ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10213 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

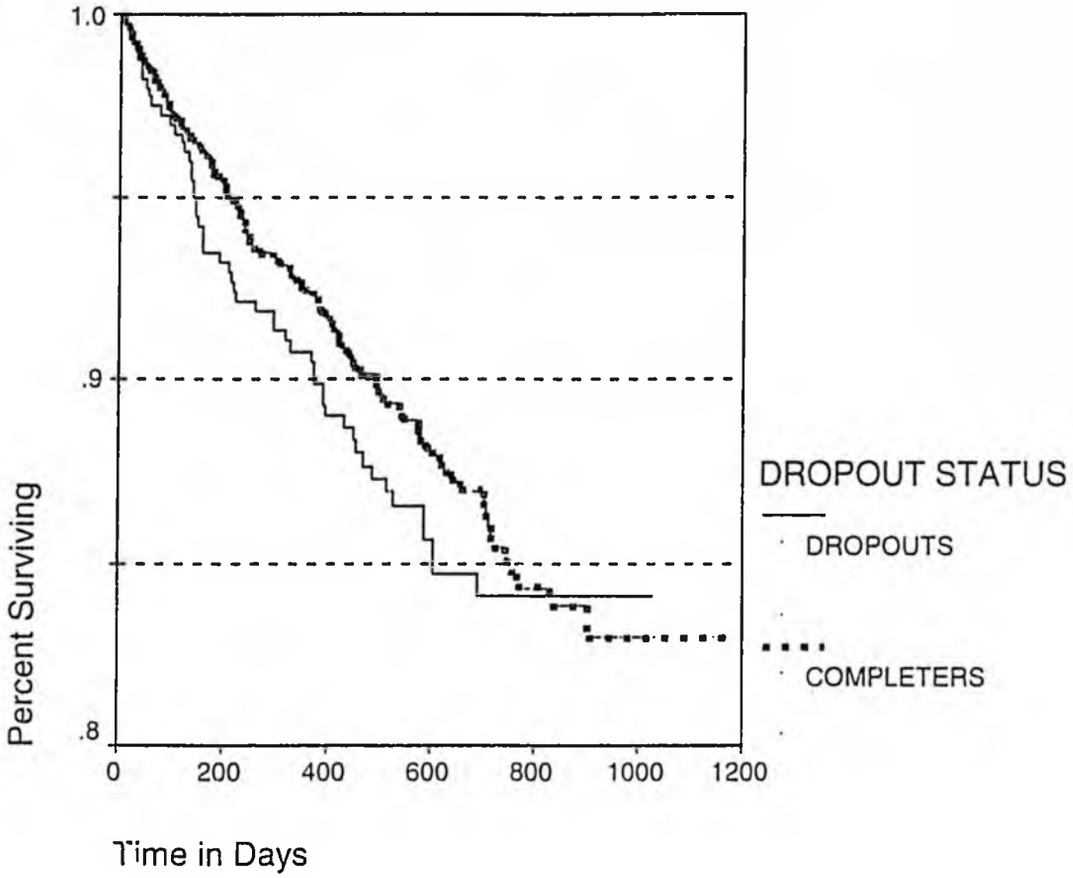

1.0
.9
.8
Percent Surviving
0
200
400
600
800
1000
1200
Time in Days
DROPOUT STATUS
DROPOUTS
COMPLETERS

Figure 4. Proportional hazards survival functions by program type, adjusted for initial client risk

(excluding episodic cases and surveillance effect reports)

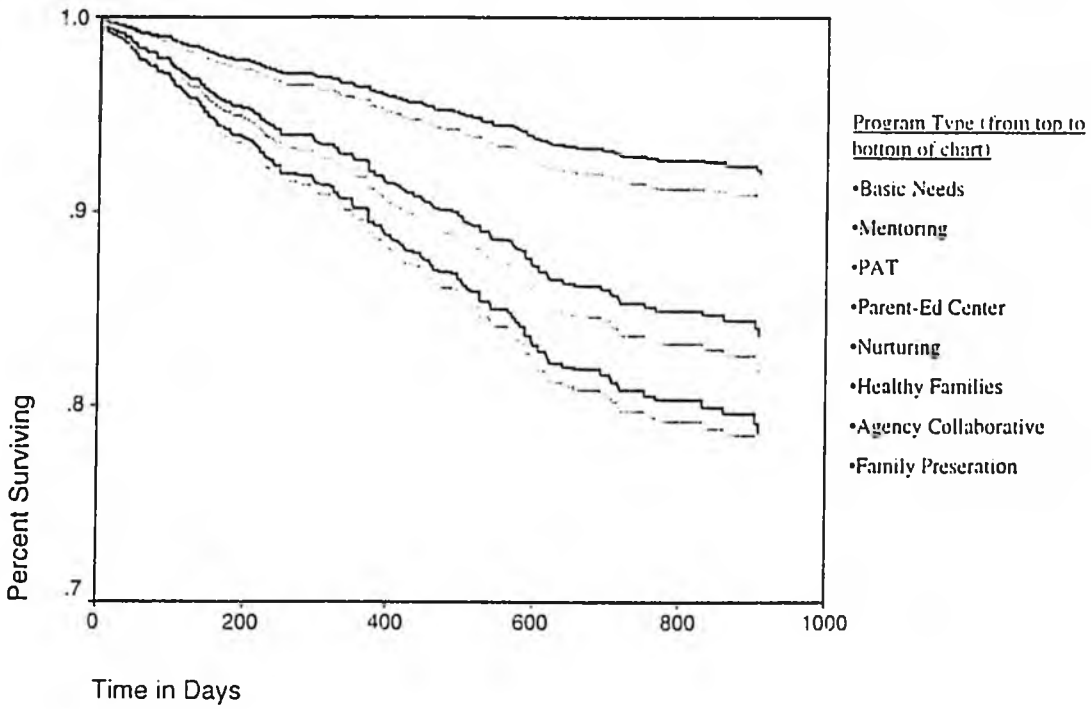
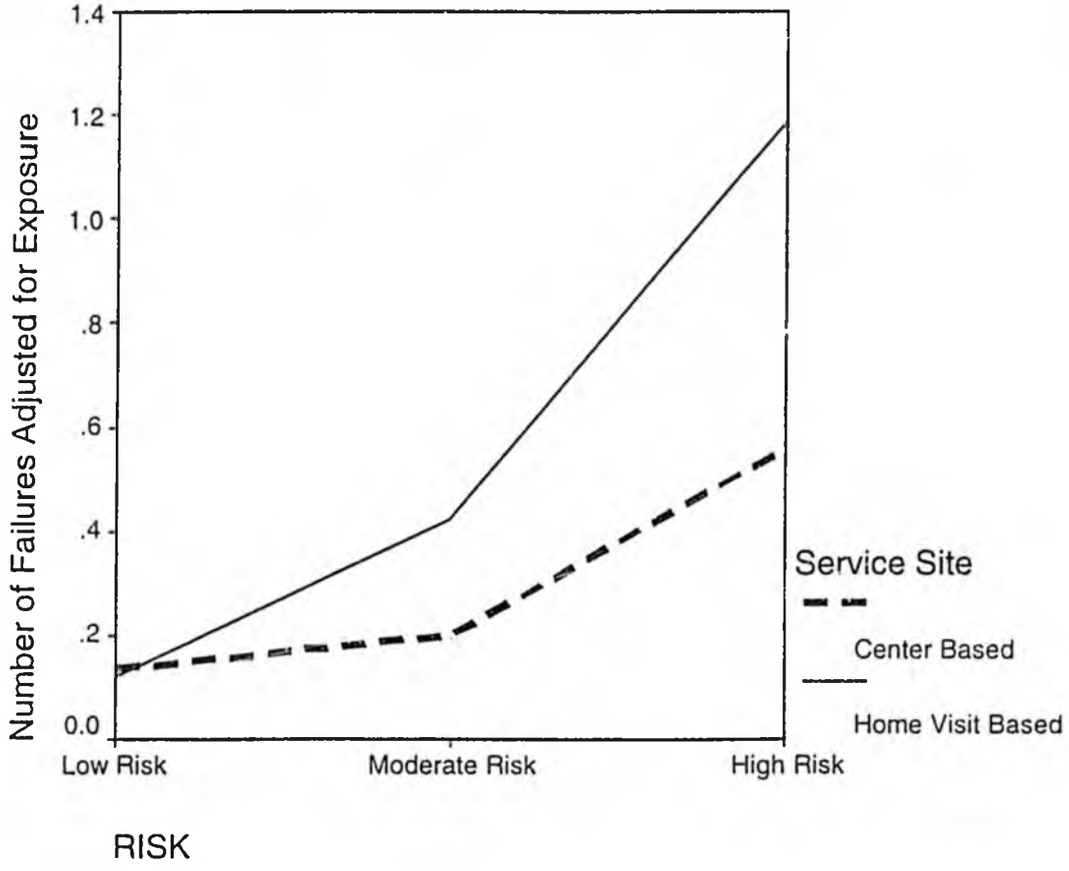

1.0
.9
.8
.7
Percent Surviving
0
200
400
600
800
1000
Time in Days
Program Type (from top to bottom of chart)
•Basic Needs
•Mentoring
•PAT
•Parent-Ed Center
•Nurturing
•Healthy Families
•Agency Collaborative
•Family Preseration

Figure 5. Failure rates by service site (center-based vs. home-visit)


1.4
1.2
1.0
.8
.6
.4
.2
0.0
Number of Failures Adjusted for Exposure
Low Risk
Moderate Risk
High Risk
RISK
Service Site
Center Based
Home Visit Based

22-LS0454\L
Lauterbach
2/15/02

CS FOR HOUSE BILL NO. 252(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Dyson

A BILL

FOR AN ACT ENTITLED

"An Act relating to the construction of certain statutes relating to children; relating to the scope of duty and standard of care for persons who provide services to certain children and families; relating to intensive family preservation services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 47.10.005 is amended to read:

Sec. 47.10.005. Construction. The provisions of this chapter shall be liberally construed to

(1) recognize that parents possess inherent, individual rights to direct and control the education and upbringing of their children; and

(2) achieve the end that a child coming within the jurisdiction of the court under this chapter may receive the care, guidance, treatment, and control that will promote the child's welfare **and the parents' participation in the child's upbringing**.

