

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9130 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

Difference Between Father's and Mother's Age
Alaska, 1994-1996

Father's Age

Mother's Age	Younger	Same Age	1-4 Years Older	5-9 Years Older	10-19 Years Older	20+ Years Older	Unknown
13	0	0	1	1	0	0	6
14	0	0	12	1	1	1	27
15	0	4	52	22	6	1	72
16	6	16	131	63	17	1	168
17	14	35	238	95	33	2	219
Total	20	55	434	182	57	5	492
% <17	1.6%	4.4%	34.9%	14.6%	4.6%	0.4%	39.5%
18	47	84	372	152	52	4	230
19	79	117	542	223	73	10	257
Total	126	201	914	375	125	14	487
% 18-19	5.6%	9.0%	40.8%	16.7%	5.6%	0.6%	21.7%
Total	146	256	1348	55	182	19	979
% all teens	4.9%	8.6%	45.2%	1.8%	6.1%	0.6%	32.8%

TO: House H.E.S.S. Committee
REGARDING: HB 372
DATE: March 31, 1998
FROM: Rick Micham
PO Box 210124
Anchorage, AK 99521

I am here today in support of House Bill 372, where any medical authority who prescribes contraceptive drugs ~~or devices~~ may not prescribe them to a minor without first in good faith effort obtain relevant medical records for the minor. This is simply for the physical safety of that person. There is no way to know whether any prescription will have any serious health consequences for that minor. It is always common practice before any doctor prescribes medication for any person to first know if they are on any other medication or is allergic to anything. It is common practice to know of the medical history of the family. It is unlikely that all minors know fully of their medical background or any family history of diseases. Please support this common sense practice and support HB 372. Thank you.

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I am a licensed practicing obstetrician and gynecologist in Anchorage. Currently I am acting as spokesperson for the Alaska Section of the American College of Obstetricians and Gynecologists or ACOG which is a national organization of Board Certified OB/GYN physicians which is a specialty dealing with women's health. Many local ACOG physicians are concerned about recent bills which we feel will have a negative impact on Alaskan women.

ACOG is especially concerned about Dyson's Bill - - HB 372.

Contraceptives save lives. A healthy nonsmoking female who carries a pregnancy to full term is six times more likely to die than if she used oral contraceptives.

And this is just the beginning of the story. Oral contraceptives alone save this country millions of health care dollars every year.

Some people feel this figure is conservative and may extend into the billions of dollars. It does this by preventing about 130,000 hospitalizations annually. This includes hospitalization for women with breast disease,

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ovarian cysts, anemia, pelvic inflammatory disease, ectopic pregnancy, rheumatoid arthritis, and uterine and ovarian cancer.

Yes, you read correctly -- in addition to the prevention of death and severe illness from unwanted pregnancies, oral contraceptives also have a profound beneficial effect on many diseases in women, including a 50% reduction in uterine and ovarian cancer.

Multiple medical studies in the last 10 to 20 years have resulted in a new thinking about oral contraceptives, so that now they are commonly used for treatment and prevention of disease, not just prevention of pregnancy. Because of this, ACOG has long supported the view that oral contraceptives should be provided to women by their insurance companies, just as any other prescriptive medication. We defy anyone to name any other medication ever approved by the FDA that has had such a profound and far-reaching positive impact on the lives of so many worldwide. We submit to you that there is no logical reason not to cover contraceptives. The medical facts are overwhelming.

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The only reason that can be conceived is that insurance companies do not make preventive care a priority and oral contraceptives are associated with reproductive health benefiting only women. As we well know, women have historically received low priority when it comes to health care dollars.

Dyson's House Bill 372 would limit access of oral contraceptives to minors, by requiring parental permission for minors to receive oral contraceptives. Because teenagers will frequently not admit sexual activity to their parents, the result would be decreased access to teenagers of contraceptives and sexually transmitted disease counseling. In light of the medical benefits of oral contraceptives, it seems that this bill would discriminate on the basis of age Minors would not have access to the same health care benefits that older women enjoy.

Beyond this, the logic of this bill is not apparent in light of current knowledge regarding teenage pregnancy. Multiple studies have shown that teenage sexual activity is not affected by availability of contraception. Rather, the most successful deterrent to teenage sexual activity is parental openness to discussion of sexual issues with their teenagers.

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A recent USA Today article summarized studies from the Center for Disease Control, which showed a link between teenagers who delay their first sexual encounter beyond 20 years of age with educational level of their parents. Indeed, two out of three teens with college educated parents report remaining virgins well into young adulthood. This finding is being interpreted as proof that teens with future goals start sexual activity later and obviously their parents are serving as examples.

Whether or not a teenager will have intercourse is determined by an internal moral compass which is most profoundly influenced by his or her parents, personal goals and sense of self-esteem. Teenage pregnancy prevention programs, which address these issues, will be successful. Simply passing a bill, which limits access to contraception, will simply increase the teenage pregnancy rate without addressing the real issues surrounding teenage sexuality.

Research shows that teenage pregnancy costs society about 37 billion dollars annually. This is because "teenage mothers are significantly less likely to receive a high school diploma than women who postpone

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childbearing. They are more likely to live in poverty, receive public assistance, and have long periods of welfare dependency. Adolescent fathers finish fewer years of schooling, earn less income annually by age 27, and participate less in the work force than men who delay fathering until age 21. Children of adolescents are more likely to have health and cognitive disadvantages and to be neglected or abused. The daughters of adolescents are more likely to become adolescent mothers themselves, and the sons of adolescents are more likely to be incarcerated." Obviously limiting access of contraceptives to teenagers would increase health care costs significantly and would have a negative impact on all of us.

Include ACOG Fact Sheet, 1998

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Adolescent Pregnancy Fact Sheet

In 1994, an estimated 910,600 U.S. teenagers 15–19 years old became pregnant in the United States, resulting in 505,500 live births, 276,380 induced abortions, and 128,730 fetal losses. The same year, nearly 29,000 women under age 15 also became pregnant (1). Compared with other industrialized countries, the U.S. teen pregnancy rate is twice as high as in England, Wales, and Canada, and more than nine times as high as in the Netherlands and Japan (2).

Health Risk Behaviors of Adolescents

Data on trends in health risk behaviors come primarily from the following four sources:

- The 1995 national school-based Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control and Prevention on the sexual behavior of U.S. high school students. More than 16,000 students in grades 9–12 from the 50 states, the District of Columbia, and the U.S. Territories were interviewed for the survey. The survey is a component of the Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System (3). Previous surveys were conducted in 1990, 1991, and 1993.
- The 1995 National Survey of Family Growth (NSFG) conducted by the National Center for Health Statistics on factors affecting pregnancy and women's health in the United States. The data are based upon in-person interviews with a national sample of 10,847 women aged 15–44 years (4). Previous surveys of this type were conducted in 1973, 1976, 1982, 1988, and 1990.
- The 1995 National Survey of Adolescent Males (NSAM) conducted by the Urban Institute and sponsored by the National Institute of Child Health and Human Development and the Office of Population Affairs. To compile data on reproductive and sexual behaviors, a nationally representative sample of over 1,700 males aged 15–19 years were interviewed. The data from the 1995 survey have been compared with a 1988 survey of the same type to analyze trends (5).
- The most recent survey on the health risk behaviors of adolescents is the National Longitudinal Study on Ado-

lescent Health. This study was undertaken by the National Institute of Child Health and Human Development in response to a congressional mandate in 1993. It is a school-based study of more than 90,000 students in grades 7–12 attending 145 schools, the school administrators, and 18,000 parents across the United States designed to assess how individual, family, and school characteristics affect sexual behaviors, contraceptive use, and pregnancy history, among other adolescent health behaviors. Due to its newness, trend data is not available from this survey (6).

Sexual Behavior

According to the YRBS, a small decrease occurred from 1991 to 1995 in the percentage of high school students who reported having had sexual intercourse (Table 1) (3, 7). This trend was confirmed by the NSFG and the NSAM, although it was more pronounced in the latter two surveys. Nearly 50% of adolescent females between the ages of 15 and 19 years reported in the 1995 NSFG that they had had sexual intercourse, compared with 55% in 1990 (4). Similarly, 55% of adolescent males aged 15–19 years reported in the 1995 NSAM that they had had sexual intercourse, compared with 60% in 1988 (5). A slight decrease also occurred in the percentage of high school students reporting in the YRBS that they have had sexual intercourse with four or more partners during their lifetime. There was also a slight increase in the percentage of students reporting that they had sexual intercourse during the 3-month period before the survey (3, 7).

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Contraceptive Use

The percentage of high school students who reported in the YRBS that they used birth control pills before last sexual intercourse decreased to 17.4% in 1995 after a steady increase to 18.4% in 1993 (Table 1). Improvements, however, can be seen in condom use (Table 2). In 1995, sexually active African-American teens were most likely to report condom use, as has been the case since 1991. Specifically, 66.1% reported condom use in 1995, which represents an increase of 9.6% from 1993. Reported condom use for all sexually active adolescents has increased as

Table 1. Youth Risk Behavior Survey—1991, 1993, 1995. Percentage of High School Students Who Reported Selected Sexual Risk Behaviors by Year

Behavior	1991	1993	1995
Ever had sexual intercourse	54.1	53.0	53.1
Have had sexual intercourse with four or more partners ever lifetime	18.7	18.8	17.8
Had sexual intercourse during the 3 months preceding the survey	37.5	37.6	37.9
Used birth control pills prior to last sexual intercourse*	17.8	18.4	17.4

* The wording of the question about birth control pill use in the 1995 Youth Risk Behavior Survey was changed to inquire about birth control use prior to last sexual intercourse, instead of at last sexual intercourse.

Data from the Centers for Disease Control and Prevention. Trends in sexual risk behavior among high school students—United States, 1990, 1991, and 1993. *MMWR* 1995;44:124-125.

Kann L, Warren CW, Harris WA, Collins JL, Williams BI, Ross G, et al. Youth Risk Behavior Surveillance—United States, 1995. *MMWR CDC Surveill Summ* 1996;45:18-19, 64-71.

Table 2. Youth Risk Behavior Survey: Percentage of High School Students Reporting Condom Use at Last Sexual Intercourse, 1991, 1993, and 1995*

Characteristic	1991	1993	1995
Sex			
Female	39.0	48.0	48.6
Male	54.6	59.2	60.5
Race/Ethnicity			
White	46.8	52.3	52.5
African American	48.0	56.5	66.1
Hispanic	37.6	40.1	44.1
Total	48.2	52.6	54.4

* Only students reporting sexual intercourse during the 3 months preceding the survey are included.

Data from Centers for Disease Control and Prevention. Trends in sexual risk behavior among high school students—United States, 1990, 1991, and 1993. *MMWR Morbidity and Mortality Weekly Rep* 1995;44:124-125.

Kann L, Warren CW, Harris WA, Collins JL, Williams BI, Ross G, et al. Youth Risk Behavior Surveillance—United States, 1995. *MMWR CDC Surveill Summ* 1996;45:18-19, 64-71.

well from 46.2% in 1991 to 54.4% in 1995 (3, 7). Results of the NSFG and the NSAM also indicate increased condom use at first intercourse (4, 5).

Early Sexual Intercourse

Teens who are at greatest risk for engaging in early intercourse are those who 1) live in rural areas; 2) have parents who receive welfare; 3) are African American; and 4) are from the South (6). In addition, the likelihood of early first intercourse among females is higher when there is a large age difference between the female adolescent and her partner. A large difference in age of this type is also correlated with the following factors: 1) lower likelihood of contraceptive use at first intercourse; 2) higher likelihood of teen birth; 3) higher number of sexual partners among females during the teen years; and 4) higher likelihood among females of experiencing voluntary, but unwanted, first sexual intercourse (Fig. 1) (8).

Teens who are younger than age 16 years when they have first sexual intercourse are more likely to report that it was nonvoluntary. Specifically, 16% of female adolescents under 16 years of age reported in the NSFG that their first intercourse was nonvoluntary, compared with 7% of those whose first intercourse occurred at age 16 years or older. For those females reporting voluntary first intercourse before the age of 16, 1% stated that their partner was between the ages of 20 and 25 years; 6% stated their partner was 23 years of age or older (4).

Several factors related to schooling have been identified as being associated with a delay in first intercourse: 1) feeling connected to school; 2) attending a parochial school; and 3) attending a school with a high overall average daily attendance. The following family characteristics also protect adolescents from early sexual intercourse: 1) feeling connected to parents and family; 2) perceived disapproval by parents of adolescent sex; and 3) perceived disapproval by parents of adolescent use of contraception (6).

Sexually Transmissible Infections

Each year, 3 million adolescents are infected with sexually transmissible infections. This accounts for 25% of the 12 million new cases of sexually transmissible infections in the United States annually. Rates of sexually transmissible infections for females tend to be higher than those for males. This discrepancy can be attributed partially to the focus of screening programs on females that result in a lack of identification of males with sexually transmissible infections. Also, many sexually transmissible infections are

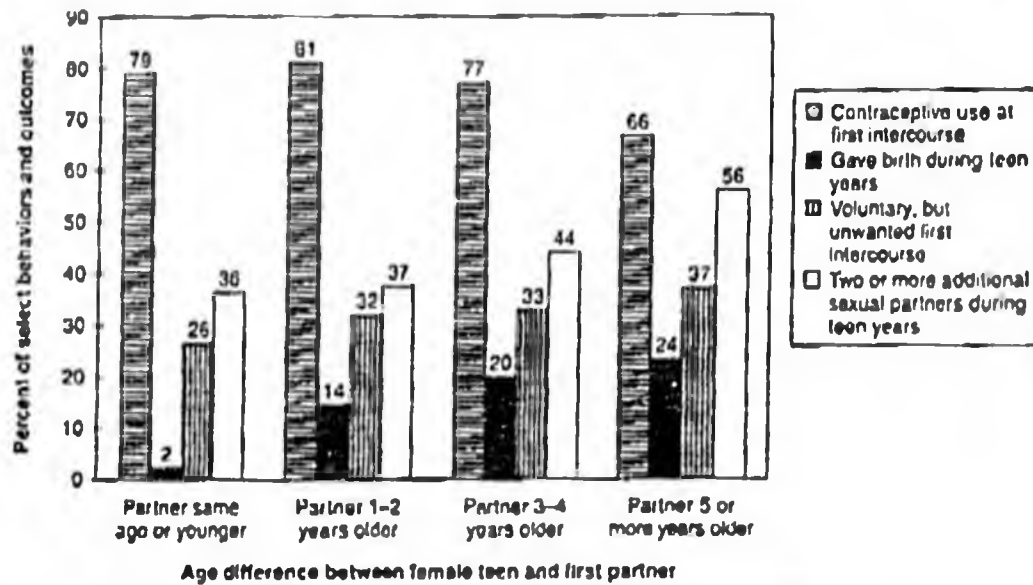


Fig. 1. Percent of select female teen (aged 15-19) behaviors and outcomes by age difference between female teen and first partner. (Data from Moore KA, Driscoll A. Partners, predators, peers, protectors: males and teen pregnancy. Washington, DC: Child Trends, Inc, 1997.)

transmitted more efficiently from males to females than from females to males. The cost to society of sexually transmissible infections to adolescents, as well as adults, was nearly \$17 billion in 1994 (9).

