formal rate setting mechanism which is not totally controlled by the Department, but would allow them to influence the rate setting process.

In addition, they would like system reimbursement of a predetermined number of beds rather than per diem, a prepayment system on monthly basis, and for payment of all allowable expenses. They would like to salaries to be not less than 80% nor more than 100% of the comparable State salaries, not including benefits. They would also like to see accreditation by a body like JCAH, CWLA, or NAHC.

The state representatives felt an ideal system would allow the state program control and a predictable system to forecast costs for budget, would provide for competition/cost-effectiveness, would require an 85% census for full payment and 70% for emergency shelter care.

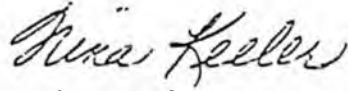
CONCLUSIONS

After review of the above methods, the Committee requested the staff members to prepare for the next meeting two items for their consideration:

1. An amendment to AS 47.40
2. A bill for contracting

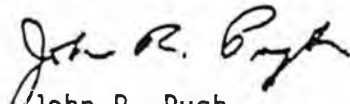
The next meeting was set for Monday, February 7, 1983, in Juneau.

Minutes taken by:



Nina Keeler
Social Services Program
Coordinator

Approved by:



John R. Pugh
Director

	Address	Phone	Director	Licensed Capacity	Days of Care	FY '83 Budget	Capital Investment
1.	Alaska Children's Services, Inc. 1200 E. 27th Ave Anchorage, Ak. 99504	(907) 276-4515	John C. Garvin	107	27,468	\$5,000,000	\$6,000,000
2.	Alaska Baptist Family Service Center SRA Box 1791A	(907) 349-2222	Gordon Lantrip	12	3,216	\$ 406,000	\$750,000 - L \$500,000 - B ec
3.	North Slope Receiving Home Box 371 Barrow, Ak. 99723	(907) 852-7007	Charles Tadgerson	10			
4.	Bethel Group Home, Inc. Box 385 Bethel, Ak. 99559	(907) 543-2846	Kent R. Kaltenbacher	8	1,692	\$ 120,000	\$200,000
5.	Salvation Army Booth Memorial Home Pouch SA 3-063 Anchorage, Ak. 99501	(907) 279-0522	Lt. Gene Ragan	18		\$1,100,000	
6.	Presbyterian Hospitality House, Inc. 1401 Kellum St. Fairbanks, Ak. 99701	(907) 456-6445	Linden Staciokas	28	3,524	\$ 870,000	
7.	Juneau Receiving Home P.O. Box 2839 Juneau, Ak. 99803	(907) 789-7610	Dale Voltz	12	4,123	\$ 435,000	
8.	Kenai Peninsula Community Care Center Drawer 3573 Kenai, Ak. 99611	(907) 283-7635	Billie Hardy	10	2,847	\$ 276,000	\$480,000
9.	Ketchikan Children's Home P.O. Box 6555 Ketchikan, Ak. 99901	(907) 225-2360	Carl Robins	23	6,580	\$ 717,709	\$ 8,000
10.	Kodiak Baptist Mission, Inc. Box 785 Kodiak, Ak. 99615	(907) 486-5181	David Cook	30	6,112	\$ 400,000	\$2,000,000
11.	Nome Receiving Home, Inc. P. O. Box 1033 Nome, Ak. 99762	(907) 443-2154	Bill Webb	5	1,170	\$ 168,438	
12.	Crossroads Youth Center P.O. Box 1349 Delta Junction, Ak. 99737	(907) 895-4521	Duane Schlekau	5		\$ 129,298	\$ 29,410
13.	Turning Point Boys Ranch Box 1070 Willow, Ak. 99688	(907) 495-6241	Ilene Hahn	40		\$1,200,000	\$1,400,000
14.	Sitka Receiving Home Box 664 Sitka, Ak. 99688	(907) 747-3682	Dave Dapceovich (Bd. member)				

	Date Founded	Board of Directors	No. of Staff	% of State Cost of Care	Amount of Endowment	Related to	Accreditation/Affiliation
Alaska Children' Services, Inc.	1970	18 members	150	94%	\$1,900,000	United Methodist/ American Baptist/ American Lutheran/ Disciples of Christ/ Community	Council on Accreditation Child Welfare League of Amer United Way
Alaska Baptist Family Service Center	1973	9 members	8.5	70%	\$ 950,000	Southern Baptist City of Barrow	National Assn. of Homes for Children
North Slope Receiving Home							
Bethel Group Home, Inc.	1972	7 members	5	100%		Community	Natl. Assn. Homes for Childr
Salvation Army Booth Memorial Home		18 member Council	26	80%		Salvation Army	United Way Natl. Assn. Homes for Childr
Presbyterian Hospitality House, Inc.	1957	12 members	25	90%		United Presbyterian Church	United Way Natl. Assn. Homes for Childr
Juneau Receiving Home	1961	11 members	12	95%		Community	
Kenai Peninsula Community Care Center	1973	9 members	7 full 2 pt	98%		Community	
Ketchikan Children's Home	1957	11 members	17	95-100%			Natl. Assn. Homes for Childr
Kodiak Baptist Mission, Inc.	1893	12 members	14	80%		American Baptist Church	Natl. Assn. Homes for Childr American Baptist Homes and Hospitals
Nome Receiving Home, Inc.	1977	7 members	4	100%		Community	Natl. Assn. Homes for Childr
Crossroads Youth Center	1982	10 members	6	100%		Community	
Turning Point Boys Ranch	1970	12 members	35	85-90%		Community	American Corrections Assn.
Sitka Receiving Home						Community	

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July 4, 1982

Dr. Michael Graf, President
Alaska Psychological Association
P.O. Box 4-1885
Anchorage, AK 99509

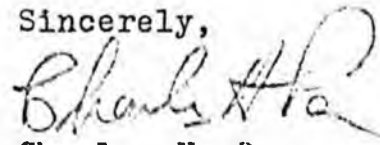
Dear Dr. Graf:

Thank you for your letter of June 29. I would be delighted to speak at your next meeting, assuming I'm not already committed for the date you select.

As you know, I was heavily involved in each of the issues you mention in your letter. Since SB 823 passed exactly as my HESS Committee had written it I was highly disappointed that the governor relied on bad advice and vetoed it. Next year we will have a different governor....