* **Sec. 2.** AS 47.10.086(a) is amended to read:

(a) Except as provided in (b) and (c) of this section, the department shall make timely, reasonable efforts to provide family support services to the child and to the parents or guardian of the child that are designed to prevent out-of-home placement of the child or to enable the safe return of the child to the family home, when appropriate, if the child is in an out-of-home placement. **Within appropriations available for the purpose, the department shall also offer intensive family preservation services when those services are available and the child's safety in the home can be maintained during the time the services are provided.** The department's duty to make reasonable efforts under this subsection **to provide family support services** includes the duty to

(1) identify family support services that will assist the parent or guardian in remedying the conduct or conditions in the home that made the child a child in need of aid;

(2) actively offer the parent or guardian, and refer the parent or guardian to, the **family support** services identified under (1) of this subsection; the department shall refer the parent or guardian to community-based family support services whenever community-based services are available and desired by the parent or guardian; and

(3) document the department's actions that are taken under [(1) AND (2) OF] this subsection**, including whether intensive family preservation services were appropriate, offered, used, or available**.

* **Sec. 3.** AS 47.10.086(b) is amended to read:

(b) If the court makes a finding at a hearing conducted under AS 47.10.080(l) that a parent or guardian has not sufficiently remedied the parent's or guardian's conduct or the conditions in the home despite reasonable efforts made by the department in accordance with this section, the court may conclude that continuation of reasonable efforts of the type described in (a) of this section are not in the best interests of the child. The department shall then make reasonable efforts to place the child in a timely manner in accordance with the permanent plan and to complete whatever steps are necessary to finalize the permanent placement of the child. **If the**

court concludes that continuation of reasonable efforts of the type described in (a) of this section are not in the best interests of the child and intensive family preservation services were not provided in the case, the court shall enumerate in the record the reasons the services were not provided.

* **Sec. 4.** AS 47.10.142(b) is amended to read:

(b) The department shall offer available counseling services and intensive family preservation services to the person having legal custody of a minor described in AS 47.10.141 and to the members of the minor's household if it determines that counseling services or intensive family preservation services would be appropriate in the situation. If, after assessing the situation, offering available [COUNSELING] services to the legal custodian and the minor's household, and furnishing appropriate social services to the minor, the department considers it necessary, the department may take emergency custody of the minor.

* **Sec. 5.** AS 47.10 is amended by adding new sections to read:

Article 3A. Intensive Family Preservation Services.

Sec. 47.10.500. Statewide program. Subject to AS 47.10.510 and 47.10.520, the department shall, within appropriations available for the purpose, provide intensive family preservation services on a statewide basis. The department may provide the services directly or through contracts with private nonprofit providers.

Sec. 47.10.510. Effectiveness required. (a) The department shall develop measurable standards that must be met by a provider before a contract may be awarded to the provider under AS 47.10.500.

(b) The department may not renew a contract with a provider of services unless the provider can demonstrate that provision of the services prevented or terminated out-of-home placement in at least 70 percent of the cases served by the provider and that out-of-home placement was avoided for a period of at least six months after termination of the services.

(c) The department may not continue direct provision of services unless the department can demonstrate that provision of the services prevented or terminated out-of-home placement in at least 70 percent of the cases served and that out-of-home placement was avoided for a period of at least six months after termination of the

services.

Sec. 47.10.520. Eligibility for services. (a) The department may provide intensive family preservation services to a child, the child's family, and other appropriate nonfamily members only if

(1) there are no other available means that will prevent out-of-home placement of the child or make it possible to immediately return the child to the child's home; and

(2) the child has been placed in out-of-home care or is at actual, imminent risk of out-of-home placement due to

(A) child abuse or neglect;

(B) a serious threat of substantial harm to the child's health, safety, or welfare; or

(C) family conflict.

(b) The department need not provide services to an otherwise eligible family if

(1) services are not available in the community in which the family resides;

(2) services cannot be provided because the program is filled to capacity;

(3) the family refuses the services;

(4) the child's case plan does not include reunification of the child and family; or

(5) the safety of a child, a family member, or a person providing the services would be unduly threatened.

Sec. 47.10 530. Solicitation of funding sources. The department shall solicit federal and private resources that may be available to fund intensive family preservation services.

Sec. 47.10.590. Definition. In AS 47.10.500 - 47.10.590, "intensive family preservation services" and "services" mean intensive family preservation services, as defined in AS 47.10.990.

* **Sec. 6.** AS 47.10.990 is amended by adding a new paragraph to read:

(28) "intensive family preservation services" means services provided

to a family with a child who is in an out-of-home placement or is at imminent risk of out-of-home placement that

(A) are designed to address problems creating the need for out-of-home placement by assisting the family to improve parental and household management competence and by solving practical problems that contribute to family stress so as to improve parental performance and enhance functioning of the family unit; and

(B) have the following characteristics:

(i) are persistently offered but provided at the family's option;

(ii) are provided in the family's home;

(iii) are available 24 hours a day and seven days a week;

(iv) are provided within 24 hours of initial contact for assistance;

(v) are provided for a maximum of 40 days by a single case worker whose caseload is not more than two families at any one time; and

(vi) may, in appropriate instances and subject to available appropriations, include monetary assistance for special needs of the family, such as to obtain food, shelter, or clothing or to purchase other goods or services that will enhance the effectiveness of other services offered to help preserve the family.

* **Sec. 7.** AS 47.17.030(d) is amended to read:

(d) Before the department or a local government health or social services agency may seek the termination of parental rights under AS 47.10, it shall offer protective social services and pursue all other reasonable means of protecting the child. **The department or agency shall also consider the eligibility of the child and family for intensive family preservation services under AS 47.10.500 - 47.10.590.**

* **Sec. 8.** AS 47.10.960 is repealed.

* **Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

STUDY. (a) The Department of Health and Social Services shall conduct a study in at least one region of the state in order to

(1) develop a valid and reliable process for accurately identifying clients who are eligible for intensive family preservation services;

(2) collect data on which to base projections of service needs, budget requests, and long-range planning related to intensive family preservation services;

(3) develop regional and statewide projections of needs for intensive family preservation services;

(4) develop a cost estimate for implementation and expansion of intensive family preservation services on a statewide basis;

(5) develop a long-range plan and time frame for ultimately making intensive family preservation services available to all eligible families; and

(6) collect data regarding the number of children in foster care, group care, institutional care, and other out-of-home care due to medical needs, mental health needs, developmental disabilities, and juvenile offenses and to assess the feasibility of expanding intensive family preservation services eligibility to include all of these children.

(b) By November 30, 2004, the Department of Health and Social Services shall submit a report to the governor describing the study required under this section and including the department's conclusions and recommendations that are based on the study. The department shall notify the legislature that the report is available.

(c) In this section, "intensive family preservation services" has the meaning given in AS 47.10.990.

* **Sec. 10.** Section 1 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 11.** Sections 2 - 7 and 9 of this Act take effect July 1, 2002.

22-LS0454\J.1
Lauterbach
2/14/02

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE COGHILL

TO: CSHB 252(HES), Draft Version "J"

Page 1, line 5 - 13:

Delete all material and insert:

"* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. By the amendment of AS 47.10.005 in sec. 2 of this Act, the legislature intends to express its recognition that parents possess inherent, individual rights to direct and control the education and upbringing of their children.

* **Sec. 2.** AS 47.10.005 is amended to read:

Sec. 47.10.005. Construction. The provisions of this chapter shall be liberally construed to the end that a child coming within the jurisdiction of the court under this chapter may receive the care, guidance, treatment, and control that will promote the child's welfare **and the participation of the child's parents in the child's upbringing**."

Renumber the following bill sections accordingly.

Page 2, line 1:

Delete "Section 1 of this Act takes"

Insert "Sections 1 and 2 of this Act take"

Amendments for HB 252

1. Sec. 3: AS 47.10.086 (a) (3) following "or available" insert "and enumerating the reasons specific to the case for providing Intensive Family Preservation Services"

2. Sec. 6: AS 47.10.520 (2) (c) change "family conflict" to "any mitigating factor that could lead to out-of-home placement not already covered under (A) and (B)"

3. Sec. 6: AS 47.10.520 (b) (5) delete "unduly"

4. Sec. 7: AS 47.10.990 (28) (A) following "competence" delete "and by solving" and insert ", solve day to day"; following "stress" insert ", identify the factors which created the risk of out-of-home placement and assist in the development of a case plan"

22-LS0454\O
Lauterbach
2/20/02

CS FOR HOUSE BILL NO. 252(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Dyson

A BILL

FOR AN ACT ENTITLED

"An Act relating to the construction of certain statutes relating to children; relating to the scope of duty and standard of care for persons who provide services to certain children and families; relating to intensive family preservation services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

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* **Sec. 2.** AS 47.10.005 is amended to read:

Sec. 47.10.005. Construction. The provisions of this chapter shall be liberally construed to the end that a child coming within the jurisdiction of the court under this chapter may receive the care, guidance, treatment, and control that will

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(1) identify family support services that will assist the parent or guardian in remedying the conduct or conditions in the home that made the child a child in need of aid;

(2) actively offer the parent or guardian, and refer the parent or guardian to, the **family support** services identified under (1) of this subsection; the department shall refer the parent or guardian to community-based family support services whenever community-based services are available and desired by the parent or guardian; and

(3) document the department's actions that are taken under [(1) AND (2) OF] this subsection; **the documentation required under this paragraph must include**

(A) documentation about whether intensive family preservation services were appropriate, offered, used, or available to the family; and

(B) if intensive family preservation services were appropriate or offered to the family, enumeration of the reasons specific to the case explaining why intensive family preservation services were appropriate or offered.