Chlamydia

In 1996, 366,406 cases of chlamydial infection were reported to the Centers for Disease Control and Prevention. Adolescent females aged 15-19 years had the highest rates of chlamydial infection, with 2,068.6 cases per 100,000 females in that age group. Of the 306,694 cases in females for whom age data were available in 1996, 8,889 (3%) were of those 10-14 years old; 134,359 (44%) were of those 15-19 years old; and 99,543 (32%) were of those 20-24 years old (10). The Centers for Disease Control and Prevention estimates that the actual annual incidence of chlamydia is 4 million cases—half of which are among females 15-19 years of age—and that as many as 1 in 10 adolescent females tested for chlamydia is infected.

Gonorrhea

Gonorrhea rates have declined fairly steadily overall since 1975 (Fig. 2). In 1996, rates of gonorrhea in 10-14-year-old and 15-19-year-old adolescents decreased to 329 cases per 100,000 and 570.8 cases per 100,000, respectively. Even with these decreases, 15-19-year-old females had the highest and 15-19-year-old males had the second highest age-specific rates among females and males, re-

spectively. In addition, the disparity between rates for white and African-American adolescents is considerable. In 1996, African-American females aged 15-19 years had gonorrhea rates of 3,790.9 cases per 100,000; African-American males had rates of 2,357.2 per 100,000. These rates are on average 24 times higher than those for their white counterparts (10).

Herpes

It is estimated that by the mid-1990s, 5.6% of the 12-19-year-old population was infected with the herpes simplex virus type 2. The seroprevalence of herpes simplex virus type 2 among white teenagers between the ages of 12 and 19 was 0.96% in the late 1970s. This rate quintupled to 4.9% by the mid-1990s. Among African Americans, the increase over this period was smaller and did not reach statistical significance. However, the seroprevalence of herpes simplex virus type 2 among African Americans remains higher than that of whites at 8.7% (11).

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome

In 1996, 554 new cases of human immunodeficiency virus (HIV) infection were reported among adolescents 13-19 years old; 1,680 new cases were reported among 20-24 year olds. African-American adolescents are especially vulnerable to HIV. Among youths 13-19 years old with HIV, 64% are African American. In addition, although the

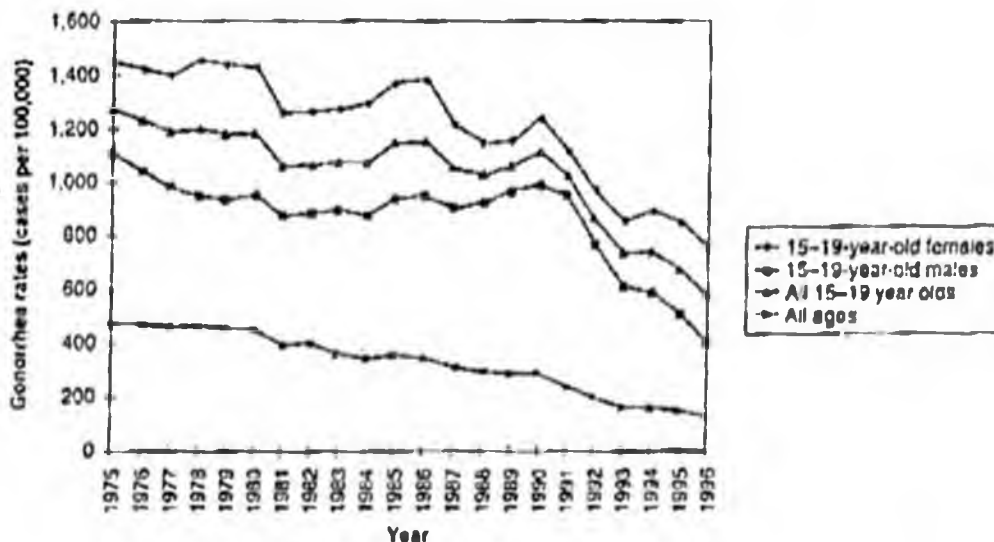


Fig. 2. Gonorrhea rates for adolescents as compared with the entire population: 1975-1996. (Data from numerous editions of Centers for Disease Control and Prevention. Sexually transmitted disease surveillance. U.S. Department of Health and Human Services, Public Health Service. Atlanta, Georgia; Centers for Disease Control and Prevention.)

number of adolescents aged 13-19 with acquired immunodeficiency syndrome (AIDS) is relatively low, it has risen from 1 case in 1981 to 2,754 cases in 1996; 403 of these cases were newly diagnosed in 1996. There were also 2,171 new cases of AIDS diagnosed among those 20-24 years of age (12). This is a decrease from 586 and 3,910, respectively, in 1993 (13). Because infection may occur 10 years or more before AIDS is diagnosed, most of the people aged 20-24 were infected with HIV as either adolescents or preadolescents.

Syphilis

Rates of primary and secondary syphilis in 15-19-year-old adolescents have decreased substantially since 1993. Rates for females 15-19 years of age decreased from 23.5 cases per 100,000 in 1993 to 8.6 per 100,000 in 1996. For males, the rates fell from 10.8 cases per 100,000 in 1993 to 4.3 per 100,000 in 1996. Rates for 10-14-year-old adolescents decreased from 0.9 cases per 100,000 in 1993 to 0.3 cases per 100,000 in 1996. The rates for 10-14-year-old girls decreased from 1.6 cases per 100,000 in 1993 to 0.5 cases per 100,000 in 1996. For boys, the rates fell from 0.3 cases per 100,000 in 1993 to 0.1 per 100,000 in 1996 (10).

Adolescent Pregnancy

The estimates of pregnancies are the sum of live births, induced abortions, and fetal loss outcomes. Although national data on the number of live births are published

annually by the National Center for Health Statistics, it is more difficult to assemble timely data on induced abortions and fetal losses. Therefore, the most recent year for which detailed information on teen pregnancy is available is 1994. Pregnancy rates for teenagers remain high in the United States, even though decreases have been occurring in the past few years. In 1994, the pregnancy rate for teens 15-19 years old decreased to 106.1 per 1,000 from 115.0 per 1,000 in 1990 (Table 3) (1, 14).

The most recent comparative state data available on adolescent pregnancy are from 1992. For more recent data on an individual state, contact the state's health department. In 1992, the pregnancy rates for females 15-19 years old decreased in many states from those in 1991. In 1991, pregnancy rates for 15-19 year olds ranged from 54.3 per

Table 3. Pregnancy Rates (per 1,000 Women in Specified Group) by Age

Age (y)	1980	1985	1990	1994
<15	32	36	33	32
15-19	110.0	106.9	115.0	106.1

*Calculation of 1994 rates for adolescents less than 15 years of age is based on data from Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997; and U.S. Bureau of the Census. U.S. population estimates, by age, race, sex, and Hispanic origin, 1990 to 1996. PPL-97. Gaithersburg, Maryland: U.S. Bureau of the Census, 1997.

Verone SJ, Tapel SM, Mosher WD, Wilson JB, Hananaw S. Trends in pregnancies and pregnancy rates: estimates for the United States, 1960-92. Monthly vital statistics report, vol 43, no 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1993.

Henshaw SK. U.S. teenage pregnancy statistics. New York: The Alan Guttmacher Institute, 1997.

1,000 in North Dakota to 109.2 per 1,000 in Georgia. In 1992, the rates ranged from 53.7 per 1,000 in Wyoming to 106.9 per 1,000 in Georgia (Table 4). From 1991 to 1992, pregnancy rates for 15-19 year olds decreased significantly in 31 of the 42 states for which age-specific data were available. Among states with decreased pregnancy

rates, the percentage decrease generally was greater for whites than for African Americans (15).

In 1991, pregnancy rates for those younger than 15 years of age ranged from 1.8 per 1,000 in Idaho to 10.6 per 1,000 in Georgia. In 1992, the pregnancy rates ranged from 2.0 per 1,000 in Idaho to 10.9 per 1,000 in Mississippi (15).

Table 4. Pregnancy Rates (per 1,000) for Women 15-19 Years Old by State and Race, United States 1991-1992

State	1991			1992		
	White	African American	All Women	White	African American	All Women
Alabama	77.2	139.1	97.0	73.4	134.7	93.2
Arizona	—	—	106.2	102.3	150.6	103.5
Arkansas	83.4	153.3	98.2	76.7	142.6	90.7
Colorado	—	—	82.3	—	—	79.8
District of Columbia	—	—	226.1	—	—	208.4
Georgia	82.2	165.1	109.2	79.6	162.9	106.9
Hawaii	70.3	—	89.0	64.7	—	86.4
Idaho	63.9	—	63.9	59.4	—	59.7
Indiana	66.3	161.2	75.3	62.9	156.7	72.2
Kansas	73.1	177.2	80.1	77.8	211.9	87.0
Kentucky	82.2	155.0	86.3	75.5	149.9	81.7
Louisiana	66.3	131.4*	92.0	65.3	133.7†	92.6
Maine	64.4	—	64.6	54.9	—	55.2
Maryland	55.6	136.3	79.6	51.0	137.1	76.9
Massachusetts	—	—	74.0	—	—	69.6
Michigan	—	—	82.9	—	—	79.7
Minnesota	—	—	59.5	47.3	216.1	55.2
Mississippi	—	—	105.5	71.9	135.1	100.8
Missouri	65.1	193.0	82.6	60.9	166.0	76.0
Montana	68.9	—	75.6	61.8	—	70.2
Nebraska	—	—	69.4	—	—	63.4
Nevada	106.0	166.6	108.9	101.9	171.2	106.0
New Jersey	52.4	179.1	74.6	41.2	179.7	69.7
New Mexico	101.4	132.7	103.0	102.2	100.8	101.6
New York	76.1	173.2	94.4	77.3	176.9	96.6
North Carolina	86.5	163.2	108.8	83.3	153.3	104.6
North Dakota	47.5	—	54.3	47.6	—	54.2
Ohio	—	—	80.9	—	—	74.6
Oregon	66.3	200.9	89.5	72.4	181.7	81.0
Pennsylvania	59.0	214.9	75.9	53.5	211.5	71.7
Rhode Island	60.7	214.5	89.4	78.0	211.8	86.1
South Carolina	74.2	129.5	94.6	68.6	119.6	88.0
South Dakota	46.4	—	57.5	46.5	—	59.4
Tennessee	85.6	168.4	102.0	77.4	162.4	94.0
Texas	98.2	152.3	104.3	96.2	140.8	103.7
Utah	56.4	—	59.4	54.2	—	55.6
Vermont	77.9	—	78.0	68.4	—	68.7
Virginia	69.2	143.9	84.8	62.9	139.4	79.0
Washington	—	—	91.7	—	—	85.1
West Virginia	62.9	100.3	63.8	64.6	116.5	66.1

* — indicates pregnancy rate could not be determined due to a lack of data.

† Also includes all races other than white.

Center for Disease Control and Prevention. State specific pregnancy and birth rates among teenagers—United States 1991-1992. *MMWR Morbidity and Mortality Weekly Report* 1993; 42: 678-686.

Table 5. Number (Rate) of Abortions Among Adolescents by Year and Age*

Age (y)	1975	1980	1985	1990	1994
<15	15,260 (1.5)	15,340 (1.7)	16,970 (2.0)	12,580 (1.5)	12,150 (1.3)
15-19	326,780 (31.2)	444,780 (42.8)	399,200 (43.5)	350,970 (40.6)	276,380 (32.2)

* Abortion rate is number of abortions per 1,000 women of specified age group.

Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997.

Ventura SJ, Taffel SM, Mosher WD, Wilson JB, Henshaw S. Trends in pregnancies and pregnancy rates: estimates for the United States, 1980-92. Monthly vital statistics report, vol 43, no. 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1995.

Pregnancy Outcome

Abortion

In 1995, 1,210,883 legal abortions for females of all ages were reported to the Centers for Disease Control and Prevention—a 4.5% decrease from the number reported in 1994. These data are preliminary. As a result, abortion data specific to teens less than 15 years of age and to teens 15-19 years of age are not yet available. It is estimated that 243,387 abortions were performed on teens less than 19 years of age (16). The most recent age-specific data indicate that an estimated 276,380 abortions were performed on adolescents 15-19 years old in 1994 (Table 5). The 1994 abortion rate for teens was 32.2 abortions per 1,000 females aged 15-19 years (1). The percentage of pregnancies to adolescents aged 15-19 years ending in abortion has decreased from 46.0% in 1985 to 35.3% in 1994 (Table 6) (1, 17).

Births to Adolescent Mothers

In 1996, 12.6% of all births in the United States were to adolescents 15-19 years old. That year, a total of 494,272 babies were born to females 15-19 years old in the United States—representing a decline in both the number of births and the birth rate from 1990 (Table 7). The 1996 birthrate for 15-19 year olds was 54.7 per 1,000 females. The number of births among African-American teens 15-19

years old steadily declined from 151,613 in 1990 to 131,059 in 1996 (18).

In 1996, 11,242 infants were born to adolescents under age 15, a decrease from 11,657 in 1990, although the birthrate has not declined considerably. A total of 5,227 babies were born to African-American teenagers under age 15 years in 1996; that year, 5,570 babies were born to white teenagers in the same age group (18).

The number of births to adolescent mothers (Table 8) and the birthrates to adolescents vary dramatically by state. From 1991 to 1995, birthrates decreased significantly in all but five states and the District of Columbia. These declines were especially large for teenagers between the ages of 15 and 17 years and among African-American teenagers (19).