My brief statement for your newsletter is enclosed. I hope it will of some interest to your membership.

Sincerely,



Charles H. Parr

Statement by Charlie Parr

Research, wide dissemination of research findings, and intensive schooling have in recent decades made medicine more of a science and less of an art. If current experiments with the use of computers in medicine bear fruit, the sphere of intuition and subjective judgment will be even smaller. Although advances have been made in the diagnosis and treatment of both physical and mental illness, our knowledge of the mind still lags behind that of the body, and the number of "judgment calls" continues to be higher.

Lay policymakers have a difficult task. We have obligations to the general public, the recipients of services, and the practitioners, and our obligations must be met within the framework of the U.S. and State constitutions. Our actions must also fit within budget constraints and not run contrary to perceived public opinion. We are not privy to arcane knowledge, and our tendency is to trust the experts (in this case the psychiatrists and psychologists) whenever possible.

This trust cannot be unqualified. We do have experience, including that of other states, to draw on; we have heard of "turf protection" and "snake pits". We know that not every practitioner keeps up with all of the latest research findings and that not all research is properly done. We hope that the experts will police their own ranks, for that is the greatest protection for the recipients of services and for the general public.

Finally, we hope that practitioners will develop--and show us conclusive evidence for--workable, affordable ways to prevent rather than cure mental illness.

1992 Statement by
past ALPA President
Dr. Michael Graf

For those who would deregulate society in general and professional practice in particular, there is little that can be said in favor of a psychological Board of Examiners and the continued licensure of psychologists. Like attorneys, morticians, veterinarians, and certain other professionals, psychologists only rarely make decisions which truly have life and death consequences. Why not let the marketplace and peer pressure alone decide who may practice law, veterinary medicine, psychology and other professional disciplines? This question, both philosophical and practical, is being asked widely and at many levels. It has an immediate appeal and on the face of it seems to promise a great deal: less government intrusion in people's lives, wider availability of professional services at lower cost, an emphasis upon self-reliance rather than reliance upon government, etc.

The broad philosophical question "What should be the purpose(s) of government and to what lengths should it go in fulfilling such purpose?" will not be explored in any depth here and those who embrace a radical libertarian philosophy will see little merit in our arguments. We take the position that regulation of these professions is a proper role for state government, that such regulation can and should serve to protect the public, that professionals have an obligation to police their own ranks and should have mechanisms available by which to do so, and that a professional board of examiners is critical to the accomplishment of these tasks.

We do not intend a point-by-point rebuttal of all the various charges contained in the recent Division of Legislative Audit report other than to point out that the Division appears to have begun with the premises that professional regulation is not a proper activity for state government, and now is a good time for the Alaskan government to begin getting out of such affairs. Working from these premises, it has resurrected old charges, given credence to transparently self-serving complaints of disgruntled applicants, and failed to seek or accept information which might support the record of hard work and solid results turned in by the current Board of Examiners.

Overburdened in the extreme, understaffed, composed of too

few members and funded for only a few meeting days each year, the Board has made remarkable progress in overcoming a legacy of administrative indifference, legislative uncertainty, constant pressure and an overwhelming backlog. In the face of impossible and sometimes contradictory demands, the Board has made excellent progress, deserving better than the one-sided evaluation conducted by the Division.

A measure of the inadequacy of the Division investigation is that at no point was the state psychological association contacted for comment, licensed psychologists weren't surveyed, and no apparent consideration was given to the carefully prepared and closely reasoned July 7, 1981 letter of Board member, Dr. Delys-Baglien. In it she responded at length to an Interim Letter from Mr. Dan Allen which in all significant respects paralleled the final Division report. It is evident from an examination of the final report that her letter was ignored. Dr. Delys-Baglien and the Board are well able to respond to specific criticisms of Board policies and actions and will continue to do so. We would like to point out some pragmatic reasons for working to improve, not eliminate, the regulation of psychological practice in Alaska.

It is well known that the vast majority of health care costs are now paid by government, insurance companies, and other third party payors. This situation holds equally true for the payment of treatment services provided by psychologists. Almost universally, the payors have chosen to hold down costs and protect consumers by reimbursing only licensed psychologists. Similarly, the 1981 Alaska legislature recognized a need to protect the public when it required licensure of psychologists involved in SB-100 involuntary commitment proceedings.

In 1979 the Governors Mental Health Advisory Council, a citizen group composed primarily of consumers, passed and later reaffirmed the following resolution:

Whereas the consuming public has a right to expect that individuals providing psychological treatment are professionally licensed qualified psychologists and psychological associates and;

Whereas many insurance providers require that psychologists be licensed for the payments of benefits and;

Whereas the judicial system and certain federal agencies such as federal disability certification programs require the participation of licensed psychologists and;

Whereas the present board, the Alaska Board of Psychologists and Psychological Associate Examiners, provides professional licensing standards under the existing statutory scheme AS 08.86.230.

Be it resolved that the Mental Health Advisory Council supports the continuation of a Board of Psychologists and Psychological Associate Examiners.

The points they raised in 1979 are equally valid in 1982 and the Alaska Psychological Association strongly supports the continuation and improvement of current statutory provisions for the regulation of psychological practice. The professional Board of Examiners is an essential component of this effort. We pledge ourselves to work with the Alaska Legislature, the Division of Occupational Licensing, and professionals throughout the state to continue to improve the quality, availability and accessibility of professional psychological services throughout Alaska.

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

Bill Sheffield, Governor

POUCH D
JUNEAU, ALASKA 99811
PHONE: (907) 465-2534

January 3, 1983

Dr. Cheryl Frair
Alaska Psychiatric Institute
2900 Providence Avenue
Anchorage, Alaska 99504

Dear Dr. Frair:

I am writing regarding your presentation before the Board of Psychologist and Psychological Associate Examiners on December 6, 1982. At that meeting, you indicated that you were appearing as president-elect of the Alaska Psychological Association (ALPA) to report on certain actions taken by the ALPA executive committee. Two aspects of your report were of particular concern to me.