* **Sec. 4.** AS 47.10.086(b) is amended to read:

(b) If the court makes a finding at a hearing conducted under AS 47.10.080(l) that a parent or guardian has not sufficiently remedied the parent's or guardian's conduct or the conditions in the home despite reasonable efforts made by the department in accordance with this section, the court may conclude that continuation of reasonable efforts of the type described in (a) of this section are not in the best interests of the child. The department shall then make reasonable efforts to place the child in a timely manner in accordance with the permanent plan and to complete whatever steps are necessary to finalize the permanent placement of the child. **If the court concludes that continuation of reasonable efforts of the type described in (a) of this section are not in the best interests of the child and intensive family preservation services were not provided in the case, the court shall enumerate in the record the reasons the services were not provided.**

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Article 3A. Intensive Family Preservation Services.

Sec. 47.10.500. Statewide program. Subject to AS 47.10.510 and 47.10.520, the department shall, within appropriations available for the purpose, provide intensive family preservation services on a statewide basis. The department may provide the services directly or through contracts with private nonprofit providers.

Sec. 47.10.510. Effectiveness required. (a) The department shall develop measurable standards that must be met by a provider before a contract may be awarded to the provider under AS 47.10.500.

(b) The department may not renew a contract with a provider of services unless the provider can demonstrate that provision of the services prevented or terminated out-of-home placement in at least 70 percent of the cases served by the provider and that out-of-home placement was avoided for a period of at least six months after termination of the services.

(c) The department may not continue direct provision of services unless the department can demonstrate that provision of the services prevented or terminated out-of-home placement in at least 70 percent of the cases served and that out-of-home placement was avoided for a period of at least six months after termination of the services.

Sec. 47.10.520. Eligibility for services. (a) The department may provide intensive family preservation services to a child, the child's family, and other appropriate nonfamily members only if

(1) there are no other available means that will prevent out-of-home placement of the child or make it possible to immediately return the child to the child's home; and

(2) the child has been placed in out-of-home care or is at actual, imminent risk of out-of-home placement due to

(A) child abuse or neglect;

(B) a serious threat of substantial harm to the child's health, safety, or welfare; or

(C) any other factor that could lead to out-of-home placement.

(b) The department need not provide services to an otherwise eligible family if

(1) services are not available in the community in which the family resides;

(2) services cannot be provided because the program is filled to capacity;

(3) the family refuses the services;

(4) the child's case plan does not include reunification of the child and family; or

(5) the safety of a child, a family member, or a person providing the

services would be threatened.

Sec. 47.10 530. Solicitation of funding sources. The department shall solicit federal and private resources that may be available to fund intensive family preservation services.

Sec. 47.10.590. Definition. In AS 47.10.500 - 47.10.590, "intensive family preservation services" and "services" mean intensive family preservation services, as defined in AS 47.10.990.

* **Sec. 7.** AS 47.10.990 is amended by adding a new paragraph to read:

(28) "intensive family preservation services" means services provided to a family with a child who is in an out-of-home placement or is at imminent risk of out-of-home placement that

(A) are designed to address problems creating the need for out-of-home placement by assisting the family to improve parental and household management competence, solve day-to-day practical problems that contribute to family stress, identify the factors that created the risk of out-of-home placement, and participate in the development of the family's case plan so as to improve parental performance and enhance functioning of the family unit; and

(B) have the following characteristics:

(i) are persistently offered but provided at the family's option;

(ii) are provided in the family's home;

(iii) are available 24 hours a day and seven days a week;

(iv) are provided within 24 hours of initial contact for assistance;

(v) are provided for a maximum of 40 days by a single case worker whose caseload is not more than two families at any one time; and

(vi) may, in appropriate instances and subject to available appropriations, include monetary assistance for special needs of the family, such as to obtain food, shelter, or clothing or to purchase

other goods or services that will enhance the effectiveness of other services offered to help preserve the family.

* **Sec. 8.** AS 47.17.030(d) is amended to read:

(d) Before the department or a local government health or social services agency may seek the termination of parental rights under AS 47.10, it shall offer protective social services and pursue all other reasonable means of protecting the child. **The department or agency shall also consider the eligibility of the child and family for intensive family preservation services under AS 47.10.500 - 47.10.590.**

* **Sec. 9.** AS 47.10.960 is repealed.

* **Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

STUDY. (a) The Department of Health and Social Services shall conduct a study in at least one region of the state in order to

(1) develop a valid and reliable process for accurately identifying clients who are eligible for intensive family preservation services;

(2) collect data on which to base projections of service needs, budget requests, and long-range planning related to intensive family preservation services;

(3) develop regional and statewide projections of needs for intensive family preservation services;

(4) develop a cost estimate for implementation and expansion of intensive family preservation services on a statewide basis;

(5) develop a long-range plan and time frame for ultimately making intensive family preservation services available to all eligible families; and

(6) collect data regarding the number of children in foster care, group care, institutional care, and other out-of-home care due to medical needs, mental health needs, developmental disabilities, and juvenile offenses and to assess the feasibility of expanding intensive family preservation services eligibility to include all of these children.

(b) By November 30, 2004, the Department of Health and Social Services shall submit a report to the governor describing the study required under this section and including the department's conclusions and recommendations that are based on the study. The

department shall notify the legislature that the report is available.

(c) In this section, "intensive family preservation services" has the meaning given in AS 47.10.990.

* **Sec. 11.** Sections 1 and 2 of this Act take effect immediately under AS 01.10.070(c).

* **Sec. 12.** Sections 3 - 8 and 10 of this Act take affect July 1, 2002.

AMENDMENT NO. ____

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: CSHB 252 (HES) Version O

Page 6, Line 10:

Delete line 10 and insert:

* **Sec. 9.** AS 47.10.960 is amended to read:

Sec. 47.10.960. Civil liability [DUTY AND STANDARD OF CARE] not created. Failure to comply with a provision of this title or a regulation adopted under this title is not a basis for civil liability, but may be the basis for employee discipline or administrative action authorized by law [NOTHING IN THIS TITLE CREATES A DUTY OR STANDARD OF CARE FOR SERVICES TO CHILDREN AND THEIR FAMILIES BEING SERVED UNDER AS 47.10].

AMENDMENT

OFFERED IN THE HOUSE **BY REPRESENTATIVE CISSNA**

TO: CS for . 3 252 version O

Page 2, lines 8-9:

Delete "available for the purpose"

Insert "identified by the department for the specific purpose of intensive family preservation services"

Page 3, lines 26-27:

Delete "the purpose, provide intensive family preservation services on a statewide basis"

Insert "intensive family preservation services, develop and implement intensive family preservation services systematically and over time, with the ultimate goal of providing intensive family preservation services on a statewide basis."

Page 3, line 31:

Following "awarded", insert "or renewed"

Page 4, line 1-10:

Delete subsections (b) and (c)

Page 5, line 19:

Delete "persistently" and "but provided"

Page 5, lines 26-28:

Delete wording under (v) and replace with "are provided on a time limited basis by a single caseworker whose caseload is congruent with the intensive family preservation services standards established by the Child Welfare League of America. Caseloads should be kept low to allow for the necessary intense level of interaction with the family. Services should be most intensive at the time of a crisis."

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the HOUSE HES S
Committee Name

Committee on HB 252 Dated 2-21-02
Bill / Subject

(CURRENT DOCUMENT NOT AVAILABLE IN FBKS)

AS HAS CONSISTENTLY BEEN THE CASE, FOR THE PAST EIGHT YEARS THAT I HAVE WATCHED CAREFULLY, A GOOD AND SIMPLE, NECESSARY BILL, IS BEING MADE UNNECCESSARILY LARGER AND WEAKER THAN IT WAS.

THE REPEAL OF A.S. 47.10.960 IS ESSENTIAL. THE PARENTAL RIGHTS LANGUAGE IS ESSENTIAL. THE REST IS "FLUFF" AND A CRUEL DIVERSION, FOR VICTIMS OF STATE FRAUD BY DFYS., ET. AL.

SIGNED: _____
Testifier

SCOTT TRAFFORD CALDER
Representing

P.O. 75011 / FBKS / 99707 (907) 474-0174
Address / Phone Number

EMAIL (THECALDER@HOTMAIL)

FISCAL NOTE

DRAFT

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB 252 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: RELATING TO CONSTRUCTION OF THE CINA STATUTES AND SCOPE OF DUTY FOR SOCIAL WORKERS
BRU: Family and Youth Services
Component: FYS Management
Sponsor: COGHILL
Requestor: HOUSE (HES)
Component Number: 2306

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual	80.0	50.0	50.0			
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	80.0	50.0	50.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	80.0	50.0	50.0			
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
TOTAL	80.0	50.0	50.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The intent of this proposed legislation appears to be one that is in line with the department's desire to provide support to families who can benefit from it, to improve safety and well being of children. Intensive Family Preservation services are provided in many communities across the nation. These programs work intensely with a small number of families, for a short period of time, to help the family through a threatening time of crisis. Intensive Family Preservation services can be beneficial in preventing children from entering protective custody, and in reducing the amount of time children spend in protective custody. These services have limits in their appropriateness and effectiveness. The legislation, as written, does obligate the department to provide these services within appropriations available. Currently, DFYS receives federal and state funds to provide family support, family preservation and time limited family reunification services. These funds are disbursed through the grant

Prepared by: Theresa Tanoury, Director — Phone 465-3191
Division: Family & Youth Services — Date/Time 02/14/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner — Date 02/14/2002
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

DRAFT

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. CS HB 252 (HES)

ANALYSIS CONTINUATION

ANALYSIS CONTINUED:

process to 26 agencies in communities throughout Alaska.