Births to Unmarried Adolescent Mothers

Of all births to females 15-19 years old in 1996, a total of 375,805 babies (76% of all births to teenagers) were born to unmarried teenagers (18). The percentage of births to

Table 7. Number of Babies Born to Adolescent Mothers (Rate) by Age, Race, and Year*

Age and Race	1985	1990	1996
10-14 y			
All races	10,220 (1.2)	11,657 (1.4)	11,242 (1.2)
White	4,101 (0.6)	4,274 (0.7)	5,570 (0.8)
African American	1,860 (4.5)	6,238 (4.9)	5,227 (3.7)
15-19 y			
All races	467,485 (51.3)	521,826 (59.9)	494,272 (54.7)
White	318,725 (42.8)	354,482 (50.8)	348,509 (48.4)
African American	134,270 (97.4)	151,613 (112.8)	131,159 (91.7)

* Birthrates shown are per 1,000 women in specified age and racial group.

National Center for Health Statistics. Year statistics of the United States, 1988, vol. 1, natality. Health publication no. (PHS) 88-1113. Washington, DC: U.S. Government Printing Office, 1988.

National Center for Health Statistics. Year statistics of the United States, 1990, vol. 1, natality. Washington, DC: Public Health Service, 1994.

Ventura SJ, Peters RT, Martin JA, Mauser LG. Births and Deaths in the United States, 1996. Monthly vital statistics report, vol 46, no. 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1997.

Table 6. Abortion Ratio Among Adolescents by Year and Age*

Age (y)	Percentage, by Year				
	1975	1980	1985	1990	1994†
<15	55	60	62	52	48
15-19	38	45	46	43	35

* Abortion rate is the percentage of pregnancies (including miscarriages) ending in abortion.

† Calculation of 1994 rates is based upon data from Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997, and U.S. Bureau of the Census. U.S. population estimates by age, race, sex, and Hispanic origin, 1980 to 1992. PPL 57. Bethesda, Maryland: U.S. Bureau of the Census, 1997.

Moore RA, Snyder HO. Facts at a glance. Washington, DC: Child Trends, Inc, 1996.

Table 8. Numbers of Babies Born to Mothers Under Age 20, by Age, Race, and State, 1995

State	Number of Births					
	By Age of Mother (y)			By Race of Mother*		
	Total Under 20	<15	15-19	White (Nonmarital %)	African American (Nonmarital %)	Hispanic (Nonmarital %)
Alabama	11,181	324	10,857	5,577 (47)	5,424 (96)	116 (47)
Alaska	1,151	15	1,136	551 (85)	79 (82)	75 (63)
Arizona	10,974	229	10,745	4,030 (73)	470 (93)	5,454 (81)
Arkansas	6,931	191	6,740	4,271 (50)	2,425 (95)	164 (59)
California	68,409	1,645	66,764	15,012 (85)	7,437 (83)	42,084 (62)
Colorado	6,598	134	6,464	3,228 (89)	490 (90)	2,684 (73)
Connecticut	3,603	87	3,716	1,386 (82)	951 (95)	1,270 (85)
Delaware	1,352	51	1,301	620 (81)	599 (98)	124 (82)
District of Columbia	1,471	67	1,404	32 (88)	1,336 (97)	93 (78)
Florida	25,829	739	25,088	11,369 (70)	9,551 (95)	4,601 (89)
Georgia	18,322	595	17,727	8,069 (55)	9,278 (96)	815 (43)
Hawaii	1,862	41	1,841	208 (42)	55 (64)	355 (87)
Idaho	2,531	42	2,489	2,001 (57)	15 (1)	441 (49)
Illinois	24,043	576	23,467	8,615 (77)	9,799 (98)	5,455 (71)
Indiana	12,155	222	11,933	8,221 (74)	2,344 (96)	501 (76)
Iowa	4,067	43	4,024	3,402 (80)	268 (97)	251 (69)
Kansas	4,978	75	4,801	3,387 (69)	768 (94)	553 (71)
Kentucky	4,008	184	3,819	7,897 (56)	1,260 (95)	87 (66)
Louisiana	12,559	351	12,207	4,875 (61)	7,417 (96)	1,000 (79)
Maine	1,426	20	1,406	1,325 (81)	10 (1)	22 (77)
Maryland	7,437	228	7,211	2,807 (80)	4,114 (97)	345 (75)
Massachusetts	6,116	115	6,001	3,244 (89)	920 (97)	1,734 (98)
Michigan	16,844	377	16,467	8,593 (81)	5,983 (98)	967 (77)
Minnesota	5,327	60	5,241	3,448 (85)	857 (96)	359 (74)
Mississippi	8,162	334	7,848	3,264 (49)	5,799 (97)	27 (56)
Missouri	10,499	214	10,282	7,275 (68)	2,908 (98)	220 (70)
Montana	1,407	12	1,395	958 (70)	7 (1)	62 (73)
Nebraska	2,321	38	2,283	1,373 (76)	297 (96)	295 (73)
Nevada	3,473	72	3,361	1,737 (73)	436 (96)	1,092 (77)
New Hampshire	1,108	5	1,103	979 (84)	10 (1)	34 (71)
New Jersey	9,384	233	9,151	2,508 (83)	3,766 (96)	2,947 (83)
New Mexico	4,954	110	4,844	1,133 (85)	115 (95)	3,059 (82)
New York	25,264	328	24,936	6,657 (74)	7,812 (96)	8,447 (86)
North Carolina	15,473	424	15,049	7,682 (58)	6,599 (98)	720 (63)
North Dakota	811	11	800	586 (73)	3 (1)	25 (72)
Ohio	21,086	455	20,631	14,479 (77)	5,787 (98)	862 (84)
Oklahoma	7,809	161	7,639	5,013 (58)	1,181 (94)	494 (82)
Oregon	5,553	105	5,448	4,103 (75)	233 (98)	999 (64)
Pennsylvania	16,365	386	15,979	9,430 (84)	5,079 (96)	1,664 (87)
Rhode Island	1,291	24	1,267	632 (88)	142 (97)	295 (88)
South Carolina	8,601	263	8,518	3,988 (82)	4,637 (96)	118 (62)
South Dakota	1,180	11	1,179	771 (73)	9 (1)	30 (77)
Tennessee	12,292	274	12,118	7,865 (55)	4,279 (98)	170 (56)
Texas	53,507	1,372	52,135	15,850 (59)	8,183 (83)	27,920 (80)
Utah	4,279	57	4,222	3,398 (59)	47 (83)	623 (70)
Vermont	537	4	533	511 (80)	6 (1)	4 (1)
Virginia	10,538	276	10,270	2,444 (61)	4,774 (95)	575 (70)
Washington	8,882	173	8,709	5,709 (75)	548 (91)	1,852 (67)
West Virginia	3,636	52	3,584	3,465 (63)	211 (95)	11 (1)
Wisconsin	7,112	180	6,932	4,169 (81)	1,873 (98)	627 (77)
Wyoming	949	12	937	735 (81)	13 (1)	137 (68)

* Births are reported by the National Center for Health Statistics by race of mother, not race of child as done prior to 1983.

* Figures do not meet standards of reliability or precision, based on fewer than 70 births.

Data from Division of Vital Statistics, National Center for Health Statistics, 1997.

unmarried teenagers varies considerably by state and race (Table 8). More specific data on births to unmarried teenagers are available only for 1995. The birthrate for white unmarried mothers 15-19 years old decreased slightly in 1995 to 35.5 per 1,000 unmarried females, compared with 36.2 per 1,000 in 1994. It increased from 33.6 per 1,000 in 1993. Among unmarried African-American mothers in the same age group, the rate declined in 1995 to 92.8 per 1,000 compared with 100.9 per 1,000 in 1994 and 102.4 per 1,000 in 1993 (20).

Adoption

More than 90% of teenagers who give birth choose to raise the infant themselves. Teens rarely relinquish their children for adoption (21). Nationwide, 8% of infants born to unmarried adolescents who are 17 years old or younger are placed for adoption (22).

Prenatal Care

Adolescents are more likely to experience higher levels of pregnancy complications than older females and are more likely to have low-birth-weight babies. This occurs primarily because adolescents do not receive prenatal care early in pregnancy. In 1995, 66.3% of teenagers 15-19 years old began prenatal care in the first trimester (Table 9), compared with those 76.0% of 20-24 years old and 88.2% of those 30-34 years old. That same year, 7.6% of teenagers 15-19 years old received late or no prenatal care. Just over 25% began prenatal care during the second trimester (20).

Table 9. Number (Percentage) of Live Births by Month Prenatal Care Began and by Race and Age of Mother, 1995

Age and Race	All Births	Early Prenatal Care (1st-3rd Month)	Late (7th-9th Month) or No Care
< 15 y			
All races	12,242	5,682 (46.4)	1,801 (14.7)
White	5,854	2,908 (49.7)	837 (14.4)
African American	5,927	2,484 (41.9)	874 (14.7)
15-19 y			
All races	499,873	322,348 (64.5)	30,878 (6.2)
White	349,835	234,518 (67.0)	23,596 (6.8)
African American	133,694	78,211 (58.6)	11,721 (8.8)

Venura SJ, Martin JA, Curnin SC, Mathews TJ. Report of final natality statistics, 1995. Monthly vital statistics report, vol. 45, no. 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1997.

Table 10. Number of Babies Born at Low Birth Weight by Age and Race of Mother, 1995

Age and Race	All Births	Low-Birth-Weight Babies
< 15 y		
All races	12,242	1,647 (13.5)
White	5,854	642 (11.0)
African American	5,927	959 (16.2)
15-19 y		
All races	499,873	46,511 (9.3)
White	349,835	27,785 (8.0)
African American	133,694	17,356 (13.0)

Venura SJ, Martin JA, Curnin SC, Mathews TJ. Report of final natality statistics, 1995. Monthly vital statistics report, vol. 45, no. 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1997.

Low Birth Weight

In 1995, there were 46,511 low-birth-weight babies ($\leq 2,500$ g or less) born to mothers 15-19 years old (Table 10). This figure represents 9.3% of all babies born that year to adolescents in that age group. In that same year, 1,647 low-birth-weight babies were born to mothers under age 15. For both age groups, a larger percentage of low-birth-weight babies were born to African-American mothers than to white mothers (20).

Impact of Teenage Childbearing

Teenage mothers are significantly less likely to receive a high school diploma than women who postpone childbearing. They are more likely to live in poverty, receive public assistance, and have long periods of welfare dependency. Adolescent fathers finish fewer years of schooling, earn less income annually by age 27, and participate less in the work force than men who delay fathering until age 21. Children of adolescents are more likely to have health and cognitive disadvantages and to be neglected or abused. The daughters of adolescents are more likely to become adolescent mothers themselves, and the sons of adolescents are more likely to be incarcerated. Researchers estimate that if all the differences between adolescent and adult childbearers were eliminated, the net gain to society in higher productivity and lower public assistance and social service costs would exceed \$37 billion annually (23).

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USA
Today

3/4/98

Front page
Life section**education
dissuades
teen sex****College plans
may be a factor**By Marilyn Elias
USA TODAY

Despite all the talk about teens and sex, 2 out of 3 high school students with college-educated parents haven't started sexual activity, suggests a federal survey to be reported Thursday.

The more educated parents are, the more likely their 14- to 17-year-old children are to report being virgins, John Santelli of the Centers for Disease Control and Prevention will tell the Society for Adolescent Medicine meeting in Atlanta. "This shows we shouldn't lump all teens together. Some have started intercourse by middle school, but others are waiting a while lot longer."

The survey of 3,965 adolescents, a nationally representative sample, was taken through audio headsets, with written response forms provided to make it easier for teens to give candid answers to adult questions, Santelli says.

It was conducted in 1992, but the figures are the most recent to link teen sex with parental education, and Santelli believes the trend has continued since then. "There's no reason to think there's any change here," he says.

Among the findings:

► If at least one parent finished college, 79% of girls had sexual experience, 45% if a parent graduated from high school, 36% if a parent had no high school diploma.

► For boys, 34% with a college grad parent had engaged in sex, 47% if a parent finished high school, 10% if a parent had no high school diploma.

Well-educated parents may be able to provide closer supervision, Santelli says. Also, teens may delay intercourse if they know they're expected to follow their parents' example in attending college, and they fear early pregnancy.

New studies show adolescents tend to start sex later when parents talk openly about sexuality and convey clear expectations for delayed intercourse, says Debra Halper, president of the Sexuality Information and Education Council of the United States. "We'd need more research to prove it, but I'd guess college-educated parents are more likely to do this," Halper says.

There's proof that teens with college parents start sex later, and educated parents may limit their future planning, she says.



Legislative Affairs Agency
Division of Administrative Services
Delta Junction Legislative Information Office
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Phone: (907) 895-4236 Fax: (907) 895-5017

To: House HES
Fax: 465-3871 Phone: _____

Seabornmy

Date Sent: 3/31/98 No. of Pages Including Cover Sheet: 2

Thank You,
Tammy Rence
Tammy Rence' Hall
Information Assistant



Alaska State Legislature

Please enter into the record my testimony to the _____ committee name
committee on HB 372, dated 3-31-98
bill/ subject

I urge passage of this Bill based on the reasons already identified by the sponsor as well as the fact that parents are the ones primarily responsible for their minor children and as such should be the ones who give/or don't give their permission for the prescription of contraceptives. IF my child is given a prescription for oral contraceptives without my knowledge or consent, who then is responsible should complications arise? The Doctor or the State? I am against the current "sueing" craze, but would be inclined to sue both under such circumstances. I might also point out that giving contraceptives to minors has NOT reduced the rate of teen pregnancy. If anything, it has had the opposite effect. Check the statistic

Signed: Delna J. Santos
Testifier
Republican Party of Alaska, Dist. 35 Chairwoman
Representing (Optional)
Box 377 Delta, AK 99737
Address
(907) 895-4565
Phone No.

31 March, 1998

To: Members of the House HESS
and Interior Delegation

From: Dodie Delaney, nurse practitioner

RE: HB 372

As a nurse practitioner in a family planning clinic and STD (sexually transmitted disease) clinic, I would like you to NOT vote for HB 372 requiring minors to have parental consent to obtain contraceptives.

My personal and religious views are such that I do not believe in sexual relations without marriage. But in the real world this often does not happen. Though I personally would prefer a teen abstain, I am so thankful that ~~they~~ those that come to see me for birth control are taking on that responsibility. Most of the teens I see have been sexually active for a year or more and should've been on birth control long before I see them. Yes, I emphasize the need to communicate with their parents and encourage teens to do so.

