	state labeled with ADD/ADHD and taking such drugs, as well recording what pressures families have experienced when placing their child on these drugs.			
North Carolina SB 542	Calls for the establishment of a statewide database on the administration of psychotropic drugs to children who receive state services.	03/19/01	PASSED	05/25/01
Utah HB 170	Amends the definition of "substantiated child abuse" to exclude failure to administer psychiatric drugs or course of treatment if the parent has not been told of the opportunity to obtain a physical exam; authorizes Division of Child and Family Services to report an individual who is not a licensed health care provider to the appropriate licensing authority for making medical recommendations regarding administration of psychiatric drugs to children.	01/26/01	PASSED	03/15/01

2002:

State	Description	Introduced	Active	Passed
Illinois SB 1718	Requires school board to adopt and implement policy prohibiting disciplinary action that is based totally or in part on the refusal of a student's parent or guardian to administer or consent to administer a psychotropic or stimulant drug.	01/10/02	PASSED	07/16/02
Virginia HB 90	Board of Education to develop and implement policies prohibiting school personnel from recommending the use of psychotropic drugs for any student. Student cannot be evaluated by a medical practitioner	01/31/02	PASSED	04/01/02

	unless with the written consent of the student's parents.			
National National Foundation of Women Legislators (NFWL) Resolution	National Foundation of Women Legislators (NFWL) urges federal government to pass regulations or laws in relation to schools receiving federal funds that protect children from being wrongly diagnosed and stigmatized as mentally disordered, and forced onto psychotropic drugs as a requisite for their education.	11/23/02	PASSED	11/23/02
Texas HB 320	Refusal to administer or consent to administration of psychotropic drugs or any other psychiatric or psychological treatment to a child does not by itself constitute neglect.	12/20/02	INTRODUCED 12/20/02	

2003:

State	Description	Introduced	Active	Passed
Federal HR 1170	As a condition of receiving funds under any program or activity administered by the Secretary of Education, each State shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services.	3/11/03	Passed the House 5/21/03. Received in the Senate and referred to Committee on Health, Education, Labor and Pensions 5/22/03	
Federal Amendment to HR 1350	Amendment added to federal bill H.R. 1350 reauthorization of the Individuals with Disabilities Education Act: "State educational agency develops and implements policies and procedures prohibiting school personnel from requiring a child to	4/10/03	Passed the House 4/30/03. Received in the Senate and referred to Committee on Health,	

	obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services."		Education, Labor and Pensions 5/01/03	
Alaska SB 5	Prohibits school personnel from recommending or requiring a child take a psychotropic drug as a requisite for attending public school. Also prohibits filing a report to authorities of suspected child abuse or neglect based solely on the parent's/guardian's refusal to consent to the administration of a psychotropic drug or psychiatric, psychological, or behavioral treatment of child. And prohibits a court from making ruling of neglect or abuse against parent solely based on the same allegation.	01/10/03	Referred to Health Education and Social Services Committee and Finance Committee 1/21/03	
California AB 1424	Refusal of a parent or guardian to administer, or consent to administration of any medication or medical treatment for child does not constitute, in and of itself, a basis for child being removed from physical custody of parent or guardian.	2/21/03	Referred to Health committee 4/07/03	
Colorado HB 1172	Requires each school board to adopt a policy prohibiting school personnel from recommending or requiring the use of a psychotropic drug by any student.	1/15/03	PASSED	06/05/03
Hawaii HB 272	Prohibits the Department of Health personnel from requiring, suggesting, or implying that a student take psychiatric drugs as a requisite to attending school.	1/17/03	Passed First Reading 1/21/03	
	Replicates House Bill 274 for the Senate, requiring the Dept. of			

Hawaii SB 981	Health, assisted by the Dept. of Ed., to report annually for 5 years on number of children in schools diagnosed with ADD or ADHD; number of those children who receive special education; how many of those are prescribed and using psychiatric drugs.	1/21/03	Passed First Reading 1/21/03	
Hawaii HB 275	Requires the Dept. of Health and the Dept. of Education to re-examine the legitimacy of the diagnoses of ADHD and ADD in their assessment of children under the category of attention problems and hyperactivity.	1/17/03	Passed First Reading 1/21/03	
Hawaii SB 982	Replicates House Bill 275 for the Senate: Requires the Dept. of Health and the Dept. of Education to re-examine the legitimacy of diagnoses of ADHD and ADD in their assessment of children under the category of attention problems and hyperactivity.	1/21/03	Passed First Reading 1/21/03	
Indiana HB 1974	Prohibits teachers from attempting to influence a parent or guardian to obtain psychotropic drugs for students, and forbids a student from being forced to take a psychotropic drug as a requisite for readmission after suspension for behavioral problems.	1/23/03	To House Committee on Education 1/23/03. Still in House Committee on Education. Rep. Reske added as coauthor 2/18/03	
Kentucky HJR 67	House Joint Resolution that says, because of the concern about psychotropic drug effects and the increase of prescriptions for such drugs to children, the Kentucky Department of Education is requested to provide education and training to school personnel regarding the use of psychotropic drugs, it urges the Cabinet for Families and Children to adopt policy to ensure that a parent's refusal to place a child	1/10/03	Posted in Health & Welfare Committee 2/18/03	