In your statement, you indicated that ALPA was distressed that the Division of Occupational Licensing had not taken any steps to introduce legislation for continuation of the board. I must confess that I am both confused and concerned by this statement. To my knowledge, ALPA has not contacted either the Division of Occupational Licensing or the board regarding any aspect of the Division of Occupational Licensing's position on psychology licensing legislation.

Please be assured that the Division of Occupational Licensing has been, is, and will continue, to work for licensing legislation in the public interest. Any substantive assistance that ALPA would like to give the Division of Occupational Licensing in determining what type of legislation would most be in the public interest would be appreciated. This invitation has been extended in the past and continues unchanged.

You also indicated at the board meeting that ALPA has sent a "strongly worded letter to the task force that is dealing with the licensure agency expressing concern over the lack of professionalism with which the Board of Psychologist and Psychological Associate Examiners has been handled by the Division of Occupational Licensing." Needless to say, I do not agree with the sentiments you expressed at the meeting and, as a matter of professional courtesy, I would appreciate receiving a copy of the text of the letter. My main concern here is to have the opportunity to correct any erroneous information that may be damaging to the Division of Occupational Licensing or to the licensure process itself.

Dr. Cheryl Frair

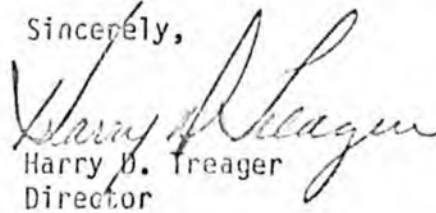
-2-

January 3, 1983

In closing, I would like to reiterate my desire to receive any information or constructive comments on psychology licensing that would assist in the development of the best possible licensing legislation.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Harry D. Treager".

Harry D. Treager
Director

HDT/saM/27

cc: James W. Greenough, Ph.D., Chairman
Board of Psychologists and Psychological
Examiners

ALPA ALASKA PSYCHOLOGICAL ASSOCIATION

29 Jan 1983

Harry D. Treager, Director
Division of Occupational Licensing
Pouch D
Juneau, Alaska 99811

Dear Director Treager,

On behalf of the Alaska Psychological Association and in assistance to our President, Cheryl Frair, Ph.D., I have composed this response to your letter dated January 3, 1983.

ALPA is delighted that you are concerned with our dissatisfaction with the Division of Occupational Licensing. If you remain its director we look forward to you improving the support given to the Board of Psychologist and Psychological Associate Examiners. We would be pleased to hear of the results of your review of past support to the Board both in the administrative and the investigative areas.

Your statement that ALPA has never contacted the Division in regard to licensing legislation is false. I personally spoke with you on the telephone and you twice failed to keep meetings with me in Anchorage. I also spoke with and met your former aide Nick Coti on two occasions, once at a meeting of the Governor's Advisory Council on Mental Health and again individually for a working lunch session. All these interactions occurred prior to your sudden withdrawal of support to the Board.

Your statements are further misleading if one recalls your testimony before the joint HESS committees last year. That testimony is a matter of public record and shows your non-support of the Board despite overwhelming evidence that Board continuation and enactment of last year's S.B. 823 was "in the public interest". Your work for licensing legislation will be further called into question should you support the most recent draft of the Code Revision Commission proposed regulations pertaining to the licensing of professions. We ask that you express in writing your non-support of that draft in regard to its placing regulatory functions of the Boards under the Director's control. We also ask that you endorse the professional boards having oversight, disciplinary, investigatory and decision making authority over the practice of their professions in Alaska. We further ask that you pledge the support of the Director of Occupational Licensing and his staff to the professional boards as they attempt to faithfully exercise their authority in the public interest.

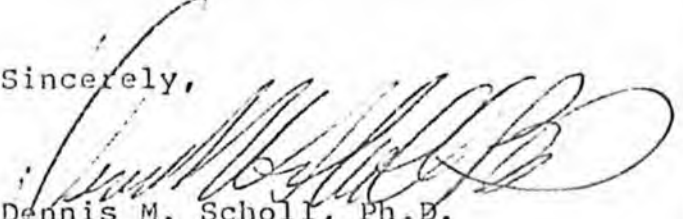
At the December meeting of the Executive Committee of ALPA I submitted a motion asking for a strongly worded letter to the

Governor's transition team regarding your and your Division's lack of professionalism in regarding the psychology board. The motion was approved with the amendment that the letter be first reviewed by our lobbyist Jana Varatti. Jana advised that the wording be less strong based upon her belief that, despite your inconsistency last year and the incompetence of some of your staff, you were in her opinion one of the best Director's the Division has had. A copy of the letter submitted to Commissioner Lyon is attached for your information and as a professional courtesy.

Please take this letter as another expression of the support of ALPA to the Board and to legislation equivalent to last year's S.B. 823. It is our belief that had you supported the bill last year the unfortunate veto by Governor Hammond may not have occurred. The fact of your non-support has cost our association considerable time and money. Our resources could have been better spent on other matters pertaining to the Mental Health of all Alaskans, in the public interest.

We look forward to the support of the Director to citizen Boards.

Sincerely,



Dennis M. Scholl, Ph.D.
Executive Officer



26 Jan 1983

Dick Lyon, Commissioner
Department of Commerce and
Economic Development
Pouch D
Juneau, Alaska 99811

Dear Commissioner,


The Alaska Psychological Association asks that you evaluate the adequacy of support given by the Division of Occupational Licensing and its' Director, Harry Treager, to the State Board of Psychologist and Psychological Associate Examiners.

During 1982, and indeed since the Board was given an extension of two years before being "Sunset", the performance of the Division in support of the Board has been questionable at best. The most flagrant example is the non-professional manner in which Director Treager, at the last moment, withdrew his support of the Board and submitted an extensive written testimony to the joint Health, Education and Social Services Committee asking that the Board be "Sunsetted" and that its' functions be assumed by the Division. This attitude appears to have continued if Director Treager supports the recent draft proposed legislation of the Code Revision Commission in which the power and authority of all the professional boards is taken over by the Division Director and the Boards themselves are put into a figurehead advisory capacity to the Director.

We have come to question whether Mr. Treager actually supports regulation of the professions in a manner that is in the public interest. Please look into the division support of the Psychology Board, the competency of investigators and administrative staff in the division and the Division's position regarding citizen Boards in general.