1340 Spring Glade
Fairbanks, AK 99709
March 31, 1998

To: House Health & Social Services Committee

Re: HB 372

I urge you to reject HB 372, along with the underlying assumptions it makes. Yes, we all want our teens to delay sexual activity; and yes, we all want open, frank dialogue with our teens, and yes, we as parents want to know what our kids are doing. But the reality is that these are not going to be brought about by legislation. HB 372 simply ensures that those kids who most need birth control - because they are already having sex - will now add the burden of an unplanned -

CORRECTION

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



Rev. 6/98

Central Microfilm Services
Department of Education
State of Alaska

31 March, 1998

To: Members of the House HESS
and Interior Delegation

From: Dodie Delaney, nurse practitioner

RE: HB 372

As a nurse practitioner in a family planning clinic and STD (sexually transmitted disease) clinic, I would like you to NOT vote for HB 372 requiring minors to have parental consent to obtain contraceptives.

My personal and religious views are such that I do not believe in sexual relations without marriage. But in the real world this often does not happen. Though I personally would prefer a teen abstain, I am so thankful that ~~they~~ those that come to see me for birth control are taking on that responsibility. Most of the teens I see have been sexually active for a year or more and should've been on birth control long before I see them. Yes, I emphasize the need to communicate with their parents and encourage teens to do so.

Many parents have not or will not provide for their child or teach them what they need to know.

Even though I am personally very conservative, I would much rather see a teen who NEEDS birth control be able to obtain it and use it than the misery of an unwanted pregnancy.

Thank you

Dodie Mcaney, AWP

1340 Spring Glade
Fairbanks, AK 99709
March 31, 1998

To: House Health & Social Services Committee

Re: HB 372

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pregnancy to their lives. I work with adolescents and I have a teen-aged son. I know that what we want for ~~the~~ our kids does not necessarily reflect what they choose to do - and we cannot + should not watch them 24 hours a day.

This is not a perfect world and imperfect decisions will be made. Let us at least permit our kids some measure of safety - and access to caring health care providers who offer another voice of caution and who share most parent' concerns for the health and well-being of all our kids.

Sincerely

Diana Lingle

Diana Lingle



ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House HES
Committee Name
 Committee on HB 372, Contraceptives/minors Dated 3/31/98
Bill / Subject

This bill is the best possible way to
INCREASE teen pregnancies in AK.
 I urge you to vote "NO!"

I can only wonder if the people behind this bill
 were virgins when they got married? And if not,
 I certainly hope the first people they told when
 they decided to have sex...was their parents!

We bombard today's teens with sex in every
 form of media... and then you propose we take
 away the tools they need for safety and protection.
 I am amazed that a bill like this could even
 be taken seriously. ~~XXXXXXXXXX~~

May God protect us from people with an agenda
 like this.

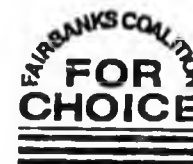
SIGNED:

Connie Page
Testifier

Reality
Representing

2211 Penrose Lane FORTS AK
Address / Phone Number
99709

Lisa Peñalver
 President,
FAIRBANKS COALITION FOR CHOICE
 P.O. Box 74264, Fairbanks, Ak 99707
 457-1458, fx 457-4243
 March 30, 1998



Please send the following testimony to the attention of the Alaska State House Health Education and Social Services Committee, Alaska State House of Representatives, Juneau Alaska
 (For TELECONFERENCE HEARING - Tuesday, March 31, 3:00pm)
 ****To be included in the Record of Testimony on HB 372 - Parental Consent for Contraception

Dear Representatives,

I strongly urge you to oppose HB 372. While I appreciate parents' desire to be involved in their teens decisions about sexuality, several thousands of teen pregnancies prove that this is rarely the case. Confidentiality in contraceptive services is one of the few things that has been PROVEN - both in our own country and abroad - to succeed in reducing teen pregnancy and limiting the transmission of sexually transmitted diseases. To breach that confidentiality is misguided, and we do it at our own peril!

This is a Truly Bad Idea - if you threaten health care providers and require parental involvement, you might as well be banning the use of any contraceptives by teens. This proposal will NOT stop sexual behavior - but it will GUARANTEE that sex will be more dangerous - even deadly (in the case of AIDS or pregnancy among young girls in immature bodies) - for many of our young people.

- ◆ Federal and state lawmakers have long recognized that, while parental involvement is desirable, confidentiality can be crucial to encouraging young people to address sensitive issues such as pregnancy prevention.
- ◆ Federally funded Title X family planning programs *have always provided confidential services* to adolescents, and no state (in its right mind) explicitly mandates parental involvement for a minor to obtain contraceptive services.
- ◆ Research done by the Alan Guttmacher Institute (AGI) shows that at least 7 in 10 teenage women and their partners currently use a contraceptive method. Restricting access to contraceptives in Alaska could dramatically lower this statistic.
- ◆ AGI research reveals that a sexually active teenager who doesn't use contraception has a 90% chance of pregnancy within one year.
- ◆ Research done by the Alaska Division of Public Health shows that 74% of births to teenagers are unplanned. The report states "Because a number of serious adverse health and education outcomes to both the mother and infant may result..." These results suggest the potential for a crisis situation. Restricting access to contraceptive services will only make things worse!
- ◆ Unwanted childbearing has been linked with costly consequences for families, children and the state.
 Unwanted children:
 - experience more mental handicaps and are twice as likely to receive psychiatric care at government expense;
 - are more than twice as likely as wanted children to have a record of juvenile delinquency;
 - are six times more likely to receive some form of welfare between the ages of 16 and 21;
 - are at increased risk of suffering abuse, neglect, abandonment and removal to foster homes or institutions.
- ◆ *Kids Count Alaska* reported in their 1996 Data Book report that teenage, never-married mothers are distinguished from the general population of single parents by their extreme poverty: significantly lower educational attainment, social resources, and potential earnings.
- ◆ In 1992, 52% of all the mothers collecting AFDC had their first children as teenagers
- ◆ This bill is sexist - in that its impact will overwhelmingly be felt by young women who find themselves unable to get protection from either pregnancy and sexually transmitted diseases

Please do not ignore the evidence before your very eyes! I am one of your constituents, as well as President of the Fairbanks Coalition for Choice, representing several thousand pro-choice voters in the Fairbanks area, and I urge you to oppose this bill.

Sincerely,

To: Members of the House Health and Interior
Delegation

As a nurse practitioner at the Fairbanks
Regional Public Health Center, I see a number
of TEENS who are sexually active.
There are currently 12 girls who are
pregnant at one of our local high
schools. This number is unacceptable
and yet - this is with birth control
available without parental consent.

While I routinely encourage parental
involvement, there are situations/circumstances
where it is UNAVAILABLE. More important
is the AVAILABILITY of birth control
to prevent unwanted pregnancies.
Better a teen take responsibility
for herself by preventing
a pregnancy than being forced into
a premature responsibility for
RAISING A child.

Please reconsider HB 372. It is
an unrealistic answer for an
age-old problem. If passed, it
will only serve to bring many
more children who will not be
properly cared for & loved.

Thank you,  Nancy Snyder
Family Nurse Practitioner

3-31-98

TO: House Hess Committee and the Interior Delegation
RE: House Bill 372
FROM: Linda Rasmussen ANP
P.O. Box 82053
Fairbanks, AK 99708

Dear Representatives,

I do not support House Bill 372 which would require parental consent for contraceptives for minors. As a Nurse Practitioner who has worked with teens for 15 years I feel strongly that having birth control methods available to teens greatly impacts the number of unplanned pregnancies and "crisis pregnancy abortions".

Almost all of the teens that I see are already sexually active, a fact that dismays me particularly the younger they are. Histories of sexual abuse, dysfunctional parents and families, drug use and peer pressures all are big social problems which contribute to the teens sexual activity. These issues are "out there" to take into consideration. What I see is a teen in the clinic who is currently sexually active and right now needing to prevent further trauma in her life and the life of another child.

Good, open communications among family members on all issues including sexuality issues is an area I stress with all of the teens. In an ideal world I know this level of communication is healthiest for the teen. I also know that some of my patients family situation may inherently not be healthy or not healthy enough at the moment to discuss sexual issues. Because they are already sexually active I need to intervene to help them to not get pregnant while their own world and our world in general is getting "straightened-out".

Requiring parental consent to supply a minor with the birth control which they need would result in an increase in unplanned pregnancies and abortions for this age group. These kids already have enough on their plate without further confounding their lives!

Linda Rasmussen

March 31, 1998

House of Representatives
House HSS Committee
Insurance Subgroup

Dear Representatives:

We are writing to request your "no" vote with regard to HB 372 regarding parental consent for adolescent prescriptions.

In an ideal world, parents would accept responsibility for providing adolescents in their jurisdiction with access to the quality of care that young men and women deserve and (for young men and their parents) be physically active in helping themselves to the appropriate and appropriate medical education and training. Please help our state. To request that you support this bill, please contact your representative. Thank you for your leadership.

Respectfully,
Cecilia Stearns

Cecilia Stearns

Health and Social Services
House Committee and In Person Delegation.

Date: 3-31-97

RE: HB # 372

Dear Committee members:

HB # 372 will make it illegal for Alaska teenagers to receive any prescriptive medicine without parental consent.

I strongly encourage you not to consider the passing of this bill. HB # 372 will have long term effects on our teen populations.

Unfortunately, we have parents & families in our communities that are unable to talk to their teenagers about important health care issues. Many of these issues are life changing and life threatening. Some parents are unaware of the current stresses and situations our teens may face. Likewise many teens cannot discuss health issues with their parents.

Providers throughout Alaska provide a safe, confidential place for teenagers to obtain up to date information about options and treatments. This information always includes preventative health messages. Options to pregnancy & STD (sexually transmitted diseases) are important. Some of these options require medical treatment that should not be postponed. With early treatment epidemics & chronic health problems can be managed.

HB 372 would only make fast, safe treatment more difficult for teenagers.

Sincerely,
Chris Davis

To: All members of Health + Social Services
House Committee
+ Interior Delegation

Date: 3/31/98

RE: HB # 372

As the mother of a teen daughter + young
adult male, a public health nurse,
and a Christian who believes in family
values, I recommend the above bill
be not considered for passage.
All teens need access to free
birth control and STD exams
without having to seek parental
permission. Teens should not
have to be parents when they are
still children themselves.

Sherry L. Harris, RN
Fairbanks Homeowner
487 Slater Drive
Fbks., Ak. 99701
1-907-4521952



MEMORANDUM

TO: Health and Social Services Committee,
House of Representatives

DATE: March 31, 1998

FROM: Glenda Lee, Private Citizen (P.O. Box 72274, Fairbanks, AK 99707)

Glenda Lee

SUBJECT: House Bill-372

If this bill pass, I personally feel this HB-372 will discourage our young people (ages 12 - 17) from taking steps to prevent pregnancy, Sexual Transmitted Diseases, etc... Majority of our young people would not feel very comfortable at all getting parental consent to get on birth control.

Would you?

I mean really take time out and think about when you were this age, imagine yourself going to your father or mother or guardian and asking permission to use birth control. Most parents cannot deal with their teenagers having sex. I'm a mother of two teenagers, and I am also a Christian mother. I do not want my teenagers having sex, but I have to come to the reality that my teenagers are human and even though they know right from wrong sometimes hormones overpower their knowledge. If they had to get consent from their parents before getting on birth control it would cause them to go through weeks of nervousness, trying to think how to go about this, to the point of, maybe they will forget about it or just decide to take chances and hopefully not get pregnant or come up with a sexual transmitted disease before they will get consent from their parents.

I deeply oppose this bill. I would rather my teenagers have the freedom to go to the local health provider, physician, outpatient care etc... to take the steps necessary to keep from having other responsibilities that will affect their future. When our young people take responsibility to get on birth control they are not only looking out for themselves, but also for the welfare of their parents.

Thank you in advance for not passing this HB-372.

3-31-98

House of Representatives, HSS Committee
Interior Delegation

Re HB 372

Teen pregnancy is one of the most pressing social issues of the day. Abstinence & open parental discussion are the ideal & to be encouraged. The reality is that many teens are sexually active & in need of birth control.

Without free & confidential access to clinics, the rate of unintended & out of wedlock births would soar in this youngest & most vulnerable group.

Birth control "buys some time" for kids to grow up, get an education/job & straighten out their priorities.

I am opposed to HB 372.

Sincerely,

Janet Lokken, Public Health Nurse -
parent, grand parent

1300 Skyline Dr
Fairbanks, AK 99712

Karen Miller
10021 Crestview Lane
Eagle River, Alaska 99577
(907) 694-2710

facsimile transmittal

To: Representative Fred Dyson Fax: (907) 465-4587
[Click here and type name] Date: 04/01/98
Re: HB 372 Parental Consent for Contraception Pages: two
CC: Representatives: Con Bunde, Chair; Joe Green, Chair, Brian Porter, Al Verey

Urgent For Review Please Comment Please Reply Please Recycle

It is tough to be a teenager, no matter where you live, but it is especially difficult for teens in our Alaskan villages. It is a rebellious time when kids may least want to talk to their parents and in a number of homes reasonable discussion is not possible.

It has been a decade and a half since my daughter was a teenager. Although we were a close family where family conferences, discussions were common, this was one area she didn't want to talk to us about. Whatever her reason I was comfortable and glad that she was able to access a family clinic that addressed her needs.

Confidentiality is crucial in dealing with sensitive health concerns. I can not possibly see where requiring parental consent for contraception would have a desirable effect on the quality of family relations. I feel funding family clinics and making counselors readily accessible would do far more in improving both the physical and emotional health of our teenagers and strengthening families.

Restricting the prescribing of contraceptive drugs and devices by health providers certainly hinders these providers in dealing with teenagers in an open and positive manner. Why overburden our present court system with yet another law that they have to administer.

Our children need social, emotional and psychological support as they traverse the turbulent years of childhood to adult hood. Raising children is very labor-intensive. Please do not make this more difficult for both parents and teenagers by creating another layer of government interference.

Sincerely,

Karen F. Miller

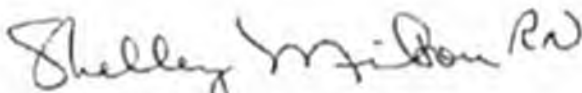
To: Legislature Information Office
Leg 376-6180

3/31/98

To Whom it May Concern:
Re: HB 372

I would like to express my concerns about HB 372 as it limits the access of minors to birth control without parent permission or a court order. I know of very few teenagers who, when faced with the need for birth control are willing, or able, to have the conversation necessary to obtain parent permission. They will be less willing to take the required steps to obtain a court order for that same permission. You can rest assure that they will not delay having sex. By requiring parent permission, you are effectively raising the birth rate of unwed teenage parents. The cost to the state for these babies who will be having babies will be enormous. This proposed House Bill 372 is not the forum in which to debate public morality. I think we all agree that our young people in Alaska need to have a future in which they can reach their greatest potential. HB 372 will be a deterrent to that future.