The Division would either have to get an increased appropriation or would have to eliminate current services to provide grant money for Intensive Family Preservation services. The legislation obligates the division to consider using Intensive Family Preservation services when and where available; and it allows the division to determine the appropriateness of the services.

The legislation also states an expectation that the department will research and pursue outside funding to develop these services. The detailed prospective study, data analysis and projection process will need to be completed by an outside source with specific expertise. This fiscal note is for the expected cost of this process. Funding to cover the cost of this process is requested for three years.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB 252 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: RELATING TO CONSTRUCTION OF THE CINA STATUTES AND SCOPE OF DUTY FOR SOCIAL WORKERS
BRU: Family and Youth Services
Component: FYS Management
Sponsor: COGHILL
Requestor: HOUSE (HES)
Component Number: 2306

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual	80.0	50.0	50.0			
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	80.0	50.0	50.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	80.0	50.0	50.0			
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
TOTAL	80.0	50.0	50.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The intent of this proposed legislation appears to be one that is in line with the department's desire to provide support to families who can benefit from it, and to improve safety and well being of children. Intensive Family Preservation services are provided in many communities across the nation. These programs work intensely with a small number of families, for a short period of time, to help the family through a threatening time of crisis. Intensive Family Preservation services can be beneficial in preventing children from entering protective custody, and in reducing the amount of time children spend in protective custody. These services have limits in their appropriateness and effectiveness.

Currently, DFYS receives federal and state funds to provide family support, family preservation and time

Prepared by: Theresa Tanoury, Director
Phone 465-3191
Division Family & Youth Services
Date/Time 02/22/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner
Date 02/22/2002
Agency Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. CS HB 252 (HES)

ANALYSIS CONTINUATION

ANALYSIS CONTINUED:

limited family reunification services. These funds are disbursed through the grant process to 26 agencies in communities throughout Alaska.

The legislation obligates the division to consider using Intensive Family Preservation services when and where available; and it allows the division to determine the appropriateness of the services.

The legislation also states an expectation that the department will research and pursue outside funding to develop these services. The detailed prospective study (which includes development and training), data analysis, and projection process will need to be completed by an outside source with specific expertise. This fiscal note is for the expected cost of this process. Funding to cover the cost of this process is requested for three years. Cost covers expenses related to the required study. Since the CS HB252 allows phase in of these services to occur, the department will spend first year funding on developing and training for intensive family preservation services.

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

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 22, 2002

SUBJECT: CSHB 252(HES) (Work Order No. 22-LS0454\P)

TO: Representative Fred Dyson
Attn: Jason

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is the CS you requested.

By way of legal advice, I have two comments to make about the language the committee added in sec. 8 of the CS to AS 47.10.990(28)(B)(v).

The first comment is about the reference to the Child Welfare League of America on page 5, lines 25-26, of this CS. Ordinarily, the contents of a statute may not depend on the actions and policies of a private body. That would constitute excessive delegation of legislative power because it would give a private group the power to change a state law. It may be that the requirement in this language that the caseloads merely be "congruent" with the private body's standards (and not exactly the same as the private body's standards) will save this statute from being unconstitutional. However, a good argument could be made that even requiring only congruency or consistency is an excessive delegation of legislative power.

My second comment about this language concerns the two uses of the word "should" at lines 27 and 29 on page 5. Ordinarily, a law does not use the term "should." Laws set duties and requirements. The use of the term "should" is more appropriate for a resolution or for a bill section of temporary law that explains the legislature's intent about something. If you really want caseloads to be kept low and to be most intensive at the time of crisis, "shall" is the word to use in place of "should." If this is truly just intent language and not intended to carry the force of law, then I advise that the two clauses simply be deleted as being non-statutory in nature.

If I may be of further assistance, please advise.

TML:med
02-194.med

Enclosure

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If I may be of further assistance, please advise.

TML:med
02-194.med

Enclosure

JPBW HB 252 Packets

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the HOUSE (H.E.S.S.)
Committee Name

Committee on HB 252 Dated 12-14-02
Bill / Subject

I SUPPORTED THE ORIGINAL BILL. NOW, I QUESTION THE NEED TO REMOVE PARENTAL RIGHTS RECOGNITION FROM CONSTRUCTION, AND TO PLACE IT IN INTENT, LANGUAGE. THE DEPARTMENT MUST ACTUALLY DO THIS; NOT SIMPLY INTEND TO DO THIS, WHILE ACTUALLY NOT "RECOGNIZING" PARENTAL RIGHTS. REPRESENTATIVE CISSNA'S AMENDMENTS CAN NOT BE ASSESSED UNTIL WRITTEN COPIES ARE AUAILABLE IN THE FAIRBANKS L.I.O. THANK YOU.

SIGNED: Scott Calder
Testifier

SCOTT TRAFFORD CALDER

SELF + OTHERS
Representing

P.O. 75011 / FBKS / 99707 / (907) 474-0174
Address / Phone Number

Possible substitute for § 2 of CSHB 252 (HES):

***Sec. 2.** AS 47.10.960 is amended to read:

Sec. 47.10.960. Civil liability [duty and standard of care] not created. Failure to comply with a requirement of this title does not give rise to a civil cause of action for damages [Nothing in this title creates a duty or standard of care for services to children and their families being served under AS 47.10].

An alternative would be to expand the language:

***Sec. 2.** AS 47.10.960 is amended to read:

Sec. 47.10.960. Civil liability [duty and standard of care] not created. Failure to comply with a requirement of this title or a regulation adopted under this title is not a basis for civil liability, but may be the basis for employee discipline or administrative action authorized by law [Nothing in this title creates a duty or standard of care for services to children and their families being served under AS 47.10].

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the HOUSE HES.S.
Committee Name

Committee on HB 252 Dated 2-21-02
Bill / Subject

(CURRENT DOCUMENT NOT AVAILABLE IN FBKS)

AS HAS CONSISTENTLY BEEN THE CASE, FOR THE PAST EIGHT YEARS THAT I HAVE WATCHED CAREFULLY, A GOOD AND SIMPLE, NECESSARY BILL, IS BEING MADE UNNECESSARILY LARGER AND WEAKER THAN IT WAS.

THE REPEAL OF A.S. 47.10.960 IS ESSENTIAL. THE PARENTAL RIGHTS LANGUAGE IS ESSENTIAL. THE REST IS "FLUFF" AND A CRUEL DIVERSION, FOR VICTIMS OF STATE FRAUD BY DFYS., ET. AL.

SIGNED: [signature]

Testifier

Scott TRAFFORD CALDER

Representing

P.O. 75011 / FBKS / 99707 (907) 474-0174

Address / Phone Number

EMAIL (THECALDER@HOTMAIL)

HB

255

Alaska State Legislature

State Capitol
Juneau, AK 99801-1182
(907) 465-3720
(907) 465-2689

Official Business
Fax: (907) 465-3472

Speaker of the House of Representatives

SPONSOR STATEMENT
HOUSE BILL 255

"An Act establishing the Statewide Suicide Prevention Council; and providing for an effective date."

It is devastating to lose someone to suicide at any age, but it is especially tragic to lose a young person who has so much to live for. Suicide is preventable.

In 1999, the United States Surgeon General issued "A Call to Action" to prevent suicide. The report made 15 recommendations categorized in the areas of awareness, intervention and methodology. House Bill 255 is another step in answering both the state's and the national call to action.

House Bill 255 will establish a statewide suicide prevention council made up of fourteen private and public members representing rural and urban Alaska. Two members from both the House and Senate would sit on the council. The governor would appoint ten members, including experts in substance abuse and mental health, as well as people who have been directly impacted by suicide and who work with youth across the state.

Suicide is an on-going epidemic in many parts of the state. In rural Alaska and in the Matanuska-Susitna Valley, the numbers are at an all-time high. We all must work together to reduce the toll suicide is having on the people of our state.

The council will focus on finding ways to reduce suicide rates, broaden public awareness of the suicide warning signs, and enhance suicide prevention services and programs throughout the state. Each March the council will submit a report to the Legislature and the governor with its findings and recommendations.

Alaska State Legislature

Official Business
Fax: (907) 465-3472

Speaker of the House of Representatives

State Capitol
Juneau, AK 99801-1182
(907) 465-3720
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SECTIONAL ANALYSIS

COMMITTEE SUBSTITUTE FOR HOUSE BILL 255

"An Act establishing the Statewide Suicide Prevention Council; and providing for an effective date."

Section 1: Amends AS 39.25.120(c). Partially exempt service. Adds members of the Statewide Suicide Prevention Council to the list of boards, councils or commissions that fall under the statutes (AS 39.25.120) pertaining to positions within state government that have partially exempt status.

Section 2: Adds new sections to AS 44.29. Department of Health and Social Services. Establishes the Statewide Suicide Prevention Council. These new sections to AS 44.29 lists the qualifications of the 14 members who comprise the council; their terms of office; compensation, per diem and expenses; officers and staffs; meetings; the duties of the council; an annual report; and, the definition of council to mean the Suicide Prevention Council as it appears throughout AS 44.29.300-44.29.390.