We look forward to your interest in and findings regarding this branch of your department. Thank-you.

Sincerely,



Dennis M. Scholl, Ph.D.
Executive Officer

cc: Treager

A Summary of State Laws Regulating the Practice of Psychology
By Licensure (L) or Certification (C)

January, 1980

State	Type	Year	Coverage	Requirements							Examining Board					
				Educational Requirements	Post Degree	Supervision	Total Experience	ABPP Recognized	Mandatory Examination	Continuing Ed. for Renewal	Renewal Every	Psych. Members	Public Members	Terms	*Grandparenting* Ends	
Alabama	L	1963	Practice of Psychologists	Doctorate	-	-	0	yes	yes	no	1 yr.	5	-	5	10/1/65	
(Alaska)	L	1967	Psychologist	Doctorate	1	1	1	yes	yes	no	2 yrs.	3	2	3	1/1/68	
			Psychological Associate	Masters	1	1	3	-	yes	no	2 yrs.					
Arizona	C	1965	1978	Psychologist	Doctorate	-	-	0	yes	yes	no	1 yr.	5	2	5	1974
Arkansas	L	1955	Psychologist	Doctorate	-	-	1	-	yes	no	1 yr.	5	1	5	7/1/57	
			Psychological Examiner	Masters	-	-	0	-	yes	no	1 yr.					
California	L	1957	Psychologist	Doctorate	1	2	2	yes	yes	yes	2 yrs.	5	3	4	8/20/70	
	C	1969	Psychological Assistant													
Colorado	L	1961	Psychologist	Doctorate	2	2	2	yes	yes	yes	1 yr.	7	2	3	7/1/63	
Connecticut	L	1945	1969	Psychologist (Clinical or Consulting)	Doctorate	-	-	1	yes	yes	no	1 yr.	5	0	5	6/24/69
Delaware	L	1962	Practice of Psychology	Doctorate	2	2	2	yes	yes	no	2 yrs.	5	0	3	6/11/64	
Dist. of Col.	L	1971	Practice of Psychology	Doctorate	2	-	2	yes	yes	no	1 yr.	5	0	3	4/8/72	
(Florida)	L	1961	1979	Practice of Psychology	Doctorate	1	2	2	yes	yes	no	2 yrs.	5	1	4	6/22/61
Georgia	L	1951	Pract. of Applied Psch.	Doctorate	-	-	1	yes	yes	yes	2 yrs.	5	0	5	5/1/53	
Hawaii	L	1967	Practice of Psychology	Doctorate	-	1	1	-	yes	no	2 yrs.	5	2	2	6/6/68	
Idaho	L	1963	Practice of Psychology	Doctorate	-	-	2	-	yes	no	1 yr.	3	0	3	7/1/64	
Illinois	C	1963	Psychologist	Doctorate	-	2	2	-	yes	no	2 yrs.	5	0	5	8/15/71	
Indiana	C	1969	Psychologist in Private Practice	Doctorate	3	-	3	yes	yes	no	2 yrs.	5	0	3	7/1/72	
			Psychologist	Doctorate	-	-	3	yes	yes	no	2 yrs.				12/31/69	
Iowa	L	1974	Practice of Psychology:	Doctorate	1	1	1	yes	yes	yes	1 yr.	5	2	3	1976	
				Masters	-	2	5	-	yes	yes	1 yr.					
Kansas	C	1967	Psychologist	Doctorate	1	2	2	-	no	no	2 yrs.	7	0	3	7/1/69	
Kentucky	L	1948	Practice of Psychology (certificand)	Doctorate	-	-	1	yes	yes	no	3 yrs.	4	1	4	7/1/65	
				Masters	-	-	-	-	yes	no	3 yrs.					
Louisiana	L	1964	Psychologist	Doctorate	2	2	2	yes	yes	no	1 yr.	5	0	3	7/1/66	
Maine	L	1953	Psychologist	Doctorate	-	-	2	-	yes	no	2 yrs.	5	1	5	10/1/68	
			Psychologist Examiner	Masters	-	1	1	-	yes	no	2 yrs.					
Maryland	C	1957	Psychologist	Doctorate	1	1	2	yes	yes	yes	1 yr.	5	0	3	12/31/59	
Massachusetts	L	1971	Psychologist	Doctorate	1	2	2	yes	yes	no	2 yrs.	5	0	5	12/31/73	
Michigan	L	1959	1978	Psychologist (Limited License)	Doctorate	-	-	2	-	yes	yes	1 yr.	5	3	4	10/1/80
				Pect./Mast.	-	-	-	-	-	-						
Minnesota	L	1951	1973	Consulting Psychologist	Doctorate	2	-	2	yes	yes	no	2 yrs.	7	4	4	7/1/75
				Psychologist	Masters	2	-	2	yes	yes	no	2 yrs.				
Mississippi	L	1966	Psychologist	Doctorate	1	1	1	yes	yes	no	1 yr.	5	0	3	7/1/67	
Missouri	L	1977	Psychologist	Doctorate	-	-	1	-	yes	no	1 yr.	5	0	5	4/28/78	
				Masters	-	-	3	-	yes	no	1 yr.					
Montana	L	1971	Practice of Psychology	Doctorate	1	-	2	yes	yes	no	1 yr.	3	0	3	1/1/73	
Nebraska	L	1967	1978	Practice of Psychology (Also specialty cert. for clinical)	Doctorate	-	-	0	-	yes	no	1 yr.	5	0	5	1/1/71
							2								1/1/79	
Nevada	L	1963	Practice of Psychology	Doctorate	1	4	1	-	yes	yes	2 yrs.	4	1	3	7/1/64	
New Hampshire	C	1957	Registered	Psychologist	Doctorate	1	2	2	yes	yes	no	1 yr.	3	0	3	7/1/59
				Associate Psychologist	Masters											
New Jersey	L	1966	Practice of Professional Psychological Services	Doctorate	1	2	2	yes	yes	no	2 yrs.	7	3	3	1/1/68	
New Mexico	C	1963	Psychologist	Doctorate	2	-	2	yes	yes	yes	1 yr.	5	0	3	12/31/64	
New York	C	1956	Psychologist	Doctorate	-	2	2	yes	yes	no	2 yrs.	12	1	5	7/1/59	
North Carolina	L	1967	Practicing Psychologist	Doctorate	2	2	2	yes	yes	no	1 yr.	5	0	3	7/1/69	
			Psychological Associate	Masters	-	-	0	-	yes	no	1 yr.					
North Dakota	L	1967	Psychologist	Doctorate	-	-	0	yes	yes	no	1 yr.	5	0	3	7/1/68	
Ohio	L	1972	1972	Practice of Psychology	Doctorate	1	2	2	yes	yes	no	2 yrs.	6	1	5	11/22/76
				Pract. of School Psych.	Masters	3	1	4	-	yes	no	2 yrs.				
Oklahoma	L	1965	Practice of Psychology	Doctorate	-	2	2	yes	yes	no	1 yr.	5	0	3	6/28/66	
Oregon	L	1973	Practice of Psychology	Doctorate	-	2	2	yes	yes	yes	1 yr.	7	2	3	1/1/74	
	L	(Limited)	Psychologist Associate	Masters	-	3	-	-	yes							
Pennsylvania	L	1972	Practice of Psychology	Doctorate	2	1	2	yes	yes	no	2 yrs.	7	2	3	5/23/72	
				Masters	4	2	4	-	yes	no	2 yrs.					
Rhode Island	C	1969	Consulting Psychologist	Doctorate	1	2	2	yes	yes	no	1 yr.	4	1	3	12/31/70	
South Carolina	L	1966	Practice of Psychology	Doctorate	1	2	2	yes	yes	no	2 yrs.	7	0	5	3/21/69	
(South Dakota)	L	1977	1979	Psychologist	Doctorate	-	2	2	-	yes	yes	2 yrs.	5	1	3	7/1/77
				Psychologist Associate	Masters	-	1	1	-	yes	yes	2 yrs.				
Tennessee	L	1953	Psychologist	Doctorate	-	-	1	yes	yes	no	perm.	5	0	5	7/1/55	
			Psychological Examiner	Masters	-	-	0									
Texas	L	1969	1975	Psychologist (Also specialty cert. for Health Service Provider)	Doctorate	1	1	2	yes	yes	no	1 yr.	6	0	6	12/31/70
	C	1975	Psychological Associate	Masters				(450 Clock Hrs.)	yes	no						
Utah	L	1959	Practice as Psychologist	Doctorate	1	2	2	no	yes	yes	1 yr.	5	0	5	12/31/62	
Vermont	L	1976	Practicing Psychologist	Doctorate	2	2	3	yes	yes	yes	2 yrs.	3	-	5	6/30/77	
			Psychological Associate	Masters	3	3	4	-	yes	yes	2 yrs.					
Virginia	L	1946	1966	Psychologist	Doctorate	2	2	2	yes	yes	yes	2 yrs.	5	0	5	none
				Clinical Psychologist	Doctorate	2	2	2	yes	yes	yes					
			1976	School Psychologist	Masters	4	2	4	yes	yes	no	2 yrs.				
Washington	L	1955	Practice of Psychology (Also 'certif. of qualification'-limited license below Doctorate)	Doctorate	1	1	1	yes	yes	yes	1 yr.	5	0	3	6/10/66	
			Psychological Assistant													
West Virginia	L	1970	Practice of Psychology	Doctorate	1	1	1	yes	yes	yes	2 yrs.	5	1	3	11/12/70	
				Masters	5	5	5	-	yes	yes	2 yrs.					
Wisconsin	L	1969	1979	Practice of Psychology	Doctorate	1	1	1	yes	no	no	2 yrs.	4	1	3	7/1/70
				School Psychologist	Masters											
Wyoming	L	1965	Practice of Psychology	Doctorate	-	-	0	yes	yes	no		5	0	3	12/31/65	