Sincerely,



Shelley Milton RN
School Nurse
Palmer Junior Middle School



Alaska State Legislature

Please enter into the record my testimony to the HOWEY HESS
committee name

committee on HB 372, dated 3-31-96
bill/subject

I AM BOTH A PEDIATRIC NURSE AND A SUBSTITUTE SCHOOL NURSE. I OFTEN HAVE THE PLEASURE OF WORKING WITHIN SENIOR HIGH SCHOOLS. I KNOW THAT THE POSITION OF THE SCHOOLS IS TO ENCOURAGE OR CONDONE ABSTINANCE. UNFORTUNATELY, NOT ALL KIDS HEED THIS ADVICE. I FIND GREAT DIFFICULTY IN SUPPORTING A BILL THAT HAS THE POTENTIAL OF INCREASING TEEN PREGNANCY RATES. THIS BILL HAS HAS THE POTENTIAL TO CREATE A MULTITUDE OF SOCIAL AS WELL AS HEALTH PROBLEMS FOR YOUNG PEOPLE AND SOCIETY AS A WHOLE. AS A HEALTH CARE PROFESSIONAL I STRONGLY URGE YOU CONSIDER THE RAMIFICATIONS THAT WOULD ARISE SHOULD THIS BILL BE PASSED.

Signed: Therese A. Hoff, RN BSN
Testifier

Representing (Optional)

HC 72, Box 6525E, Wasilla, AK 99657
Address

907-795-3679
Phone No.

HB

375

File 1

(7)

Date Referred to Committee: February 2, 1998

FURTHER REFERRALS:

Judiciary
Finance

Date of Committee Action: 4/2/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 375

HOUSE BILL NO. 375

CRIMES AGAINST CHILDREN/FOSTER CARE

"An Act relating to children in need of aid matters and proceedings; relating to murder of children, criminally negligent homicide, kidnapping, criminal non-support, the crime of indecent exposure, and the crime of endangering the welfare of a child; relating to registration of certain sex offenders; relating to sentencing for certain crimes involving child victims; relating to the state medical examiner and reviews of child fatalities; relating to teacher certification and convictions of crimes involving child victims; relating to access, confidentiality, and release of certain information concerning the care of children, child abuse and neglect, and child fatalities; authorizing the Department of Health and Social Services to enter into an interstate compact concerning adoption and medical assistance for certain children with special needs; authorizing the establishment of a multidisciplinary child protection team to review reports of child abuse or neglect; relating to immunity from liability for certain state actions concerning matters involving child protection and fatality reviews and children in need of aid; relating to persons required to report suspected child abuse or neglect; relating to foster care placement and to payment for children in foster and other care and the waiver of certain foster care requirements; relating to the access to certain criminal justice information and licensure of certain child care facilities; amending Rule 218, Alaska Rules of Appellate Procedure; amending Rules 1, 3, 15, 18, and 19, Alaska Child in Need of Aid Rules; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 375 (HES) the same title a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

fiscal note(s) Corrections, H+SS
Court System

fiscal note(s) Multiple 12/2/98

zero fiscal note(s) _____

zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>Fred Dyer</i>	<input checked="" type="checkbox"/>			
<i>Joseph Dyer</i>	<input checked="" type="checkbox"/>			
<i>Tom Bueck</i>	<input checked="" type="checkbox"/>			
<i>Tom Bueck</i>	<input checked="" type="checkbox"/>			
<i>Tom Bueck</i>	<input checked="" type="checkbox"/>			

CHAIR'S SIGNATURE

Tom Bueck

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: Child Protection BRU: State Health Services
 Sponsor: Rules Committee Component: State Medical Examiner
 Requestor: Governor COMPONENT SERIAL NO. 293
 See also (SN#): _____

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES		35.0	35.9	36.8	37.7	38.6
TRAVEL		3.0	3.0	3.0	3.0	3.0
CONTRACTUAL						
SUPPLIES						
EQUIPMENT		5.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	43.0	38.9	39.8	40.7	41.6
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF		43.0	38.9	39.8	40.7	41.6
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	43.0	38.9	39.8	40.7	41.6

POSITIONS:

FULL-TIME		1	1	1	1	1
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 50.0

ANALYSIS: (Attach a separate page if necessary)

The State Medical Examiner will be able to absorb the cost associated with a full-time clerk as the State Child Fatality Review is being established. By FY00, a full-time Administrative Clerk II will be needed to collect, collate and distribute the data, make travel arrangements and arrange for physical space for the review teams meetings, and advise attendees as to the material being discussed. The Division of Public Health will absorb the cost of the expense needed to perform the analytical portion of the program within its existing resources.

\$3.0 is being requested in Line 200 Travel for members of the review team to attend the meetings. Also included in the travel line is funding to travel to other communities to train and support local community review boards.

\$5.0 is requested in FY 00 in Line 500 Equipment for office furniture and a computer for the Administrative Clerk II.

Prepared by: Peter M. Sakamura, MD, MPH Phone: 1907 465-1090
 Division: Public Health Date: 03/12/98
 Approved by Commissioner: Karen Perdue, Commissioner Date: 3/12/98
 Agency: Department of Health & Social Services

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FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HB 375 | _____

Revision Date (Note if correction) _____ Dept. Affected Corrections
 Title An Act relating to children in need of aid matters BRU Administration and Operations
and proceedings relating to murder of children. Component ALL
 Sponsor Rules Committee
 Requester Governor Component Serial No. #0694

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous	00	58.1	58.1	106.9	203.9	240.4
TOTAL OPERATING	0.0	58.1	58.1	106.9	203.9	240.4

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	00	58.1	58.1	106.9	203.9	240.4
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	58.1	58.1	106.9	203.9	240.4

Estimate of any current year (FY98) cost: 00

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation amends several titles under Alaska statutes. This fiscal note only reflects the sections of the bill that incur costs for the Department of Corrections.

Section 4. The Department of Law (DOL) estimates the changes made to AS 11 41 110(a) will increase the minimum sentence from five (5) years to fifteen (15) years for a net gain of ten (10) years. Subtracting one third for good time, the actual increase in sentence is 6.7 years. The DOL estimates this change will effect one (1) case per year, the additional cost for incarcerations will be \$243,670. (continued)

Prepared by Bruce Richards Phone 465-3307
 Division Commissioner's Office Date 3/11/98
 Approved by Commissioner Margaret M. Pugh Date 3/11/98
 Agency Department of Corrections

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Section 5. Increases the penalty for criminally negligent homicide from a class C felony to a class B felony. This will result in an additional sentence of one and a half (1.5) years. Subtracting one third for good time results in a total increase in sentence of one (1) year. The DOL estimates this change will effect one (1) case per year. the additional cost for incarceration for one year will be \$36,525.

Sections 8 & 9. This section will increase the penalty for one form of indecent exposure from a misdemeanor to a class C felony. The DOL estimates that three people would be convicted annually under the felony provision. This is expected to increase the current average sentence of 28 days to 90 days for a net gain of 62 days. Subtracting one third for good time, the actual increase is 32 days. The additional cost of incarceration for the three cases will be \$9,600.

Section 10. The DOL estimates the changes made in this section will affect one case per year. Under current statute the sentence would have been 6 months. With the changes that sentence will increase one year for a net gain of 182 days incarceration. Subtracting one third for good time, the actual increase is 120 days, the additional cost of incarceration for one case will be \$12,009.

Section 13. The DOL estimates the changes made in this section will affect one case per year. Under current statute the offender would be sentenced to a five (5) year presumptive sentence. This proposed change will result in a seven (7) year presumptive sentence for a net gain of two (2) years. Subtracting one third for good time, the actual increase in sentence will be 482 days. The additional cost of incarceration for one case will be \$48,214.

Section 24. This section would require the Department of Corrections to register sex offenders 30 days prior to their release from incarceration. The DOC began doing this in September of 1997 and therefore does not anticipate an increase in costs.

FISCAL NOTE

Bill Version: HB 375

(H) Publish Date: 2/2/98

**STATE OF ALASKA
1998 LEGISLATIVE SESSION**

Revision Date (Note if correction) Original Dept. Affect Multiple (see analysis)
 Title "An Act relating to children in need of aid
matter and proceedings; relating to murder of children ..." BRU
 Sponsor Rules Committee Component _____
 Requester Governor Component Serial No. _____

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*****	*****	*****	*****	*****	*****

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	*****	*****	*****	*****	*****	*****

Estimate of any current year (FY98) cost: 00

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The costs of implementing a zero tolerance policy for reports of harm to children by investigating all such reports are part of the comprehensive \$14 million child protection element of the Governor's Smart Start Initiative included in the FY 99 budget. The Executive Branch agencies with significant budgetary issues related to the criminal and civil provisions set out in this bill are the Departments of Administration, Corrections, Health and Social Services, and Law. If the FY 99 Smart Start increments for those agencies are not funded, this bill cannot be fully implemented.

Continued on next page...

Prepared by Laura Baker, Budget Analyst Phone 465-4684
 Division Office of Management and Budget Date 1/30/98
 Approved by Annalee McConnell, Director Date 1/30/98
 Agency Office of Management and Budget

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Analysis Continued: "(An Act relating to children in need of aid...")

The interrelationships of the agencies' efforts are complex. The bill had not been finalized at the time the FY 99 budget was submitted, so some adjustments may be necessary to the child protection elements of Smart Start. If so, they will be presented as Governor's budget amendments within the overall amount already budgeted for Smart Start.

Agencies and programs involved:

Department of Administration

Office of Public Advocacy - The appointment of a guardian ad litem is legally required upon the filing of a child in need of aid (CINA) petition. These guardians ad litem must, following their appointment by the court, represent the best interests of the child throughout the CINA proceedings. An increase in cases will result from additional investigations expected to be undertaken by the Division of Family and Youth Services.

Public Defender - As a result of changes in policies of the Division of Family and Youth Services, the number of CINA cases is expected to significantly increase case activity. Parents have a right under Alaska law to representation by court-appointed counsel in CINA cases and criminal cases if they cannot afford their own attorney.

Department of Corrections

This legislation would expand penalties relating to certain crimes against children. These changes are expected to increase the number of incarcerations and the length of time served.

Department of Health and Social Services

This bill affects a broad range of departmental programs, including substance abuse treatment and family support services; social services for children in need; and temporary foster care or permanent adoption homes.

Additional adoption placements resulting from these changes in the law are separate from the placement backlog.

Department of Law

Criminal Division - Enactment of this legislation will add new criminal provisions as well as increase the penalties for those people who kill or harm children by abuse and neglect. The bill would make it easier to charge individuals who harm children with more serious offenses, and increase the sentences they may receive.

Civil Division - Changes in this bill include tightening definitions to clarify when a child is in need of aid and when state intervention is justified. A significant change involves time limits, the setting of deadlines, and a more concrete definition of parental responsibilities. Cases will proceed to a termination trial much faster to ensure that when reunification with family is not in the child's best interest, the child can be made legally eligible for placement in a permanent home more quickly.

Court System

The Alaska Court System is anticipated to submit a separate fiscal note regarding impacts of the bill.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 6, 1998

SUBJECT: CSHB 375(HES), version H (Child Protection)

TO: Representative Con Bunde
Attn: Lynne Smith

FROM: Terri Lauterbach *BT Apr 7 1998*
Legislative Counsel

Enclosed is CSHB 375(HES) in final.

Per your directive, I have not incorporated the conceptual amendment to page 18, line 14, of the "F" version, and I have eliminated the section at the end of the bill that would have been a revisor's instruction to change "minor" to "child" in undetermined sections of AS 47.10 because the blank lines of the revisor's instruction in the "F" version were not filled in and blank lines cannot be retained in a final. I have added sec. 26 to accommodate the changes made in AS 25.20.061 by Amendment #7.

Please let me know if I can be of further assistance on this matter.

TML:glc
98-209.glc

Enclosure

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

(907) 465-3887 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 3, 1998

SUBJECT: Domestic Violence as a CINA factor (CSHB 375(HES))

TO: Susan Wibker
Assistant Attorney General

FROM: Terri Lauterbach *TML*
Legislative Counsel

Lynne Smith, House HESS Committee staff, has requested that I get your point of view as to whether the following language, to be used at page 18, lines 13 - 14 of the F version of HB 375, would implement the HESS Committee's conceptual amendment relating to mental injury and domestic violence:

(8) conduct by or conditions created by the parent, guardian, or custodian have resulted in mental injury to the child; if the court finds that the child has been exposed to domestic violence involving a member of the child's household, there is a rebuttable presumption that mental injury to the child has occurred because of conduct by or conditions created by the parent, guardian, or custodian;

Please respond as to the appropriateness of this language at your earliest convenience so that the final (HES) version can be prepared. Thank you.

TML:jdr
98-229.jdr

✓ cc: Representative Con Bunde, Chair
House Health, Education and Social Services Committee

Post-It* Fax Note	7671	Date	4/3	# of pages	1
To	Lynne Smith	From	Terri Lauterbach		
Co/Dept	Rep Bunde	Co			
Phone #		Phone #			
Fax #		Fax #			

TONY KNOWLES, GOVERNOR

Elmer Lindstrom

OFFICE OF THE GOVERNOR

OFFICE OF MANAGEMENT AND BUDGET

P O BOX 110020
JUNEAU, ALASKA 99811-0020
PHONE: (907) 465-4660
FAX: (907) 465-3068

March 13, 1998

The Honorable Mark Hanley, Representative
The Honorable Con Bunde, Representative
Alaska State Legislature
State Capitol Building, Rm 104
Juneau AK 99801-1182

RECEIVED

MAR 13 1998

OFFICE OF THE COMMISSIONER
DHSS JUNEAU

Dear Rep. Hanley and Rep. Bunde:

The governor's FY99 budget included resources for all the agencies involved in child protection to implement a zero tolerance policy for child abuse and neglect. We know for certain that a piecemeal approach will not work to solve the immediate crisis or to establish the child protection system Alaskans demand. We must construct and fund a comprehensive, interdisciplinary approach that goes beyond a single division or department. It must balance resources to provide for prevention, early intervention and swift definitive action to protect children and provide them with safe permanent homes. This necessarily involves adding resources not only for social workers and foster care, but for troopers and VPSO's, the legal system, substance abuse treatment, and community-based prevention efforts. While these efforts are essential under current statutes, the timeframes and other provisions of HB 375 make the urgency for additional resources even greater. If stricter timelines become law, failing to adequately fund the interrelated pieces could cause further crises in an already overburdened system. I know that consequence is unacceptable to all of us.