Section 3: Adds a new section to uncodified law to allow for a transitional period for the Suicide Prevention Council to begin its work. The Council may undertake its activities on June 1, 2001, or upon appointment of its full membership, whichever is earlier.

Section 4: Immediate effective date.

The Trust

The Alaska Mental Health Trust Authority

April 23, 2001

Representative Brian Porter
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Porter:

Subject: Support for Suicide Prevention Council

This letter is to acknowledge the Trust's appreciation for your efforts at addressing the problem of Alaska's high suicide rate by establishing a statewide Suicide Prevention Council, and to confirm the Trust's commitment regarding funds for this initiative.

For FY02, the Trust is willing to match $125,000 in MHTAAR with $125,000 GF/MH to establish the Council and facilitate its work.

Trustees look forward to working with the Council and appreciate your willingness to support this important effort.

Sincerely,

Jeff Jessee
Executive Director

550 West Seventh Avenue, Suite 1820 • Anchorage, Alaska 99501
Telephone: (907) 269-7960 • Fax: (907) 269-7966

Received via email on 4/23/01

Dear Senator Halford:

I am writing to express my support for SB 198, creating a state suicide prevention council. I think I speak for many people in the Yukon-Koyukuk region when I express my gratitude for your attention to the issue of suicide. Since I became the Director of Yukon Koyukuk Mental Health here in Galena, I have seen how the suicide of one young person devastates hundreds of friends, associates, and loved ones. The people here want badly for the dying to stop. Supporting them with a council and a coordinator is a good idea.

I favor creating a suicide prevention council, but I believe it will be very important to ensure that the areas and people who are losing loved ones to suicide have the greatest say on the council. I worked in Anchorage for years and know first-hand that urban folks have a hard time understanding how things work in the Bush. Although suicide is not just a rural, Native problem, our people out here are disproportionately represented in the suicide statistics. They must be allowed to speak and plan for themselves. I also hope to see a statewide suicide prevention plan and a funded coordinator position to carry out those plans.

Again, I support your bill and hope to see our state move forward in addressing this difficult problem.

Sincerely,
Diana Weber, MS
Director, Yukon Koyukuk Mental Health Program

The Surgeon General's Call To Action To Prevent Suicide, 1999

At a Glance: Suicide in the United States

- Suicide was the eighth leading cause of death for all Americans (up from ninth in 1996) and the third leading cause of death for young people aged 15-24.
- Suicide took the lives of 30,903 Americans in 1996 (10.8 per 100,000 population). Suicides in that year accounted for only 1% of all deaths, compared with 32% from heart disease, 23% from cancer, and 7% from stroke -- the top three causes of death in the U.S.
- More people die of suicide than from homicide. In 1996, there were three suicides in the U.S. for every two homicides committed.
- Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.
- The highest suicide rates were for white men over 85, who had a rate of 65.3/100,000. However, suicide was not the leading cause of death for this age group.
- Males are four times more likely to die of suicide than are females. However, females are more likely to attempt suicide than are males.
- In 1996, white males accounted for 73% of all suicides. Together, white males and white females accounted for more than 90% of all suicides in the United States. However, during the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the rates for the general population. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Suicide rates are generally higher than the national average in the western mountain states and lower in the eastern and midwestern states.
- Nearly 3 of every 5 suicides in 1996 (59%) were committed with a firearm, while 79% of all firearm suicides are committed by white men.
- There are an estimated 16 attempted suicides for each completed suicide. The ratio is lower in women and youth and higher in men and the elderly. Suicide attempts are expressions of extreme distress that need to be addressed, and not just a harmless bid for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

For more information, please contact the following offices:

The Surgeon General's Call To Action To Prevent Suicide 1999

Department of Health and Human Services
U.S. Public Health Service

1610

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Suggested Citation:

U.S. Public Health Service. *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC: 1999.

A Letter From The Surgeon General
U.S. Department of Health and Human Services

Suicide is a serious public health problem. In 1996, the year for which the most recent statistics are available, suicide was the ninth leading cause of mortality in the United States, responsible for nearly 31,000 deaths. This number is more than 50% higher than the number of homicides in the United States in the same year (around 20,000 homicides in 1996).[1] Many fail to realize that far more Americans die from suicide than from homicide. Each year in the United States, approximately 500,000 people require emergency room treatment as a result of attempted suicide.[2] Suicidal behavior typically occurs in the presence of mental or substance abuse disorders - illnesses that impose their own direct suffering.[3-5] Suicide is an enormous trauma for millions of Americans who experience the loss of someone close to them.[6] The nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes.

In 1996, the World Health Organization (WHO), recognizing the growing problem of suicide worldwide, urged member nations to address suicide. Its document, *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*[7], motivated the creation of an innovative public/private partnership to seek a national strategy for the United States. This public/private partnership included agencies in the U.S. Department of Health and Human Services, encompassing the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institute of Mental Health (NIMH), the Office of the Surgeon General, and the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Advocacy Network (SPAN), a public grassroots advocacy organization made up of suicide survivors (persons close to someone who completed suicide), attempters of suicide, community activists, and health and mental health clinicians.

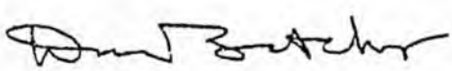
An outgrowth of this collaborative effort was a jointly sponsored national conference on suicide prevention convened in Reno, Nevada, in October 1998. Conference participants included researchers, health and mental health clinicians, policy makers, suicide survivors, and community activists and leaders. They engaged in careful analysis of what is known and unknown about suicide and its potential responsiveness to a public health model emphasizing suicide prevention.

This *Surgeon General's Call To Action* introduces a blueprint for addressing suicide – Awareness, Intervention, and Methodology, or **AIM** – an approach derived from the collaborative deliberations of the conference participants. As a framework for suicide prevention, **AIM** includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference. Recognizing that mental and substance abuse disorders confer the greatest risk for suicidal behavior, these recommendations suggest an important approach to preventing suicide and injuries from suicidal behavior by addressing the problems of undetected and undertreated mental and substance abuse disorders in conjunction with other public health approaches.

These recommendations and their supporting conceptual framework are essential steps toward a comprehensive **National Strategy for Suicide Prevention**. Other necessary elements will include constructive public health policy, measurable overall objectives, ways to monitor and evaluate progress toward these objectives, and provision of resources for groups and agencies identified to carry out the recommendations. The nation needs to move forward with these crucial recommendations and support continued efforts to improve the scientific bases of suicide prevention.

Many people, from public health leaders and mental and substance abuse disorder health experts to community advocates and suicide survivors, worked together in developing and proposing **AIM** for the American public. **AIM** and its recommendations chart a course for suicide prevention action *now* as well as serve as the foundation for a more comprehensive **National Strategy for Suicide Prevention** in the future. Together, they represent a critical component of a broader initiative to improve the mental health of the nation. I endorse the ongoing work necessary to complete a **National Strategy** because I believe that such a coordinated and evidence-based approach is the best way to use our resources to prevent suicide in America.

But even the most well-considered plan accomplishes nothing if it is not implemented. To translate AIM into action, each of us, whether we play a role at the federal, state, or local level, must turn these recommendations into programs best suited for our own communities. We must act now. We cannot change the past, but together we can shape a different future.



David Satcher, M.D., Ph.D.
Assistant Secretary for Health
and Surgeon General

Suicide as a Public Health Problem

On average, 85 Americans die from suicide each day. Although more females attempt suicide than males, males are at least four times more likely to die from suicide.[1,8] Firearms are the most common means of suicide among men and women, accounting for 59% of all suicide deaths.[1]

Over time, suicide rates for the general population have been fairly stable in the United States.[9] Over the last two decades, the suicide rate has declined from 12.1 per 100,000 in 1976 to 10.8 per 100,000 in 1996.[10] However, the rates for various age, gender and ethnic groups have changed substantially. Between 1952 and 1996, the reported rates of suicide among adolescents and young adults nearly tripled.[1,11] From 1980 to 1996, the rate of suicide among persons aged 15-19 years increased by 14% and among persons aged 10-14 years by 100%. Among persons aged 15-19 years, firearms-related suicides accounted for 96% of the increase in the rate of suicide since 1980. For young people 15-24 years old, suicide is currently the third leading cause of death, exceeded only by unintentional injury and homicide.[12] More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease ***combined***. During the past decade, there have also been dramatic and disturbing increases in reports of suicide among children. Suicide is currently the fourth leading cause of death among children between the ages of 10 and 14 years.[10]

Suicide remains a serious public health problem at the other end of the age spectrum, too. Suicide rates increase with age and are highest among white American males aged 65 years and older. Older adult suicide victims, when compared to younger suicide victims, are more likely to have lived alone, have been widowed, and to have had a physical illness.[13,14] They are also more likely to have visited a health care professional shortly before their suicide and thus represent a missed opportunity for intervention.[15]

Other population groups in this country have specific suicide prevention needs as well. Many communities of Native Americans and Alaskan Natives long have had elevated suicide rates.[16,17] Between 1980 and 1996, the rate of suicide among African American males aged 15-19 years increased 105% and almost 100% of the increase in this group is attributable to the use of firearms.[18]

It is generally agreed that not all deaths that are suicides are reported as such. For example, deaths classified as homicide or accidents, where individuals may have intentionally put themselves in harm's way are not included in suicide rates.[19-21]

Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy. Unfortunately, secrecy and silence diminish the accuracy and amount of information available about persons who have completed suicide — information that might help prevent other suicides.