(States Listed in (Brackets)): Regulatory programs have been suspended by "sunset" review legislation, with replacement legislation either planned or introduced. Previous requirements indicated on chart. In the meantime, "non-statutory" certification of psychologists qualified for practice is being provided through the APA-affiliated state psychological association.

Canada

Alberta	C	1960	Psychologist	Masters	-	-	0	-	no	no	-	8	0	1	4/11/62
British Columbia	C	1977	Registered Psychologist	Doctorate	1	1	1	-	no	no	1 yr.	5	2	2	7/6/80
Manitoba	C	1966	Psychologist	Doctorate	-	-	0	-	yes	-	-	7	0	2	12/31/72
New Brunswick				Doctorate	-	-	1	-	yes	no	-	5	0	1	6/1/71
New Scotia-PEI															
Ontario	C	1960	Psychologist	Doctorate	1	1	1	-	yes	no	1 yr.	5	0	5	6/11/66
Quebec	C	1962	Psychologue	Doctorate	-	-	0	-	-	yes	1 yr.	3	0	2	none
				Masters	-	-	0	-	-	yes	1 yr.				
Saskatchewan	C	1962	Registered Psychologist	Doctorate	-	-	0	-	yes	-	-	5	0	2	12/31/62

Certification and Licensure

State and provincial laws regulating psychological practice are usually either Licensure (L) or Certification (C) laws. Certification regulates the use of the title "psychologist." Licensure laws do the same, but they also enumerate activities which constitute the practice of psychology for which a license is required, without regard to the title by which the practitioner is identified. State laws regulating psychological practice generally extend exemptions to members of other recognized professional groups employing psychological skills or techniques in their work, provided that they not identify themselves as "psychologists." Most psychology licensure and certification laws are generic in that they confer the same license for general practice upon psychologists whatever their field of applied specialization may be. The APA Standards for Scientific and Professional Ethics and Conduct, which are referenced by many state laws, serve to limit a psychologist's practice to their particular area of competence.

State Examining Boards

State laws regulating psychological practice are generally administered by a Board of Psychologist Examiners, which may include one or more "public" (non-psychologist) members. This chart serves to briefly summarize some of the key features of psychological practice legislation. For further information on admission to the licensure or certification process, contact the appropriate State Board. A list of State Boards of Examiners is available through the APA Office of Professional Affairs.