We proposed to fund the additional resources needed for child protection with reallocated state dollars previously required to match federal Medicaid funds. As we have pointed out in testimony to your committees and others, implementing a policy of appropriate response to all reports of child abuse and neglect does not require a change in law. In fact, our current law requires such a response. The child protection resources proposed in the governor's FY99 budget are necessary to enable our child protection system to function as intended by current law. Passage of HB 375 would improve our ability to achieve the policy goal of protecting children earlier and more effectively, but we need the resources proposed in our budget regardless of any change in law.

The Honorable Mark Hanley
The Honorable Con Bunde
March 13, 1998
Page 2

The usual test for a fiscal note is whether the proposed law would cause or require a programmatic change with a fiscal impact. HB 375 would not change the current statutory policy on response to reports of harm. It would assist in achieving the goals of a zero tolerance policy by allowing earlier, more effective interventions, and establishing clear timelines for movement toward safe permanent homes for abused children.

Since the cost of strengthening our child protection teams to implement zero tolerance did not require statutory change and was already included in our Smart Start budget proposal (as subsequently modified in our amendments), we did not believe a fiscal note was appropriate. The exceptions are Corrections, where there would be additional costs because of longer sentences and the State Medical Examiner's Office to establish a Child Fatality Review process. The first year Corrections cost of \$21.6 was so minimal that we intended to absorb it within the FY99 proposed budget; likewise for the State Medical Examiner. However, as longer sentences are implemented, the cost will increase over time. Due to a miscommunication on my part, that fiscal note was not forwarded along with the bill. It is, however, a cost that will be borne only if the bill passes and therefore is appropriate for a fiscal note.

Since new staff are phased in throughout FY99, some additional costs will be incurred to annualize these positions in FY00, which we would have incorporated in next year's budget. However, it is not appropriate to assume that this will mean an overall increase in the budget. The difficult decisions about how to balance these increases within an overall responsible budget level would have taken place in the normal course of developing the governor's FY00 budget next fall.

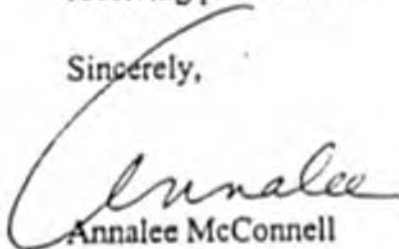
Several forces are occurring simultaneously that make it difficult to precisely define the cost of zero tolerance. First, additional staff will be required to meet statutory mandates under either the existing law or the law as revised by HB 375. Second, the heightened public awareness has already increased both reports of harm and formal legal child protection interventions significantly above the previous level. Third, many of the provisions of HB 375 would allow earlier intervention and assist in placing children in permanent homes more quickly. More intensive initial efforts may help offset the impact of increased reports. Finally, increased prevention efforts proposed in Smart Start are designed to reduce the future need for child protection response, helping to level and reduce the costs over time.

The legislature may prefer to fund the additional resources necessary for child protection through fiscal notes. If so, the attached information shows the reallocation in the

The Honorable Mark Hanley
The Honorable Con Bunde
March 13, 1998
Page 3

governor's budget needed to implement zero tolerance. Additional funds for child protection—either appropriated in the budget process or as a fiscal note associated with HB 375—will be essential to meet our legal mandate either under the current law or with changes proposed under HB 375. It will be critical to balance funding throughout the departments involved in the child protection system to assure that the system can operate effectively and that one agency's lack of resources does not prevent children from receiving protection.

Sincerely,



Annalee McConnell
Director

cc: Finance Co-Chairs

attachments

CHILD PROTECTION - SUMMARY OF ADDITIONAL RESOURCES NEEDED

Dept Name	BRU or Component	Action	FY 99		FY 2000
			FY 99 General Funds	FY 99 Other Funds	FY 2000 Increment to Annualize Staff
Direct Impacts of HB 375					
Corrections	Admin and Operations	Increased length of incarcerations due to changes in law (cost of \$21.6 will be absorbed in FY 99)			38.5
Health & Soc Svcs	State Medical Examiner	Costs related to State Child Fatality Review - no impact FY 99			43.0
Child Protection Resources Needed with or without HB 375 (already in Governor's budget)					
Administration	Office of Public Advocacy	Child Abuse Response Caseload Increase and development of volunteer program to support families in crisis.	744.0		74.8
Administration	Public Defender	Child Abuse Response Caseload Increase	875.9		67.4
Corrections	Community Corrections Director's Office	Increase Supervision of Sexual Predators	350.0		
Health & Soc Svcs	DFYS - Central	Increase Staff Training	100.0	300.0	
Health & Soc Svcs	DFYS - Northern	Increase Child Protection Services	245.5	558.3	145.6
Health & Soc Svcs	DFYS - Southcentral	Increase Child Protection Services	300.1	941.9	158.7
Health & Soc Svcs	Family Preservation	Community Based Family Assessment / Case Management Pilot	835.9	49.8	
Health & Soc Svcs	Foster Care Augmented Rate	Emergency child care placements	262.8	65.7	
Health & Soc Svcs	Purchased Services - Foster Care Special Needs	Respite Care for Foster Families	225.0	75.0	
Health & Soc Svcs	Purchased Services/ Family Preservation	Budget Amendment Family Intervention		500.0	
Health & Soc Svcs	Purchased Services/ Family Preservation	Budget Amendment Substance Abuse Treatment		350.0	
Health & Soc Svcs	Residential Child Care	Emergency Shelter Care	164.5	22.4	
Law	Civil Division - Human Svcs	Respond to Increase in Child Protection Cases in Court	989.0		220.9
Law	Criminal Division - Anchorage	Increase Child Abuse Criminal Prosecutions	250.0		
Public Safety	Troopers - Detachments	Increase Troopers for Child Protection and Abuse Response and Sex Offender Tracking	1,700.0		
Public Safety	VPSO - Contracts	Increase VPSOs for Child Abuse Response in Villages	428.0		

AMENDMENT #1

OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: CSHB 375(), Draft Version "F"

1 Page 44, lines 24 - 26:

2 Delete all material and insert:

3 "Sec. 47.14.300. Multidisciplinary child protection teams. (a) The
4 department shall create multidisciplinary child protection teams to assist in the
5 evaluation and investigation of reports made under AS 47.17 and to provide
6 consultation and coordination for agencies involved in child protection cases under
7 AS 47.10.

8 (b) If a team is created under (a) of this section, the team may invite other
9 persons to serve on the team who have knowledge of and experience in child abuse
10 and neglect matters. These persons may include

11 (1) mental and physical health practitioners licensed under AS 08;

12 (2) child development specialists;

13 (3) educators;

14 (4) peace officers as defined in AS 11.81.900;

15 (5) victim counselors as defined in AS 18.66.250;

16 (6) experts in the assessment and treatment of substance abuse;

17 (7) representatives of the district attorney's office and the attorney

18 general's office;

19 (8) persons familiar with 25 U.S.C. 1901 - 1963 (Indian Child Welfare
20 Act);

21 (9) guardians ad litem; and

22 (10) staff members of a child advocacy center if a center is located in
23 the relevant area.

24 (c) A team created under (a) and (b) of this section shall review records on
25 a case referred to the team by the department. The department shall make available

1 to the team its records on the case and other records compiled for planning on the
2 case by other agencies at the request of the department. The team may make
3 recommendations to the department on appropriate planning for the case.

4 (d) Except for a public report issued by a team that does not contain
5 confidential information, records or other information collected by the team or a
6 member of the team related to duties under this section are confidential and not
7 subject to public disclosure under AS 09.25.100 and 09.25.110.

8 (e) Meetings of a team are closed to the public and are not subject to the
9 provisions of AS 44.62.310 and 44.62.312.

10 (f) The determinations, conclusions, and recommendations of a team or its
11 members are not admissible in a civil or criminal proceeding. A member may not be
12 compelled to disclose a determination, conclusion, recommendation, discussion, or
13 thought process through discovery or testimony in a civil or criminal proceeding.
14 Records and information collected by the team are not subject to discovery or
15 subpoena in connection with a civil or criminal proceeding.

16 (g) Notwithstanding (f) of this section, an employee of the department may
17 testify in a civil or criminal proceeding concerning cases reviewed by a team even
18 though the department's records were reviewed by a team and formed the basis of that
19 employee's testimony and the team's report.

20 (h) A person who serves on a multidisciplinary child protection team is not
21 liable for damage or other relief in an action brought by the reason of the performance
22 of a duty, a function, or an activity of the team.

23 (i) In this section, "team" means a multidisciplinary child protection team
24 created under (a) and (b) of this section."

A M E N D M E N T # 2

OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: CSHB 375(), Draft Version "F"

1 Page 11, lines 9 - 18:

2 Delete all material and insert:

3 **** Sec. 18. AS 12.65 is amended by adding new sections to read:**

4 **Sec. 12.65.115. Local child fatality review teams; protocol.** (a) Each
5 district attorney or a designee of the district attorney shall establish a group, composed
6 as described in (b) of this section, to develop a protocol that will govern investigation
7 of child fatalities in the local area by local public agencies. At a minimum, the
8 protocol must establish criteria and procedures for how

9 (1) local public agencies will determine if a child's death occurred
10 under circumstances that warrant an investigation by a local child fatality review
11 team;

12 (2) local public agencies will determine on a case-by-case basis who
13 will be on a local child fatality review team to investigate a child's death;

14 (3) the investigation of a child's death by a local child fatality review
15 team will be conducted and coordinated among the public agencies involved; and

16 (4) local child fatality review teams will communicate with the state
17 medical examiner regarding a child's death.

18 (b) The protocol development group required under (a) of this section shall
19 consist, at a minimum, of the following members appointed by the district attorney
20 or by a designee of the district attorney:

21 (1) a peace officer as defined in AS 11.81.900;

22 (2) an employee of the Department of Health and Social Services; if
23 the commissioner of health and social services nominates an employee to be appointed
24 to the protocol development team, the district attorney shall appoint the nominee;

25 (3) an employee of the district attorney's office;

1 (4) an employee of the office of the attorney general; if the attorney
2 general nominates an employee to be appointed to the protocol development team, the
3 district attorney shall appoint the nominee;

4 (5) an employee of the local school district; if the governing body of
5 the local school district nominates an employee to be appointed to the protocol
6 development team, the district attorney shall appoint the nominee;

7 (6) a licensed physician or nurse;

8 (7) a licensed mental health practitioner; and

9 (8) an employee or volunteer from a child advocacy center if the
10 locality has a child advocacy center.

11 (c) A local child fatality review team formed under a protocol developed
12 under (a) of this section has the same access to information, confidentiality
13 requirements, and immunity as provided to the state child fatality review team under
14 AS 12.65.140. A meeting of a local child fatality review team formed under a
15 protocol developed under (a) of this section is closed to the public and not subject to
16 the provisions of AS 44.62.310 and 44.62.312. A review of a child fatality by a local
17 child fatality review team formed under a protocol developed under (a) of this section
18 does not relieve the state child fatality review team under AS 12.65.120 of the
19 responsibility for reviewing the death under AS 12.65.130.

20 (d) A person appointed to the protocol development group under (a) and (b)
21 of this section or serving on a local child fatality review team under a protocol
22 developed under (a) of this section is not eligible to receive compensation from the
23 state for services on the group or team, but is entitled to per diem and travel expenses
24 as authorized under AS 39.20.180.

25 **Sec. 12.65.120. State child fatality review team.** (a) The state child fatality
26 review team is established in the Department of Health and Social Services. The team
27 is composed of

28 (1) the following persons, or that person's designee:

29 (A) the state medical examiner;

30 (B) a state prosecutor with experience in homicide
31 prosecutions, appointed by the attorney general;

32 (C) an investigator with the state troopers who has experience

1 in conducting investigations of homicide, child abuse, or child neglect,
2 appointed by the commissioner of public safety;

3 (D) a social worker with the Department of Health and Social
4 Services who has experience in conducting investigations of child abuse and
5 neglect, appointed by the commissioner of health and social services;

6 (2) the following persons, or that person's designee, appointed by the
7 commissioner of health and social services:

8 (A) a physician licensed under AS 08.64 who

9 (i) specializes in neonatology or perinatology; or

10 (ii) is certified by the American Board of Pediatrics;

11 (B) a municipal law enforcement officer with experience in
12 conducting investigations of homicide, child abuse, or child neglect;

13 (C) other persons whose experience and expertise would, as
14 determined by the commissioner of health and social services, contribute to the
15 effectiveness of the team.

16 (b) A team member is not eligible to receive compensation from the state for
17 service on the team. A member appointed under (a)(2) of this section

18 (1) is eligible for travel expenses and per diem as authorized under
19 AS 39.20.180; and

20 (2) serves at the pleasure of the commissioner of health and social
21 services.

22 (c) In addition to the persons specified in (a) of this section, the team may
23 invite a person to participate as a member of the team if the person has expertise that
24 would be helpful to the team in a review of a specific death. A person participating
25 under this subsection is eligible only for travel expenses and per diem as authorized
26 under AS 39.20.180.

27 (d) The state medical examiner serves as chair of the team.

28 **Sec. 12.65.130. State child fatality review team duties.** The state child
29 fatality review team shall

30 (1) assist the state medical examiner in determining the cause and
31 manner of the deaths in this state of children under 18 years of age;

32 (2) unless the child's death is currently being investigated by a law

1 enforcement agency, review a report of a death of a child within 48 hours of the
2 report being received by the state medical examiner if

3 (A) the death is of a child under 18 years of age;

4 (B) the deceased child, a sibling, or a member of the deceased
5 child's household

6 (i) is in the legal or physical custody of the state under
7 AS 47 or under similar custody of another state or political subdivision
8 of a state; or

9 (ii) has been the subject of a report of harm under
10 AS 47.17 or a child abuse or neglect investigation by the Department
11 of Health and Social Services or by a similar child protective service
12 in this or another state;

13 (C) a protective order under AS 18.66.100 or 18.66.110 has
14 been in effect during the previous year in which the petitioner or respondent
15 was a member of the deceased child's immediate family or household; or

16 (D) the child's death occurred in a mental health institution,
17 mental health treatment facility, foster home, or other residential or child care
18 facility, including a day care facility;

19 (3) review records concerning

20 (A) abuse or neglect of the deceased child or another child in
21 the deceased child's household;

22 (B) the criminal history or juvenile delinquency of a person
23 who may have caused the death of the child and of persons in the deceased
24 child's household; and

25 (C) a history of domestic violence involving a person who may
26 have caused the death of the child or involving persons in the deceased child's
27 household, including records in the central registry of protective orders under
28 AS 18.65.540;

29 (4) if insufficient information exists to adequately determine the cause
30 and manner of death, recommend to the state medical examiner that additional
31 information be obtained under AS 12.65.020; and

32 (5) if a local child fatality review team has not been formed under

1 AS 12.65.115 or is not available, be available to provide recommendations,
2 suggestions, and advice to state or municipal law enforcement or social service
3 agencies in the investigation of deaths of children;

4 (6) collect data and analyze and interpret information regarding deaths
5 of children in this state;

6 (7) develop state and local data bases on deaths of children in this
7 state;

8 (8) develop a model protocol for the investigation of deaths of
9 children; and

10 (9) issue an annual report to the public containing statistical data and
11 other information that does not violate federal or state law concerning confidentiality
12 of the children and their families involved in the reviews; the report must include

13 (A) identification of trends, patterns, and risk factors in deaths
14 of children;

15 (B) analyses of the incidence and causes of deaths of children
16 in this state;

17 (C) recommendations for improving the coordination of
18 government services and investigations; and

19 (D) recommendations for prevention of future deaths of
20 children.