Methodology

Developing Recommendations for a National Strategy for Suicide Prevention

Developing and implementing a **National Strategy for Suicide Prevention** should achieve a significant, measurable, and sustained reduction in suicidal behaviors. The action steps presented in this document were prioritized from among a variety of recommendations developed through a public-private collaboration of nongovernmental organizations, federal and state governmental agencies, corporations and foundations, and public health/health/mental health experts.

Before the Reno Conference, experts evaluated research studies, programs, policies, and best interventions to prevent suicide among five U.S. population groups known to be at high risk of suicide. Those identified as being at increased risk were youth, the medically ill, specific population groups, persons with mental and substance abuse disorders, and the elderly. Following review of the evidence by a second expert, the lead expert extracted recommendations for suicide prevention. In extracting recommendations, experts were instructed to consider the robustness of the available data; an intervention's likelihood of reducing suicide; its perceived suitability for implementation in the real world; and estimates of the lead-time to put the recommendation into practice and produce its intended effect. They were also asked to consider the ethical implications and cultural appropriateness of each recommendation.

Those experts' draft recommendations were brought to the Reno conference. A broad cross section of conference participants and a

highly varied expert panel were identified to work with the recommendations and evaluate each one. The panel and the invited conference participants represented diverse areas of expertise and included researchers, suicide survivors, persons who had attempted suicide, public health leaders, community volunteers, clinicians, educators, consumers of mental health services, and corporate/nonprofit advocates. Financial support was made available so that socioeconomic status would not exclude panelists and participants who wanted to contribute from attending the conference. The Regional Health Administrators of the U.S. Public Health Service served as facilitators in working with over 400 participants to refine recommendations during the conference. The expert panel received over 700 written comments from participants during the course of their deliberations.

The expert panel's recommendations were derived from a rigorous review of suicide and suicide prevention research. Existing suicide research is strongest in the identification of risk factors, particularly mental and substance abuse disorders, less developed in categorizing protective factors, and only beginning to analyze the mutual interactions among risk and protective factors. Some treatments for mental and substance abuse disorders have been associated with a reduction in suicidal behaviors.[22-30] Further research is needed to determine whether these benefits will occur if treatments are offered to groups outside the small populations that were studied.

The recommendations the panel developed include past and current initiatives, programs, and interventions. Other recommendations pragmatically extend findings from existing suicide and suicide prevention research into proposed applications. Suicide prevention experts from multiple disciplines endorsed these proposed recommendations as having the greatest potential for effectiveness.

By the end of the conference, the expert panel had advanced 81 recommendations for consideration for inclusion in a **National Strategy for Suicide Prevention**. These recommendations were posted on the SPAN Web site to allow a period of further reflection and public comment. The CDC developed a tool for priority ranking the 81 recommendations. Respondents from all interested sectors prioritized the recommendations using criteria of feasibility, necessity, clarity, and likelihood of being funded. Recommendations with the highest priority scores and broadest support were combined and edited to serve as the essential first steps of an action agenda for suicide prevention.

Results

AIM to Prevent Suicide

This *Surgeon General's Call to Action* introduces an initial blueprint for reducing suicide and the associated toll that mental and substance abuse disorders take in the United States. As both evidence-based and highly prioritized by leading experts, these 15 key recommendations listed below should serve as a framework for immediate action. These recommended first steps are categorized as **Awareness, Intervention, and Methodology**, or **AIM**.

Awareness: Appropriately broaden the public's awareness of suicide and its risk factors

Intervention: Enhance services and programs, both population-based and clinical care

Methodology: Advance the science of suicide prevention.

Awareness: Appropriately broaden the public's awareness of suicide and its risk factors

- Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.

- Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.

- Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.

Intervention: Enhance services and programs, both population-based and clinical care

- Extend collaboration with and among public and private sectors to complete a **National Strategy for Suicide Prevention.**

- Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.

• Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.

• Institute training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.

• Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.

• Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.

• Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.

• Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

Methodology: Advance the science of suicide prevention

• Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals, and culture-specific interventions.

• Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs.

- Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in these systems.

- Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

Discussion

Risk and Protective Factors

Suicide risk and protective factors and their interactions form the empirical base for suicide prevention. Risk factors are associated with a greater potential for suicide and suicidal behavior while protective factors are associated with reduced potential for suicide.[31-33]

Substantial age, gender, ethnic, and cultural variations in suicide rates provide opportunities to understand the different roles of risk and protective factors among these groups. Risk and protective factors encompass genetic, neurobiological, psychological, social, and cultural characteristics of individuals and groups and environmental factors such as easy access to firearms.[34-38] This expanding base of empirical evidence generates promising ideas about what can be changed or modified to prevent suicide.

Clear progress has been made in the scientific understanding of suicide, mental and substance abuse disorders, and in developing interventions to treat these disorders. For example, increased understanding of brain systems regulated by chemicals called neurotransmitters holds promise for understanding the biological underpinnings of depression, anxiety disorders, impulsiveness, aggression, and violent behaviors.[39] Much remains to be learned, however, about the common risk factors for mental disorders and substance abuse, suicide and other forms of intentional violence including homicide, domestic violence, and child abuse. Expanding the base of scientific evidence will help in the development of more effective interventions for these harmful behaviors.

Advances in neurobiology and the behavioral sciences and their application in developing effective treatments for mental and substance abuse disorders have generated much hope. Wider public understanding of the science of the brain and behavior can reduce the stigma asso-

ciated with seeking help for mental and substance abuse disorders and consequently may contribute to reducing the risk for suicidal behavior.

Risk Factors

Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone. Some persons are particularly vulnerable to suicide and suicidal self-injury because they have more than one mental disorder present[40], such as depression with alcohol abuse[41]. They may also be very impulsive and/or aggressive[42], and use highly lethal methods to attempt suicide. As noted above, the importance of certain risk factors and their combination vary by age, gender, and ethnicity.

The impact of some risk factors can be reduced by interventions (such as providing effective treatments for depressive illness).[31,43] Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event.[31,44]

Risk factors include:

- Previous suicide attempt
- Mental disorders — particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- Influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide that have a contagious influence
- Isolation, a feeling of being cut off from other people

Some lists of warning signs for suicide have been created in an effort to identify and increase the referral of persons at risk. However, the warning signs given are not necessarily risk factors for suicide and may include common behaviors among distressed persons, behaviors that are not specific for suicide. If such lists are applied broadly, for instance in the general classroom setting, they may be counterproductive. In effect, indiscriminate suicide awareness efforts and overly inclusive screening lists may promote suicide as a possible solution to ordinary distress or suggest that suicidal thoughts and behaviors are normal responses to stress.[45] Efforts must be made to avoid normalizing, glorifying, or dramatizing suicidal behavior, reporting how-to methods, or describing suicide as an understandable solution to a traumatic or stressful life event. Inappropriate approaches could potentially increase the risk for suicidal behavior in vulnerable individuals, particularly youth.[46,47]

Protective Factors

Protective factors can include an individual's genetic or neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes.[31] Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

The risk factors that lead to suicide (especially mental and substance abuse disorders) and the protective factors that safeguard against it form the conceptual framework for the prevention recommendations developed and presented in this document and in the evolving **National Strategy for Suicide Prevention.**

Identifying and Addressing Risk

Unfortunately, it is difficult to identify particular individuals at greatest risk for suicidal behaviors or completed suicide. Measures to screen the general population for suicide risk lack the precision needed to identify in advance only those people who eventually would die by suicide. Because suicide screening in the general population currently is not feasible, it is especially important for suicide prevention programs to include broader approaches that benefit the whole population as well as efforts focused on smaller, high-risk subgroups that can be identified. Within those subgroups, a different approach to screening — screening programs for specific disorders, like depression, that are associated with suicide — can be used to identify and direct people to highly effective treatments that may lower their risk of suicide.

Often, the suicide prevention efforts in place are directed primarily at improving clinical care for the individual already struggling with suicidal ideas or the individual requiring medical attention for a suicide attempt. Suicide prevention also demands approaches that reduce the likelihood of suicide before vulnerable individuals reach the point of danger. Applying the public health approach to the problem of suicide in the United States will maximize the benefits of efforts and resources for suicide prevention.

The Public Health Approach

Suicide is a public health problem that requires an evidence-based approach to prevention. In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying and understanding patterns of suicide and suicidal behavior throughout a group or population. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities.[48,49]

Although this description suggests a linear progression from the first step to the last, in reality the steps occur simultaneously and depend on each other. For example, systems for gathering information to define the exact nature of the suicide problem may also be useful in evaluating programs. Similarly, information gained from program evaluation and implementation may lead to new and promising interventions. Public health has traditionally used this model to respond to epidemics of infectious disease. During the past few decades, the

model has also been used to address other problems that are likewise complicated and challenging to prevent, such as chronic disease and injury.

The Public Health Approach Applied to Suicide Prevention

Defining the Problem

The first step includes collecting information about incidents of suicide and suicidal behavior. It goes beyond simple counting. Information is gathered on characteristics of the persons involved, the circumstances of the incidents, events that may have precipitated the act, the adequacy of support and health services received, and the severity and cost of the injuries. This step covers the who, what, when, where, how, and how many of the identified problem.

Identifying Causes and Protective Factors

The second step focuses on why. It addresses risk factors such as depression, alcohol and other drug use, bereavement, or job loss. This step may be used to define groups of people at higher risk for suicide. Many questions remain, however, about the interactive matrix of risk and protective factors in suicide and suicidal behavior and, more importantly, how this interaction can be modified.