Educational Requirements

Most state laws establish that doctorate training in a field of study "...primarily psychological in nature" is the minimum requirement for the use of the title (noun) "psychologist" in the context of independent and unsupervised practice. Statutory recognition for training below the doctorate level is afforded in some states by use of the adjective "psychological" along with the term "assistant" or "associate." Ordinarily, psychological assistants or associates function under the supervision of a psychologist licensed or certified for independent and unsupervised practice.

Generally, degree programs held to be "primarily psychological" by State Boards of Examiners are earned in programs within institutions which are themselves accredited, or psychology programs within institutions accredited by the APA. The APA currently accredits doctoral level programs in the four generally recognized principal fields of applied psychology: clinical, counseling, industrial-organizational, and school.

Beginning in 1980, the APA will implement on a trial basis a program to "designate," by a process separate from but related to Accreditation, those programs which train providers of psychological services. Should the approach prove viable, information generated by designation will at some future point be available to students, training programs, and to State Boards of Examiners. "Designated" programs would be held to qualify as programs "primarily psychological" for purposes of licensure and certification. As presently envisioned, the criteria to be employed by the designation program parallel those already utilized by the APA Accreditation Program.

For further information on psychology training programs, consult the APA Guide to Graduate Study in Psychology.

Scope of Regulation

Laws regulating psychological practice ordinarily affect individuals identifying themselves to the public in the context of "fee-for-service" practice. Research and academic activities are also ordinarily exempt from regulation. Federal Civil Service and state civil service job classifications often do not require state licensure or certification, although this may change in the years ahead. At their higher levels involving independent practitioner skills, the federal Civil Service standards parallel state requirements for practice.

In some states, separate licensure or certification programs have been established for other professional specialties; for example, "marriage counseling" or "psychotherapist" certification. Just as psychology laws extend exemptions to other recognized groups, so too are psychologists licensed or certified for independent general practice exempted from these other regulatory programs.

Many State Departments of Education certify school psychologists, trained to the masters level, for service within educational settings. Department of Education certification as a School Psychologist ordinarily does not constitute a license or certificate for the independent general practice of psychology.

Examination of Candidates

Most State Boards of Examiners currently employ the standardized Examination for Professional Practice in Psychology in the course of administering licensure and certification programs. EPPP has been developed jointly by the Professional Examination Service for the American Association of State Psychology Boards (AASPB). State Boards may supplement the EPPP examination with written questions of their own or an oral examination. The EPPP is given each Spring and Fall. Applications for admission to the test should be made through the appropriate State Board of Examiners.

While the APA does not review or approve examination preparatory courses, many workshops or home study courses are advertised in the Monitor, the official newspaper of the American Psychological Association. Pass/fail scores for the EPPP are set by the individual State Boards, as the admission requirements for licensure and certification vary somewhat from state to state.

American Board of Professional Psychology (ABPP) Diplomate

Holders of the ABPP Diplomate automatically qualify for admission to the licensure or certification process in many states. The diplomate is conferred upon individuals who have successfully completed examination in one of the four principal fields of specialization in applied psychology: clinical, counseling, industrial-organizational, and school. Candidates for the ABPP diplomate must be trained to the doctoral level and have upwards of four years of experience. For further information on the ABPP examination, contact: American Board of Professional Psychology, c/o Margaret Ives, Ph.D., 2025 "I" Street, N.W., Suite #403, Washington, D.C. 20036.

National Register of Health Service Providers in Psychology

Since 1975, the National Register of Health Service Providers in Psychology has served to identify which generically licensed or certified psychologists are qualified in the area of health services. Current requirements for voluntary listing in the Register are: 1) doctoral training, 2) two years of experience in a health setting, and 3) training in a psychology program meeting criteria approved by the Register Council. For further information on the National Register, contact: Council for the National Register of Health Service Providers in Psychology, 1200 17th Street, N.W., Washington, D.C. 20036.

Reciprocity

Formal reciprocal licensing or certification agreements between states have generally been discontinued. State Boards now reserve the right to review credentials on a case by case basis. Should it be apparent that an individual was licensed or certified in another state with requirements reasonably similar to the new state of residence or practice, the application process may sometimes be foreshortened. Such a decision may be made only by the State Board administering the licensure or certification program.

Employment Opportunities

A comprehensive listing of current employment opportunities in all fields of psychology including applied psychology is provided in the Employment Bulletin Section of the APA Monitor, the Association's newspaper which appears monthly. The APA also provides an employment locator and interview service to registrants at its Annual Meetings, as described in the American Psychologist, the anchor journal of the Association.

Chart Explanations

In addition to formal training, experience requirements have been established in most states. Of the total requirement, that portion which must be either "post degree" or earned under the supervision of a qualified psychologist is indicated. "ABPP Recognized" refers to the American Board of Professional Psychology diplomate. "Grandparenting" refers to the last date by which psychologists meeting previous standards for practice can apply for a license or certificate without submitting themselves to the credentials review and examination process. "Grandparenting" generally occurs only at the time that a law regulating psychological practice has just been put into effect.

In January 1975, the APA Council of Representatives created the original Committee on Standards for Providers of Psychological Services. The Committee was charged with updating and revising the Standards adopted in September 1974. Members of the Committee were Jacqueline C. Bouhoutsos, Leon Hall, Marian D. Hall, Mary Henle, Durand F. Jacobs (Chair), Abel Ossorio, and Wayne Sorenson. Task force liaison was Jerry H. Clark, and Central Office liaison was Arthur Centor.

In January 1976, Council further charged the Committee to review the Standards and recommend revisions needed to reflect the varying needs of only those psychologists engaged in the activities of clinical, counseling, industrial-organizational, and school psychology. The Committee was reconstituted with one member representing each of the four applied activities, plus one member representing institutional practice and one representing the public interest.

Members were Jules Barron, clinical; Barbara A. Kirk, counseling; Frank Friedlander, industrial-organizational (replacing Virginia Schein); Durand F. Jacobs (Chair), institutional practice; M. Brewster Smith, public interest; Marian D. Hall, school; Arthur Centor was Central Office liaison.