21 **Sec. 12.65.140. Records; information; meetings; confidentiality; immunity.**

22 (a) The state child fatality review team and its members shall have access to all
23 information and records to which the state medical examiner has access under this
24 chapter. The state child fatality review team and its members shall maintain the
25 confidentiality of information and records concerning deaths under review, except
26 when disclosures may be necessary to enable the team to carry out its duties under
27 this chapter. However, the team and its members may not disclose a record that is
28 confidential under federal or state law.

29 (b) Except for public reports issued by the team, records and other
30 information collected by the team or a member of the team related to duties under this
31 chapter are confidential and are not subject to public disclosure under AS 09.25.100 -
32 09.25.220.

1 (c) Meetings of the state child fatality review team are closed to the public
2 and are not subject to the provisions of AS 44.62.310 and 44.62.312.

3 (d) The determinations, conclusions, and recommendations of the state child
4 fatality review team, or its members, are not admissible in a civil or criminal
5 proceeding. Members may not be compelled to disclose their determinations,
6 conclusions, recommendations, discussions, or thought processes through discovery
7 or testimony in a civil or criminal proceeding. Records and information collected by
8 the state child fatality review team are not subject to discovery or subpoena in
9 connection with a civil or criminal proceeding.

10 (e) Notwithstanding (d) of this section, the state medical examiner may testify
11 in a civil or criminal proceeding relating to a death, even though the death was
12 reviewed by the state child fatality review team under AS 12.65.130 and information
13 received from the review formed a basis of the state medical examiner's testimony.

14 (f) A person who is a member or an employee of, who furnishes services to,
15 or who advises the state child fatality review team is not liable for damages or other
16 relief in an action brought by reason of the performance of a duty, a function, or an
17 activity of the review team."

18 Renumber the following bill sections accordingly.

19 Page 45, line 17:

20 Delete "AS 12.65.015(e)"

21 Insert "AS 12.65.115"

22 Renumber internal references to bill sections in accordance with this amendment. Below are
23 all internal bill section references in this bill:

24 Page 51, line 12

25 Page 51, line 15

26 Page 51, line 18

27 Page 51, line 22

AMENDMENT

#3

OFFERED IN THE HOUSE

BY Brice

TO: CSHB 375 () / 0-GH2009/F

1 Page 11, line 10:

2 Delete all material and insert:

3 "(e) The state medical examiner may appoint local, regional, and district child
4 fatality review teams to assist local, regional, and district medical examiners in
5 determining the cause and manner of deaths of children under 18 years of age. If a
6 team is appointed under this section, the team shall have the same access to
7 information, confidentiality requirements, and immunity as provided to the state child
8 fatality review team under AS 12.65.140. A meeting of a team appointed under this
9 subsection is closed to the public and not subject to the provisions of AS 44.62.310 -
10 44.62.312. A review by a local, regional, or district child fatality review team does
11 not relieve the state child fatality review team under AS 12.65.120 of the responsibility
12 for reviewing these deaths under AS 12.65.130. A person appointed to a local,
13 regional, or district child fatality review team is not eligible to receive compensation
14 from the state for service on the team, but the person is eligible for travel and per
15 diem from the Department of Health and Social Services under AS 39.20.180. A
16 person appointed to a team under this subsection serves at the pleasure of the state
17 medical examiner."

18 Page 11, lines 12 - 18:

19 Delete all material and insert:

20 "Sec. 12.65.120. State child fatality review team. (a) The state child fatality
21 review team is established in the Department of Health and Social Services to assist
22 the state medical examiner. The team is composed of

23 (1) the following persons, or that person's designee:

24 (A) the state medical examiner;

1 (B) a state prosecutor with experience in homicide prosecutions,
2 appointed by the attorney general;

3 (C) an investigator with the state troopers who has experience
4 in conducting investigations of homicide, child abuse, or child neglect,
5 appointed by the commissioner of public safety;

6 (D) a social worker with the Department of Health and Social
7 Services who has experience in conducting investigations of child abuse and
8 neglect, appointed by the commissioner of health and social services;

9 (2) the following persons, or that person's designee, appointed by the
10 commissioner of health and social services:

11 (A) a physician licensed under AS 08.64 who

12 (i) specializes in neonatology or perinatology; or

13 (ii) is certified by the American Board of Pediatrics;

14 (B) a municipal law enforcement officer with experience in
15 conducting investigations of homicide, child abuse, or child neglect;

16 (C) other persons whose experience and expertise would, as
17 determined by the commissioner of health and social services, contribute to the
18 effectiveness of the team.

19 (b) A team member is not eligible to receive compensation from the state for
20 service on the team. A member appointed under (a)(2) of this section

21 (1) is eligible for travel and per diem from the Department of Health
22 and Social Services under AS 39.20.180; and

23 (2) serves at the pleasure of the commissioner of health and social
24 services.

25 (c) In addition to the persons specified in (a) and (b) of this section, the team
26 may invite a person to participate as a member of the team if the person has expertise
27 that would be helpful to the team in a review of a specific death. A person
28 participating under this subsection is eligible only for travel and per diem from the
29 Department of Health and Social Services under AS 39.20.180.

30 (d) The state medical examiner serves as chair of the team.

1 **Sec. 12.65.130. State child fatality review team duties.** (a) The state child
2 fatality review team shall

3 (1) assist the state medical examiner in determining the cause and
4 manner of the deaths in this state of children under the age of 18 years;

5 (2) unless the child's death is currently being investigated by law
6 enforcement, review any report of a death of a child within 48 hours of the report
7 being received by the medical examiner if

8 (A) the death is of a child under the age of 10 years;

9 (B) the deceased child, a sibling, or a member of the deceased
10 child's household

11 (i) is in the legal or physical custody of the state under
12 AS 47, or under similar custody of another state or political subdivision
13 of a state; or

14 (ii) has been the subject of a report of harm under
15 AS 47.17, or a child abuse or neglect investigation by the Department
16 of Health and Social Services or by a similar child protective service in
17 this or another state;

18 (C) a protective order under AS 18.66.100 or 18.66.110 has
19 been in effect during the previous year in which the petitioner or respondent
20 was a member of the deceased child's immediate family or household; or

21 (D) the child's death occurred in a mental health institution,
22 mental health treatment facility, foster home, or other residential or child care
23 facility, including a day care facility;

24 (3) review records concerning

25 (A) abuse or neglect of the deceased child or another child in
26 the deceased child's household;

27 (B) the criminal history or juvenile delinquency of a person who
28 may have caused the death of the child and of persons in the deceased child's
29 household; and

30 (C) a history of domestic violence involving a person who may

1 have caused the death of the child or involving persons in the deceased child's
2 household, including records in the central registry of protective orders under
3 AS 18.65.540;

4 (4) if insufficient information exists to adequately determine the cause
5 and manner of death, recommend to the state medical examiner that additional
6 information be obtained under AS 12.65.020; and

7 (5) if a local, regional, or district child fatality review team has not
8 been appointed under AS 12.65.015 or is not available, be available to provide
9 recommendations, suggestions, and advice to state or municipal law enforcement or
10 social service agencies in the investigation of deaths of children.

11 (b) The state child fatality review team may

12 (1) collect data and analyze and interpret information regarding deaths
13 of children in this state;

14 (2) develop state and local data bases on deaths of children in this state;

15 (3) develop a model protocol for the investigation of deaths of children;

16 and

17 (4) periodically issue reports to the public containing statistical data and
18 other information that does not violate federal or state law concerning confidentiality
19 of the children and their families involved in the reviews; these reports may include

20 (A) identification of trends, patterns, and risk factors in deaths
21 of the children;

22 (B) analysis on the incidence and causes of deaths of children
23 in this state;

24 (C) recommendations for improving the coordination of
25 government services and investigations; and

26 (D) recommendations for prevention of future deaths of
27 children.

28 **Sec. 12.65.140. Records; information; meetings; confidentiality; immunity.**

29 (a) The state child fatality review team and its members shall have access to all
30 information and records to which the state medical examiner has access under this

1 chapter. The state child fatality review team and its members shall maintain the
2 confidentiality of information and records concerning deaths under review, except
3 when disclosures may be necessary to enable the team to carry out its duties under this
4 chapter. However, the team and its members may not disclose a record that is
5 confidential under federal or state law.

6 (b) Except for public reports issued by the team, records and other information
7 collected by the team or a member of the team related to duties under this chapter are
8 confidential and not subject to public disclosure under AS 09.25.100 - 09.25.220.

9 (c) Meetings of the state child fatality review team are closed to the public and
10 are not subject to the provisions of AS 44.62.310 - 44.62.312.

11 (d) The determinations, conclusions, and recommendations of the state child
12 fatality review team, or its members are not admissible in any civil or criminal
13 proceeding. Members may not be compelled to disclose their determinations,
14 conclusions, recommendations, discussions, or thought processes through discovery or
15 testimony in any civil or criminal proceeding. Records and information collected by
16 the state child fatality review team are not subject to discovery or subpoena in
17 connection with a civil or criminal proceeding.

18 (e) Notwithstanding (d) of this section, the state medical examiner may testify
19 in a civil or criminal proceeding even though the death was reviewed by the state child
20 fatality review team under AS 12.65.130 and information received from the review
21 formed a basis of the state medical examiner's testimony.

22 (f) A person who is a member or an employee of, or who furnishes services
23 to or advises the state child fatality review team, is not liable for damages or other
24 relief in an action brought by reason of the performance of a duty, a function, or an
25 activity of the review team."

AMENDMENT

#3 *copy*

OFFERED IN THE HOUSE

BY Brice

TO: CSHB 375 () / 0-GH2009/F

1 Page 11, line 10: -

2 Delete all material and insert:

SHALL FACILITATE THE FORMATION OF

3 "(e) The state medical examiner ~~may appoint~~ *SHALL FACILITATE THE FORMATION OF* local, regional, ~~and~~ *OF* district child
4 fatality review teams to assist local, regional, and district medical examiners in
5 determining the cause and manner of deaths of children under 18 years of age. If a
6 team is ~~appointed~~ *formed* under this section, the team shall have the same access to
7 information, confidentiality requirements, and immunity as provided to the state child
8 fatality review team under AS 12.65.140. A meeting of a team appointed under this
9 subsection is closed to the public and not subject to the provisions of AS 44.62.310 -
10 44.62.312. A review by a local, regional, or district child fatality review team does
11 not relieve the state child fatality review team under AS 12.65.120 of the responsibility
12 for reviewing these deaths under AS 12.65.130. A person ~~appointed to~~ *of* a local,
13 regional, or district child fatality review team is not eligible to receive compensation
14 from the state for service on the team, but the person is eligible for travel and per
15 diem from the Department of Health and Social Services under AS 39.20.180. A
16 person appointed to a team under this subsection serves at the pleasure of the state
17 medical examiner."

18 Page 11, lines 12 - 18:

19 Delete all material and insert:

20 "Sec. 12.65.120. State child fatality review team. (a) The state child fatality
21 review team is established in the Department of Health and Social Services to assist
22 the state medical examiner. The team is composed of
23 (1) the following persons, or that person's designee:
24 (A) the state medical examiner;

AMENDMENT # 4

OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: CSHB 375 () / 0-GH2009/F

1 Page 29, line 29:

2 Following "abandonment,":

3 Insert "sexual abuse."

4 Following "torture,":

5 Insert "chronic"

6 Page 50, line 3, following "foster home.":

7 Insert "The department may extend a provisional foster home license issued under this
8 subsection for an additional period of up to 90 days in order to obtain the information from
9 the national criminal background check required under AS 47.35.017(b)(6)."

AMENDMENT * 5

OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: CSHB 375(), Draft Version "F"

1 Page 14, lines 12 - 27:

2 Delete all material and insert:

3 "(1) parents have the following rights and responsibilities relating to
4 the care and control of their child while the child is a minor:

5 (A) the responsibility to provide the child with food, clothing,
6 shelter, education, and medical care;

7 (B) the right and responsibility to protect, train, and discipline
8 the child;

9 (C) the right to determine where and with whom the child shall
10 live;

11 (D) the rights and responsibility to make decisions of legal or
12 financial significance concerning the child;

13 (E) the right to obtain representation for the child in legal
14 actions; and

15 (F) the responsibility to provide special safeguards and care,
16 including appropriate protection before as well as after birth;"

17 Renumber the following paragraphs accordingly.

18 Page 28, following line 28:

19 Insert a new bill section to read:

20 ** Sec. 42. AS 47.10.084(a) is amended to read:

21 (a) When a child is committed under AS 47.10.080(c)(1) to the department,
22 released under AS 47.10.080(c)(2) to the child's parents, guardian, or other suitable
23 person, or committed to the department or to a legally appointed guardian of the

1 person of the child under AS 47.10.080(c)(3), a relationship of legal custody exists.
2 This relationship imposes on the department and its authorized agents or the parents,
3 guardian, or other suitable person the responsibility of physical care and control of the
4 child, the determination of where and with whom the child shall live, the right and
5 duty to protect, train, and discipline the child, [AND] the duty of providing the child
6 with food, shelter, education, and medical care and the right and responsibility to
7 obtain legal representation for, and make decisions of legal or financial
8 significance concerning, the child. These obligations are subject to any residual
9 parental rights and responsibilities and rights and responsibilities of a guardian if one
10 has been appointed. When a child is committed to the department and the department
11 places the child with the child's parent, the parent has the responsibility to provide and
12 pay for food, shelter, education, and medical care for the child. When parental rights
13 have been terminated, or there are no living parents and no guardian has been
14 appointed, the responsibilities of legal custody include those in (b) and (c) of this
15 section. The department or person having legal custody of the child may delegate any
16 of the responsibilities under this section, except authority to consent to marriage,
17 adoption, and military enlistment may not be delegated. For purposes of this chapter
18 a person in charge of a placement setting is an agent of the department."