Developing and Testing Interventions

The next step involves developing approaches to address the causes and risk factors that have been identified. Testing the effectiveness of each approach is a critical part of this step to ensure that strategies are safe, ethical, and feasible. Pilot testing, which may reveal differences among particular age, gender, ethnic and cultural groups, can help determine for whom a suicide prevention strategy is best fitted.

Implementing Interventions

The final step is to implement interventions that have demonstrated effectiveness in preventing suicide and suicidal behavior. Implementation requires data collection as a means to continue evaluating effectiveness of an intervention. This is essential because an intervention that has been found effective in a clinical trial or academic study may have different outcomes in other settings. Ongoing evalua-

tion builds the evidence base for refining and extending effective suicide prevention programs. Determination of an intervention's cost-effectiveness is another important component of this step. This ensures that limited resources can be used to achieve the greatest benefit.

As interventions for preventing suicide are developed and implemented, communities must consider several key factors. Interventions have a much greater likelihood of success if they involve a variety of services and providers. This requires community leaders to build effective coalitions across traditionally separate sectors, such as the health care delivery system, the mental health system, faith communities, schools, social services, civic groups, and the public health system. Interventions must be adapted to support and reflect the experience of survivors and specific community values, cultures, and standards. They must also be designed to benefit from multi-ethnic and culturally diverse participation from all segments of the community.

As it evolves, America's **National Strategy for Suicide Prevention** must recognize and affirm the value, dignity, and importance of each person. Everyone concerned with suicide prevention shares the responsibility to help change and eliminate the societal conditions and attitudes that often contribute to suicide. Individuals, communities, organizations, and leaders at all levels should collaborate in promoting suicide prevention. Final development of a **National Strategy for Suicide Prevention** and the success of these essential action steps ultimately rest with individuals and communities and institutions and policy makers across the United States.

Implementing AIM as an Action Agenda in Communities

As states and local communities apply the public health approach to AIM recommendations, they must consider both population-based and clinical care initiatives. Their first step is to define and to describe the problem of suicide and its associated risk factors locally and measure their magnitude. Next, causes of the conditions found must be identified. Then, community interventions must be designed to address the identified needs through attention to the causes revealed. Evaluating project effectiveness provides guidance for refining the intervention and expanding benefits to other settings. The following hypothetical descriptions of community suicide prevention activities have been created to illustrate applied public health and clinical management prevention models.

Youth

Recognizing the state's increasing rates of substance abuse and suicide among youth, the state public health director in consultation with the Regional Health Administrator brought together concerned representatives to form a state youth suicide, substance abuse and depression prevention coalition. The coalition members reflected many sectors in the community including suicide survivors, educators, social service agencies, the faith community, businesses, the state cooperative extension programs (4-H), school psychologists, child psychiatrists, the PTA, substance abuse treatment counselors, public officials, and the juvenile justice system. The coalition also established a youth advisory board.

After collecting detailed information on the dimensions of youth substance abuse, depression and suicide in the state and identifying how few school systems had screening, referral, and crisis plans, the coalition formed a multidisciplinary study committee to develop a model suicide prevention plan. A broad array of public and professional organizations in the state studied and endorsed the model plan. A corporate partner from the business community provided a grant to distribute the model plan along with a curriculum guide for natural helpers to identify high-risk youth. As school districts adapted the plan and implemented it locally, followup surveys were conducted to determine patterns of use, satisfaction with the model plan and guide, and impact on substance abuse, depression and suicidal behaviors in communities statewide. Based on evidence collected from the evaluations, the model plan was revised to include more guidance on working with the media to de-sensationalize coverage of suicide, and promote abstinence from substance use as well as encourage youth to seek treatment for both substance abuse and depression.

The Elderly

The public health approach has revealed that suicide rates are highest among the elderly and that most elderly suicide victims are seen by their primary care provider within a few weeks of their suicide and are experiencing a first episode of mild to moderate depression. Recognizing that clinical depression is a highly treatable illness, but treatment has not yet been adequately provided in primary care settings, a state with a large elderly population brought together a group of health professionals and community advocates. Together they devised and supported a pilot program to follow depression screening in the primary care setting with the addition of an on-site nurse or social

worker specializing in depression services. These on-site specialists ensured that those elderly patients who screened positive for depression received depression treatment and follow up from the physician and assessed patient progress so that ongoing treatments could be adjusted to increase their effectiveness. Outcomes for patients in the pilot project were compared to those patients receiving usual treatment in comparable primary care settings. This evaluation provided information to fine tune the program and extend its benefits to other primary care settings in the state.

Advancing a National Suicide Prevention Strategy

The 15 recommendations (AIM) presented in this ***Surgeon General's Call to Action*** propose a nationwide, collaborative effort to reduce suicidal behaviors, and to prevent premature death due to suicide across the life span. The conceptual framework for AIM incorporates analysis of suicide risk and protective factors and emphasizes the benefits of effectively treating mental and substance abuse disorders. A comprehensive **National Strategy for Suicide Prevention** should include these elements along with supportive government policy, measurable objectives for the **Strategy**, means of monitoring and evaluating progress, and provision of authority and resources to carry out the **Strategy's** recommendations.

To realize success in preventing suicide and suicidal behaviors, collaboration must be fostered on this public health priority across a broad spectrum of agencies, institutions, groups, and representative individuals throughout the country. As additional elements of a comprehensive **Strategy** evolve, the public and prospective implementation partners must also sustain awareness that improved detection and treatment of mental and substance abuse disorders represent a primary approach to suicide prevention. These partners must ensure the availability of evidence-based guidance for communities to develop and refine effective suicide prevention approaches. Likewise, as communities implement approaches to recognize and reduce risk factors to prevent suicide, they must be aware of the dangers of inadvertently glamorizing suicide, and remain vigilant to avoid doing so. Ongoing review of research, policy, and program advances in suicide prevention may expand the number of effective initiatives and interventions for incorporation into the **Strategy**. Work should continue that outlines measurable objectives for an overall **Strategy**, provides mechanisms for tracking these objectives, and develops means of communicating significant progress in preventing suicide and suicidal self-injury.

Conclusion

Americans in communities nationwide can make a significant difference in preventing suicide and suicidal behaviors. The recommendations presented in **AIM** provide a bluprint and call for action now. Programs and activities that are carried out and evaluated today will generate additional recommendations for effective suicide prevention initiatives in the future. Working together locally, in states, and at the federal level to complete and implement a **National Strategy for Suicide Prevention** is an important step in responding to the major public health problem of suicide in the United States.

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Department of Health and Human Services
U.S. Public Health Service

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: April 24, 2001 **FURTHER REFERRALS: Finance**

Date of Committee Action: April 24, 2001

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 255**

HOUSE BILL NO. 255 **STATEWIDE SUICIDE PREVENTION COUNCIL**

"An Act establishing the Statewide Suicide Prevention Council; and providing for an effective date."

Recommends it be replaced with _____CS_____(_____) [ ] Same Title [ ] New Title
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____

[ ] attach amendments
[ ] add new referral to _____ Committee
[ ] Letter of Intent _____Committee

List of Abbrev. For Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LAA
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES *For Chief Clerk's Office Use Only				
FN# *	List by Dept(s):	Fiscal	Indet.	Zero
	HSS	✓		

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN #	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
John Coghill	Coghill	✓			
Peggy Wilson	Wilson	✓			
	Cissna	✓			
	Soule	✓			
Chair: Fred Dyson	Dyson	X			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 255
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: Statewide Suicide Prevention Council
BRU: Administrative Services
Component: Commissioner's Office
Sponsor: Rep. Porter
Requester: House (HES))
Component Number: 317

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	80.5	83.1	85.6	88.6	91.3	91.3
Travel	50.0	53.9	55.0	55.0	55.0	55.0
Contractual	108.5	112.0	108.4	105.4	102.7	102.7
Supplies	1.0	1.0	1.0	1.0	1.0	1.0
Equipment	10.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	250.0	250.0	250.0	250.0	250.0	250.0
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	125.0	125.0	125.0	125.0	125.0	125.0
1092 MHTAAR	125.0	125.0	125.0	125.0	125.0	125.0
TOTAL	250.0	250.0	250.0	250.0	250.0	250.0

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill establishes a 14-member Suicide Prevention Council. The Council's operating costs would include the salary for a partially exempt Executive Director, office space, travel and per diem costs for the Council to meet twice a year and monthly by teleconference. The balance of the available budget would be applied towards contracts for Suicide Prevention statewide programs and public awareness campaigns, and the completion of an annual report. See attached cost detail.

Prepared by: Janet Clarke
Phone 465-1630
Division: Administrative Services
Date/Time 4/24/01 11:42 AM
Approved by: Elmer A. Lindstrom, Special Assistant
Date 4/24/01 11:42 AM
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

ANALYSIS: (continued)

FY02 cost detail:

$80.5 Personal Services - Range 21 partially exempt program coordinator
$50.0 Travel and per diem for meetings of the full Council
$15.0 Contractual - office space for Exec director and conference room
$ 8.0 Contractual - monthly teleconferences for the full Council
$ 5.0 Contract for annual report
$80.5 Contracts for statewide suicide prevention programs, public awareness campaign
$ 1.0 Office supplies
$10.0 Computers and office furnishings (first year only)

$250.0 FY02 total

HB

259

Alaska State Legislature

House of Representatives

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Representative Harry Crawford
District 22

Memorandum

TO: Representative Fred Dyson,
Chair House Health, Education, and Social Services

FROM: Representative Harry T. Crawford, Jr.

DATE: March 4, 2002

RE: HB 259 Public School Scoliosis Exam

I respectfully request that this bill be scheduled for a hearing in your committee. All the pertinent backup materials requested are attached.