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Standards for Providers of Psychological Services

The Standards that follow are the first revision of the national Standards for Providers of Psychological Services originally adopted by the American Psychological Association (APA) on September 4, 1974.¹ [Note: Footnotes 2-24 appear at the end of the Standards. See pp. 11-14.] The intent of these Standards is to improve the quality, effectiveness, and accessibility of psychological services to all who require them.²

These Standards represent the attainment of a goal for which the Association has striven for over 20 years, namely, to codify a uniform set of standards for psychological practice that would serve the respective needs of users, providers, and third-party purchasers and sanctioners of psychological services. In addition, the Association has established a standing committee charged with keeping the Standards responsive to the needs of these groups and with upgrading and extending them progressively as the profession and science of psychology con-

tinue to develop new knowledge, improved methods, and additional modes of psychological service. These Standards have been established by organized psychology as a means of self-regulation to protect the public interest.

While these revised Standards contain a number of important changes, they differ from the original Standards in two major respects:

1. They uniformly specify the *minimally acceptable levels* of quality assurance and performance that providers of those psychological services covered by the Standards must reach or exceed. Care has been taken to assure that each standard is clearly stated, readily measurable, realistic, and implementable.

2. The revised Standards apply to a more limited range of services than the original Standards. The present Standards have been restricted to applications in "human services" with the goal of facilitating more effective human functioning. The kinds of psychological services covered by the present Standards are those ordinarily involved in the practice of specialists in clinical, counseling, industrial-organizational, and school psychology. However, it is important to note that these Standards cover psychological *functions* and not classes of practitioners.

Any persons representing themselves as psychologists, when providing any of the covered psychological service functions at

¹ Members of the Task Force on Standards for Service Facilities that submitted the original Standards in September 1974 were Milton L. Blum, Jacqueline C. Bouhoutsos, Jerry H. Clark, Harold A. Edgerton, Marian D. Hall, Durand F. Jacobs (Chair, 1972-1974), Floyd H. Martinez, John E. Muthard, Asher R. Pacht, William D. Pierce, Sue A. Warren, and Alfred M. Wellner (Chair, 1970-1971). Staff liaisons from the APA Office of Professional Affairs were John J. McMillan (1970-1971), Gottlieb C. Simon (1971-1973), and Arthur Centor (1973-1974).

any time and in any setting, whether public or private, profit or nonprofit, are required to observe these standards of practice in order to promote the best interests and welfare of the users of such services. It is to be understood that fulfillment of the requirements to meet these Standards shall be judged by peers in relation to the capabilities for evaluation and the circumstances that prevail in the setting at the time the program or service is evaluated.

Standards covering other psychological service functions may be added from time to time to those already listed. However, functions and activities related to the teaching of psychology, the writing or editing of scholarly or scientific manuscripts, and the conduct of scientific research do not fall within the purview of the present Standards.

Historical Background

Early in 1970, acting at the direction of the Association's Council of Representatives, the Board of Professional Affairs appointed a Task Force composed of practicing psychologists with specialized knowledge in at least one of every major class of human service facility and with experience relevant to the setting of standards. Its charge was to develop a set of standards for psychological practice. Soon thereafter, partial support for this activity was obtained through a grant from the National Institute of Mental Health.¹

First, the Task Force established liaison with national groups already active in standard setting and accreditation. It was therefore able to influence the adoption of certain basic principles and wording contained in standards for psychological services published by the Joint Commission on Accreditation of Hospitals (JCAH) Accreditation Council for Facilities for the Mentally Retarded (1971) and by the Accreditation Council for Psychiatric Facilities (JCAH, 1972). It also contributed substantially to the "constitutionally required minimum standards for adequate treatment of

the mentally ill" ordered by the U.S. District Court in Alabama (*Wyatt v. Stickney*, 1972). In concert with other APA committees, the Task Force also represented the Association in national-level deliberations with governmental groups and insurance carriers that defined the qualifications necessary for psychologists involved in providing health services.

These interim outcomes involved influence by the Association on actions by groups of nonpsychologists that directly affected the manner in which psychological services were employed, particularly in health and rehabilitation settings. However, these measures did not relieve the Association from exercising its responsibility to speak out directly and authoritatively on what standards for psychological practice should be throughout a broad range of human service settings. It was also the responsibility of the Association to determine how psychologists would be held accountable should their practice fail to meet quality standards.

In September 1974, after more than 4 years of study and broad consultations, the Task Force proposed a set of standards, which the Association's Council of Representatives adopted and voted to publish in order to meet urgent needs of the public and the profession. Members of Council had various reservations about the scope and wording of the Standards as initially adopted. By establishing a continuing Committee on Standards, Council took the first step in what would be an ongoing process of review and revision.

The task of collecting, analyzing, and synthesizing reactions to the original Standards fell to two successive committees. They were charged similarly to review and revise the Standards and to suggest means to implement them, including their acceptance by relevant governmental and private accreditation groups. The dedicated work of the psychologists who served on both those committees is gratefully acknowledged. Also recognized with thanks are the several hundred comments received from scores of interested persons representing professional, academic, and scientific psychology, consumer groups, administrators of facilities, and others. This input from those di-

rectly affected by the original Standards provided the major stimulus and much of the content for the changes that appear in this revision.

Principles and Implications of Standards

A few basic principles have guided the development of these Standards:

1. There should be a single set of standards that governs psychological service functions offered by psychologists, regardless of their specialty, setting, or form of remuneration. All psychologists in professional practice should be guided by a uniform set of standards just as they are guided by a common code of ethics.

2. Standards should clearly establish minimally acceptable levels of quality for covered psychological service functions, regardless of the character of the users, purchasers, or sanctioners of such covered services.

3. All persons providing psychological services shall meet minimally acceptable levels of training and experience, which are consistent and appropriate with the functions they perform. However, final responsibility and accountability for services provided must rest with psychologists who have earned a doctoral degree in a program that is primarily psychological at a regionally accredited university or professional school. Those providing psychological services who have lesser (or other) levels of training shall be supervised by a psychologist with the above training. This level of qualification is necessary to assure that the public receives services of high quality.

4. There should be a uniform set of standards governing the quality of services to all users of psychological services in both the private and public sectors. There is no justification for maintaining the double standard presently embedded in most state legislation whereby providers of private fee-based psychological services are subject to statutory regulation, while those providing similar psychological services under governmental auspices are usually exempt from such regulations. This circumstance tends to afford greater protection

under the law for those receiving privately delivered psychological services. On the other hand, those receiving privately delivered psychological services currently lack many of the safeguards that are available in governmental settings; these include peer review, consultation, record review, and staff supervision.