19 Renumber the following bill sections accordingly.

20 Renumber internal references to bill sections in accordance with this amendment. Below are
21 all internal bill section references in this bill:

22 Page 51, line 12

23 Page 51, line 15

24 Page 51, line 18

25 Page 51, line 22

AMENDMENT

#6

Offered in the House HESS

By: Representative Brice

To: CS HB 375

Page 15, line 10-11

(B) when a child is removed from the home, the department should make reasonable efforts to provide weekly supervised or unsupervised visitation between the child and the child's parent or guardian and extended family members unless a mental health practitioner experienced with treating children has determined that the visitation would be harmful to the child;

Page 32, line 19, following "Harm"
insert or sexual abuse

7
AMENDMENTS

1
2
3 OFFERED IN THE HOUSE

BY: Dyson

4
5 TC: HB 375

6
7 Page 13, following line 25:

8 Insert a new bill section to read:

9 *Sec. __. AS 25.20.061 is amended to read:

10 PRESUMPTIONS [VISITATION] IN PROCEEDINGS INVOLVING

11 DOMESTIC VIOLENCE. (a) If the court finds in a proceeding involving child custody
12 that domestic violence has occurred, rebuttable presumptions arise that it is

13 (1) detrimental to the child and not in the best interest of the child to be
14 placed in sole custody, joint legal custody, or joint physical custody with the
15 perpetrator of the domestic violence; and

16 (2) in the best interest of the child to reside with the parent who is not a
17 perpetrator of domestic violence in a location of that parent's choice, inside or
18 outside the state.

19 (b) In addition to the rebuttable presumptions that a court must consider under
20 (a) of this section, if the court finds that domestic violence has occurred, the court
21 shall consider the following factors in making an award of child custody:

22 (1) the safety and well-being of the child or of the parent who is the
23 victim of domestic violence;

24 (2) the perpetrator's history of causing physical harm, bodily injury,
25 assault, or causing reasonable fear of physical harm, bodily injury, or assault,
26 to another person.

27 (c) If a parent is absent or relocates because of an act of domestic violence by
28 the other parent, the court may not consider the absence or relocation as a factor
29 against that parent in determining custody.

30 (d) The court may award (IF) visitation (IS AWARDED) to a parent who has
31 committed a crime involving domestic violence, against the other parent or a child of the
32 two parents, only if the court finds the safety of the child and the other parent are
33 protected, [WITHIN THE FIVE YEARS PRECEDING THE AWARD OF VISITATION]

1 **(e) If visitation is awarded under (d) of this section,** the court may set conditions
2 for the visitation, including

3 (1) the transfer of the child for visitation must occur in a protected setting;

4 (2) visitation shall be supervised by another person or agency and under
5 specified conditions as ordered by the court;

6 (3) the perpetrator shall attend and complete, to the satisfaction of the court,
7 a program for the rehabilitation of perpetrators of domestic violence that meets the
8 standards set by the Department of Corrections under AS 44.28.020 (b), or other
9 counseling; the perpetrator shall be required to pay the costs of the program or
10 other counseling;

11 (4) the perpetrator shall abstain from possession or consumption of alcohol
12 or controlled substances during the visitation and for 24 hours before visitation;

13 (5) the perpetrator shall pay costs of supervised visitation as set by the
14 court;

15 (6) the prohibition of overnight visitation;

16 (7) the perpetrator shall post a bond to the court for the return and safety of
17 the child; and

18 (8) any other condition necessary for the safety of the child, the other
19 parent, or other household member.
20

21 Page 13, Following line 25

22 Insert a new bill section to read:

23 • Sec. ____, AS 25.20.070 is amended to read:

24 **TEMPORARY CUSTODY OF THE CHILD.** Unless it is shown to be detrimental to the
25 welfare of the child **or the court determines that domestic violence has occurred,** the
26 child shall have, to the greatest degree practical, equal access to both parents during the
27 time that the court considers an award of custody under AS 25.20.060 - 25.20.130.

28 Page 13, Following line 25

29 Insert a new bill section to read:

30 **FACTORS FOR CONSIDERATION IN AWARDING SHARED CHILD**
31 **CUSTODY.** In determining whether to award shared custody of a child the court shall
32 consider

- 1 (1) presumptions under AS 25.20.061:
- 2 (2) the child's preference if the child is of sufficient age and capacity to
- 3 form a preference;
- 4 (3) [(2)] the needs of the child;
- 5 (4) [(3)] the stability of the home environment likely to be offered by each
- 6 parent;
- 7 (5) [(4)] the education of the child;
- 8 (6) [(5)] the advantages of keeping the child in the community where the
- 9 child presently resides;
- 10 (7) [(6)] the optimal time for the child to spend with each parent considering
- 11 (A) the actual time spent with each parent;
- 12 (B) the proximity of each parent to the other and to the school in
- 13 which the child is enrolled;
- 14 (C) the feasibility of travel between the parents;
- 15 (D) special needs unique to the child that may be better met by one
- 16 parent than the other;
- 17 (E) which parent is more likely to encourage frequent and continuing
- 18 contact with the other parent;
- 19 (8) [(7)] any findings and recommendations of a neutral mediator;
- 20 (9) [(8)] any evidence of domestic violence, child abuse, or child neglect in
- 21 the proposed custodial household or a history of violence between the parents;
- 22 (10) [(9)] evidence that substance abuse by either parent or other members
- 23 of the household directly affects the emotional or physical well-being of the child;
- 24 (11) [(10)] other factors the court considers pertinent.

25
26 Page 13, Following line 25

27 Insert a new bill section to read:

28 *Sec. __AS 25.24.150 (c) is amended to read:

29 (c) The court shall determine custody in accordance with the best interests of the
30 child under AS 25.20.060 - 25.20.130. In determining the best interests of the child the
31 court shall consider

- 1 (1) presumptions under AS 25.20.061:
- 2 (2) the physical, emotional, mental, religious, and social needs of the child;
- 3 (3) ~~[(2)]~~ the capability and desire of each parent to meet these needs;
- 4 (4) ~~[(3)]~~ the child's preference if the child is of sufficient age and capacity
- 5 to form a preference:
- 6 (5) ~~[(4)]~~ the love and affection existing between the child and each parent;
- 7 (6) ~~[(5)]~~ the length of time the child has lived in a stable, satisfactory
- 8 environment and the desirability of maintaining continuity;
- 9 (7) ~~[(6)]~~ the desire and ability of each parent to allow an open and loving .
- 10 frequent relationship between the child and the other parent;
- 11 (8) ~~[(7)]~~ any evidence of domestic violence, child abuse, or child neglect in
- 12 the proposed custodial household or a history of violence between the parents;
- 13 (9) ~~[(8)]~~ evidence that substance abuse by either parent or other member of
- 14 the household directly affects the emotional or physical well-being of the child;
- 15 (10) ~~[(9)]~~ other factors that the court considers pertinent.

AMENDMENT 10

DELETE LINES 8-26 (INCLUSIVE)

ON PAGE 8

+ appropriate title change

A couple of more amendments

Page 17, line 18,

After "incarcerated," insert "and the incarcerated parent has not made satisfactory arrangements for the child"

(please feel free to make technical changes to fit the existing language)

Page 18, line 14,

After ";" insert "exposure to domestic violence shall be treated as in AS 25.20.061"

(again your technical assistance with this is appreciated.)

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
AS 11.41.100 (a) (2)	Murder One when 2 violent acts toward a child result in death	AS 11.41.100 (a) (2)	Same as original.	SB 218
AS 11.41.100 (a) (3)	Murder One when child dies during sex crime or kidnapping	AS 11.41.100 (a) (3)	Same as original.	SB 218
AS 11.41.110 (a) (5)	Murder Two when child dies and offender has a prior conviction for a violent crime against a child	AS 11.110 (a) (5)	Same as original.	SB 218
AS 11.41.130 (b)	Criminally Negligent Homicide is a B felony, rather than a C felony.	AS 11.41.130 (a)	Deleted per single subject rule.	SB 218
AS 11.41.300 (a)(1)(F)	Kidnapping includes restraint with sexual abuse of a minor or fear of sexual abuse	AS 11.41.300 (a)(1)(F)	Same as original	
AS 11.41.300(d)	Kidnapping mitigated by release of victim without committing sexual assault or sexual abuse in first or second degree	AS 11.41.300 (d)	Same as original.	
AS 11.41.458	Creates felony indecent exposure for sex act in presence of a child	AS 11.41.458	Same as original.	SB 323
AS 11.41.460	Misdemeanor indecent exposure amended to knowing exposure, rather than intentional exposure	AS 11.41.460		SB 323

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
AS 11.51.100	Endangering the Welfare of a Child expanded. Leave child under 6 with sex offender or violent person. Babysitter	AS 11.51.100	Broadens original to include any child under 16 as the victim, and eliminates "babysitter" defense.	HB 333; SB 282
AS 11.51.110	Creates a violation for Endangering: caring for child under 6 while possessing drugs, incapacitated or unattended child.	AS 11.51.110	Broadens original to include any child under 16 as a victim and use of drugs during childcare as a violation.	HB 333; SB 282
AS 11.51.115	Felony criminal nonsupport for: hiding assets and accumulating a \$10,000 debt.	AS 11.51.115	Requires \$30,000 cumulative debt.	
AS 11.51.120	Misdemeanor criminal nonsupport for failure to pay when ordered by an administrative agency or court	AS 11.51.120	Order must be from court, not administrative agency.	
AS 12.55.025 (i)	No amendment	AS 12.55.025 (i)	Prompted by amendment to AS 12.55.125 (k) that adds (1) and maintains (2).	
AS 12.55.125 (c)(2) (B)	Manslaughter minimum raised from 5 to 7 years when the victim is a child	AS 12.55.125 (c)(2)(B)	Same as original.	SB 218
AS 12.55.155 (e)	citation should read AS 12.55.125 (c) (2) (A)	AS 12.55.155 (e)	citation corrected AS 12.55.125 (c) (2) (A)	
AS 12.55.125 (k)	Can aggravate sentence for crim neg homicide when the victim is a child	AS 12.55.125 (k)	Same as original. Amendment: to AS 12.55.025 (i).	SB 218

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
AS 12.63.010 (a) and (b)	Tightens sex offender registration.	AS 12.63.010 (a) and (b)	Deleted per single subject rule.	HB 252
AS 12.65.005 (a) - 12.65.140	Creates child fatality review team in statute.	AS 12.65.005 (a) - 12.65.140	Open provisions in draft re: who appoints; composition; duties; records	
AS 14.20.020 (f); 14.20.030 (b)	No teaching certificates for sex offenders.	AS 14.20.020 (f); 14.20.030 (b)	Same as original.	SB 323
AS 18.65.087 (a)	Allows DOC to register sex offenders	AS 18.65.067 (a)	Deleted per single subject rule.	HB 252
AS 22.15.100	Changes minor to child to clarify CINA rather than JD status.	AS 22.15.100	No change to existing statute.	
		AS 25.23.180 (c)	Amend citation to termination statutes.	
AS 33.30.012 (a)	Allows DOC to register sex offender prior to release and forward info to DPS	AS 33.30.012 (a)	Deleted per single subject rule.	HB 252
	Legislative intent not in statute.	AS 47.05.065	Legislative intent in statute. Broader protections for children in policy	

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
AS 47.05.090	Medicaid eligibility for special needs children being adopted out of state.	AS 47.05.090	Same as original.	
AS 47.10.005	Statement to courts on how to construe statute.	AS 47.05.005	Same as original.	
AS 47.10.010	Jurisdictional statement.	AS 47.10.010	Same as original.	
AS 47.10.011	Situations where the state may legally take custody of children.	AS 47.10.011	Situations where the state may legally take custody of children.	
	(a)(1) abandoned child		(a)(1) abandoned by 1 parent and the other parent creates CINA status	
	(a)(2) incarcerated parent for DV and failure to provide care		(a)(2) one parent incarcerated and the other parent creates CINA status	
	(a)(3) child left with unwilling or unable custodian		(a)(3) same as original	
	(a)(4) runaway status creates risk to child's physical or emotional health or safety		(a)(5) same as original	

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
	(a)(5) medical neglect for both physical and emotional disorders		(a)(4) medical neglect for both physical and mental disorders	
	(a)(6) child has suffered physical harm or is at substantial risk		(a)(6) child has suffered substantial physical harm or is at substantial risk	
	(a)(7) child has suffered sexual abuse or is at substantial risk		(a)(7) same as original	
	(a)(8) emotional harm; DV as prima facie evidence of emotional harm		(a)(8) mental injury (no DV)	
	(a)(9) physical neglect		(a)(9) physical neglect	
	(a)(10) substance abuse impairs ability to parent; relapse provision		(a)(10) Brice's proposed amendments incorporated	
	(a)(11) mental illness renders incapable of proper care for extended periods of time		(a)(11) mental illness caused physical harm or creates risk of substantial physical harm	
	(a)(12) parents pressure child to act illegally		(a)(12) same as original	

Child Protection Bill Comparison

Governor's HB	Governor's HB 375	CS HB 375	CS HB 375	Other Bill
AS 47.10.013	Abandonment defined so that younger children can get permanent homes faster.	AS 47.10.013	Amended to require state to prove "intent." 3-month period for all ages.	
AS 47.10.014	Neglect defined more specifically than in AS 47.17.290	AS 47.10.014	Deletes "emotional health and development;" uses mental health and development	
AS 47.10.017	Defines physical harm as a criminal assault by a parent; includes substantial risk of injury	AS 47.10.017	Same as original.	
		AS 47.10.019	Limits jurisdiction solely based on poverty, housing, or peculiar lifestyle.	HB 366
AS 47.10.020 (a)	Format for Child In Need of Aid (CINA) petition	AS 47.10.020 (a)	Same as original, with "if known" tribe, rather than "if any."	
		AS 47.10.030(b)	Notice of hearing expanded to out of home caregivers for child, requires proof of notice by service and filed prior to hearing	
AS 47.10.050 (a)	GAL should be appointed in any CINA proceeding	AS 47.10.050 (a)	Same as original	
AS 47.10.070 (c)	Allows foster parents to receive notice of hearings, attend hearings, and be heard.	AS 47.10.070(a)	Department sends notice to parties and out of home caregivers.	