E-mail: Representative_Harry_Crawford@legis.state.ak.us

Alaska State Legislature

House of Representatives

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Representative Harry Crawford
District 22

SPONSOR STATEMENT

HB 259 – PUBILC SCHOOL SCOLIOSIS EXAM

HB 259 legislation that would establish a program to screen for scoliosis for all students in grades 6 through 10. The bill outlines that the screening may be done by a health care provider, a person who has completed a training program such as a gym teacher, or if necessary a parent or guardian.

I introduced this legislation because early detection is the only defense. This legislation may only touch a few people, but for those it does, it will make an enormous difference.

Scoliosis is a progressive disease affecting the spine. It causes a sideward curvature of the back. Adolescent idiopathic scoliosis is the most common form and occurs between the ages of 10 and 13 and most commonly in girls.

Nearly half a million adolescents have spine curvature problems. The earlier it is detected the better chance a person has to correct the problem. When detected in time the progression of smaller curves can be stopped with exercise and wearing a corrective brace. However, failing to detect this disease could result in dangerous surgery, in which steel rods are used to help straighten the spine.

Currently, 22 states are checking for scoliosis. In the State of Alaska, students who participate in sports are checked for scoliosis as part of their physical exam. However we have failed to check the remainder of Alaska's children.

Early and timely detection of curvature of the spine is absolutely mandatory, and this bill goes a long way towards making that possible.

I ask for your support.

E-mail: Representative_Harry_Crawford@legis.state.ak.us

Alaska State Legislature

House of Representatives

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Representative Harry Crawford
District 22

HB 259
Public School Scoliosis Exam

Sectional Analysis

Section 1 (16) establishes a program to detect scoliosis in students. States that a person who does the screening will be a health care provider or someone who has undergone training to screen for scoliosis.

Section 3 (5) requires all school-aged children in grades 6 and 10 to be screened for scoliosis.

E-mail: Representative_Harry_Crawford@legis.state.ak.us

HB 276

Alaska State Legislature

Representative Peggy Wilson
Putting Alaska's Families First

MEMORANDUM

Date:	February 20, 2002
To:	Representative Fred Dyson / HESS Chairman
From:	Representative Peggy Wilson PW
Re:	CSHB 276

Please schedule CSHB 276 before the HESS Committee for a hearing. This bill is essentially a "clean-up" bill related to delegation of nursing.

Attached are:

1. CSHB 276
2. Sponsor Statement
3. Letters of Support

If you have any questions, please feel free to contact my office.

Juneau: State Capitol, Rm. 409 • Juneau, AK 99801-1121 • *ph*: (907) 465-3824 • *fax*: (907) 465-3175
Wrangell LIO: PO Box 109 • Wrangell, AK 99929 • *ph*: (907) 874-3088 • *fax*: (907) 874-3955
Petersburg LIO: *ph*: (907) 772-3829 • *fax*: (907) 772-3779
Sitka LIO: *ph*: (907) 747-4665 • *fax*: (907) 747-5807
Representative_Peggy_Wilson@Legis.state.ak.us • http://www.akrepublicans.org • 1-800-686-3824

Alaska State Legislature

Representative Peggy Wilson
Putting Alaska's Families First

SPONSOR STATEMENT - HB 276

HB 276 is essentially a "clean up bill" which brings nursing statutes up to date with current nursing practice in three areas: (1) gives licensed nurses the authority to delegate nursing duties to other personnel and gives the Board of Nursing authority to promulgate regulations outlining safe delegation practices to ensure safety of the consumer; (2) the bill increases the length of time available for a temporary nursing license from 4 to 6 months to allow for the extra time it may take to get back results of criminal justice background checks required in new regulation; (3) changes the wording placement regarding licensure by endorsement that brings the wording in the statute into compliance with what is already being done in the Division.

Delegation by licensed nurses of specific nursing tasks to unlicensed assistive personnel (UAPs) such as aides and technicians has always been a part of nursing practice. The health care delivery system that includes public health, Indian Health, hospitals, clinics and community nursing facilities will continue to use UAPs. These changes allow specific statutory authority for nurses to delegate essential care to the delivery of safe and effective health care to the citizens of Alaska. I urge you to support HB 276.

12/21/01

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FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 276(L&C)
(H) Publish Date: 2/22/02

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing
BRU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Representative Wilson
Requester: House Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
New funds are not required to implement the changes of this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 2/15/02 2:46 PM
Approved by: Deborah B. Sedwick, Commissioner
Date 2/15/2002
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)

COMMITTEE COPY

D

HOUSE COMMITTEE REPORT

2-22-02

(7)
Date Referred to Committee: May 8, 2001 **FURTHER REFERRALS: HES**

Date of Committee Action: FEBRUARY 20, 2002

The LABOR AND COMMERCE Committee considered: **HB 276**

HOUSE BILL NO. 276 **REGULATION OF NURSING**

"An Act relating to nursing, nurses, and nurse aides."

Recommends it be replaced with ____CS HB 276 (LAC) [ ] Same Title [X] New Title
*For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR*____

[ ] attach amendments
[ ] add new referral to _____ Committee
[ ] Letter of Intent _____Committee

List of Abbrev. For Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LAA
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*For Chief Clerk's Office Use Only

FN# *	List by Dept(s):	Fiscal	Indet.	Zero
1	CED			X

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN #	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP (5)	DNP	NR (1)	AM
	ROKEBY				
	MEYER	✓			
	HAGGS	✓			
	CRAWFORD	✓			
	HALCRO	✓			
Chair:	MURKOWSKI	✓			
Chair:					

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

February 15, 2002

Representative Peggy Wilson
Alaska State Legislature
State Capitol, Room 409
Juneau AK 99801-1182

Dear Rep Wilson:

The House Labor and Commerce Committee will be hearing HB 276 on February 20, 2002. As the president of the Alaska State Hospital and Nursing Home Association (ASHNHA), I am writing a letter of support for the CS for House Bill No. 276, "An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties."

This bill will put into law what has always been a part of nursing practice. The bill gives licensed nurses the authority to delegate nursing duties to other personnel and give the Board of Nursing authority to set out regulations to outline safe delegation of their duties. Because there is such a severe shortage in the nursing profession, extending the temporary nursing license from 4 to 6 months will allow extra time. Any help in this area will be greatly appreciated.

ASHNHA is an organization of 34 healthcare providers around the state of Alaska. We believe that passage of this legislation will allow for better health care delivery to our citizens.

Sincerely yours,

Laraine L. Derr

Laraine L. Derr
President/CEO

426 Main Street, Juneau, Alaska 99801
Phone: 907-586-1790 • Fax: 907-463-3573 • Web: ashnha.com

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ALASKA School Nurses Association

Elizabeth Engle, RN BSN
ASNA President

To: Representative Peggy Wilson

Thank you for introducing HB 276. Nursing is a complex and often poorly understood profession, and in our efforts to meet the health needs of Alaska, we often encounter difficult and frustrating situations. This bill will help to clarify some of those issues, and give some authority in decision making to those who understand the ramifications of those decisions the best.

The Alaska School Nurse Association supports this bill.

Elizabeth Engle, RN, BSN
President, ASNA

Elizabeth Engle

Alaska Nurses Association

t/ 907-274-0827
f/ 907-272-0292

2207 East Tudor Rd, Suite 34
Anchorage, AK 99507-1069
www.aknurse.org
aknurse@aknurse.org

February 14, 2002

Honorable Peggy Wilson
State Capitol, Room 409
Juneau, Alaska 99801-1121

Dear Representative Wilson:

We are writing this letter is support of the CS for HB 276, "An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties." This bill brings the nursing statutes up to date with current nursing practice in the areas of delegation of nursing duties and the issuance of temporary licenses and licenses by endorsement.

Over the last ten years there has been an increase in the number and type of ancillary unlicensed health care workers that RNs and LPNs are required to delegate nursing duties to and have oversight of the work they perform. The Attorney General's office recently ruled that the existing statues do not give the Board of Nursing the authority to promulgate regulations covering delegation of nursing duties to persons other than nursing assistants.

It is imperative that RNs and LPNs have regulations from the Board of Nursing covering delegation of nursing tasks. Nurses rarely hire or train the unlicensed personnel they are required to work with, yet their employers require nurses to make sure these persons perform the tasks delegated to them in a safe and accurate manner. Because these individuals are unlicensed, there is no regulatory body overseeing their training and competency. Nurses need the backing of the regulations promulgated by the Board of Nursing so that they can delegate in a manner that maintains the health and safety of their patients.

The sections of CS for HB 276 which deal with temporary nursing licenses would extended the length of license from 4 to 6 months which would allow the Board of Nursing to complete necessary background checks. The section of the Bill dealing with license by endorsement would bring the statue into compliance with current practice of the Board concerning applicants who have not worked as a nurse in the past five years.

The Alaska Nurses Association is in full support of CS for HB 276.

Sincerely,

Patricia Senner MS, RN, ANP

FEB 19 2002

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: February 22, 2002 **FURTHER REFERRALS:**

Date of Committee Action: 2.26.02

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 276**

HOUSE BILL NO. 276 **REGULATION OF NURSING**

"An Act relating to nursing, nurses, and nurse aides."

Recommends it be replaced with _____CS_____(_____) [ ] Same Title [ ] New Title

For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____

[ ] attach amendments

[ ] add new referral to _____Committee

[ ] Letter of Intent _____Committee

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NEW FISCAL NOTES *For Chief Clerk's Office Use Only				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
DCED	1			✓

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Coghill	✓			
	Kohring	X			
	Dyson	✓			
	Wilson	✓			
	Cissna	✓			
	Toole	✓			
		X			
Chair:		✓			
Chair:					