5. While assuring the user of the psychologist's accountability for the nature and quality of services rendered, standards must not constrain the psychologist from employing new methods or making flexible use of support personnel in staffing the delivery of services.

The Standards here presented have broad implications both for the public who use psychological services and for providers of such services:

1. Standards provide a firmer basis for a mutual understanding between provider and user and facilitate more effective evaluation of services provided and outcomes achieved.

2. Standards are an important step toward greater uniformity in legislative and regulatory actions involving providers of psychological services, and Standards provide the basis for the development of accreditation procedures for service facilities.

3. Standards give specific content to the profession's concept of ethical practice.

4. Standards have significant impact on tomorrow's training models for both professional and support personnel in psychology.

5. Standards for the provision of psychological services in human service facilities influence what is considered acceptable structure, budgeting, and staffing patterns in these facilities.

6. Standards are living documents that require continual review and revision.

The Standards illuminate weaknesses in the delivery of psychological services and point to their correction. Some settings are known to require additional and/or higher standards for specific areas of service delivery than those herein proposed. There is no intent to diminish

the scope or quality of psychological services that exceed these Standards.

Systematically applied, these Standards serve to establish uniformly the *minimally acceptable levels* of psychological services. They serve to establish a more effective and consistent basis for evaluating the performance of individual service providers, and they serve to guide the organizing of psychological service units in human service settings.

Definitions

Providers of psychological services refers to the following persons:

A. Professional psychologists.⁴ Professional psychologists have a doctoral degree from a regionally accredited university or professional school in a program that is primarily psychological⁵ and appropriate training and experience in the area of service offered.⁶

B. All other persons who offer psychological services under the supervision of a professional psychologist.

Psychological services refers to one or more of the following:⁷

A. Evaluation, diagnosis, and assessment of the functioning of individuals and groups in a variety of settings and activities.

B. Interventions to facilitate the functioning of individuals and groups. Such interventions may include psychological counseling, psychotherapy, and process consultation.

C. Consultation relating to A and B above.

D. Program development services in the areas of A, B, and C above.⁸

E. Supervision of psychological services.

A psychological service unit is the functional unit through which psychological services are provided:

A. A psychological service unit is a unit that provides predominantly psychological services and is composed of one or more professional psychologists and supporting staff.

B. A psychological service unit may operate as a professional service or as a functional or

geographic component of a larger governmental, educational, correction, health, training, industrial, or commercial organizational unit.⁹

C. A psychologist providing professional services in a multioccupational setting is regarded as a psychological service unit.

D. A psychological service unit also may be an individual or group of individuals in a private practice or a psychological consulting firm.

User includes:

A. Direct users or recipients of psychological services.

B. Public and private institutions, facilities, or organizations receiving psychological services.

C. Third-party purchasers—those who pay for the delivery of services but who are not the recipients of services.

Sanctioners refers to those users and nonusers who have a legitimate concern with the accessibility, timeliness, efficacy, and standards of quality attending the provision of psychological services. In addition to the users, sanctioners may include members of the user's family, the court, the probation officer, the school administrator, the employer, the union representative, the facility director, etc. Another class of sanctioners is represented by various governmental, peer review, and accreditation bodies concerned with the assurance of quality.

Standard 1. Providers

1.1 *Each psychological service unit offering psychological services shall have available at least one professional psychologist and as many more professional psychologists as are necessary to assure the quality of services offered.*

INTERPRETATION: The intent of this Standard is that one or more providers of psychological services in any psychological service unit

shall meet the levels of training and experience of the professional psychologist as specified in the preceding definitions.¹⁰

When a professional psychologist is not available on a full-time basis, the facility shall retain the services of one or more professional psychologists on a regular part-time basis to supervise the psychological services provided. The psychologist(s) so retained shall have authority and participate sufficiently to enable him or her to assess the needs for services, review the content of services provided, and assume professional responsibility and accountability for them.

1.2 *Providers of psychological services who do not meet the requirements for the professional psychologist shall be supervised by a professional psychologist who shall assume professional responsibility and accountability for the services provided. The level and extent of supervision may vary from task to task so long as the supervising psychologist retains a sufficiently close supervisory relationship to meet this standard.*

1.3 *Wherever a psychological service unit exists, a professional psychologist shall be responsible for planning, directing, and reviewing the provision of psychological services.*

INTERPRETATION: This psychologist shall coordinate the activities of the psychological service unit with other professional, administrative, and technical groups, both within and outside the facility. This psychologist, who may be the director, chief, or coordinator of the psychological service unit, has related responsibilities including, but not limited to, recruiting qualified staff, directing training and research activities of the service, maintaining a high level of professional and ethical practice, and assuring that staff members function only within the areas of their competency.

In order to facilitate the effectiveness of services by increasing the level of staff sensitivity and professional skills, the psychologist designated as director shall be responsible for participating in the selection of the staff and sup-

porting personnel whose qualifications and skills (e.g., language, cultural and experiential background, race, and sex) are directly relevant to the needs and characteristics of the users served.

1.4 *When functioning as part of an organizational setting, professional psychologists shall bring their background and skills to bear whenever appropriate upon the goals of the organization by participating in the planning and development of overall services.¹¹*

INTERPRETATION: Professional psychologists shall participate in the maintenance of high professional standards by representation on committees concerned with service delivery.

As appropriate to the setting, these activities may include active participation, as voting and as office-holding members on the facility's executive, planning, and evaluation boards and committees.

1.5 *Psychologists shall maintain current knowledge of scientific and professional developments that are directly related to the services they render.*

INTERPRETATION: Methods through which knowledge of scientific and professional development may be gained include, but are not limited to, continuing education, attendance at workshops, participation in staff development, and reading scientific publications.¹²

The psychologist shall have ready access to reference material related to the provision of psychological services.

Psychologists must be prepared to show evidence periodically that they are staying abreast of current knowledge and practices through continuing education.

1.6 *Psychologists shall limit their practice to their demonstrated areas of professional competence.*

INTERPRETATION: Psychological services will be offered in accordance with the provid-