	on psychotropic drugs shall not in and of itself constitute grounds for abuse or neglect.			
Massachusetts SB 674	Prior to practitioners prescribing psychotropic drugs to a minor, they must have the parent or guardian read, or be told verbally if incapable of understanding written information, full information on the psychotropic drug(s) being prescribed from the *Physician's Desk Reference Family Guide to Prescription Drugs* and obtain written attestation that the information, including drug side effects, is understood. Written attest to be kept on file as part of child's record.	1/01/2003	To Committee on Health Care 01/01/03	
Massachusetts SB 811	A parent's or legal guardian's refusal to medicate their child with psychotropic drug(s) or refusing to have him/her receive mental health counseling shall not be considered neglect.	1/01/03	To Joint Committee on Human Services and Elderly Affairs and filed as Senate Docket 703 1/01/03	
Massachusetts SB 2227	Power of the school committee (the governing board of a town's public school system to carry out the educational policies of the state), any teacher, counselor or other agent of school committee shall not include the right to require a student be placed on a psychotropic drug to attend or remain in school, or the right to recommend or suggest the use of a psychotropic drug for any child.	1/01/03	To Committee on Education, Arts and Humanities 1/01/03	
Michigan HB 4024	Creates a psychotropic drug use advisory council to investigate, compile a report, and recommend policies pertaining to psychotropic drug use among children.	1/28/03	To Committee on Family and Children Services 1/28/03	
	Prohibits teachers from making a psychological		Passed through	

Michigan HB 4025	or medical diagnosis of a behavioral condition or disorder in a child or recommending a child having to take a prescribed psychotropic drug.	1/28/03	the House 5/08/03 and referred to Senate Committee on Education 5/13/03	
New Hampshire HB 551	Refusal of a parent or other guardian to administer or consent to the administration of any psychotropic drug to a child shall not, in and of itself, constitute grounds to take the child into custody, or for the court to order that such child be taken into custody.	1/09/03	To Children and Family Law Committee 1/09/03	
New York AB 2955	Enacts a "parent and pupil rights act" whereby all instructional material used in connection with any "psychiatric or psychological research or experimentation program or project," in elementary or secondary school, shall be available for inspection by parents or guardians; also prohibits such programs or projects having the purpose of revealing political affiliations, religious beliefs and practices, sex behavior and attitudes, and other listed privileged information.	2/03/03	Referred to Education Committee 2/03/03	
New York AB 3563	Act amends education law to prohibit all school personnel and school districts from suggesting or recommending use of psychotropic drugs for any child. Any personnel or school district found guilty of the above "may be charged with the crime of professional misconduct...which relates to the practice of medicine without a license." Refusal of a parent or guardian to administer or agree to the administration of a psychotropic drug to a child shall not, in and of itself, constitute grounds for an investigation or	2/06/03	To Education Committee 2/06/03	

	removal of the child by Child Protective Services.			
North Carolina HB 943	Prohibits school personnel from recommending or requiring use of psychotropic drugs or central nervous system stimulants for any child. Each local board of education shall adopt and implement rules and policies on these issues.	4/08/03	Through the House 4/30/03. Referred to Senate Committee on Health and Human Resources 5/01/03	
Oregon SB 456	A kindergarten through grade 12 public school administrator, teacher, counselor or nurse may not recommend student seek a prescription for a medication that is prescribed with the intent of affecting or altering the thought processes, mood or behavior of the student.	2/17/03	Passed through Senate to House 5/23/03	
Texas HB 1070	Parent's refusal to provide written consent for an employee of a school district to conduct a psychological exam, test, treatment or to permit a school employee to administer a psychotropic drug does not constitute neglect or abuse of a child. Any employee of a school district who uses or threatens to use a parent's refusal as the basis for making a report concerning abuse or neglect may be subject to a Class A misdemeanor charge and a parent may bring a civil court action against the school employee.	2/24/03	To Public Education Committee 2/24/03	
Texas HB 1406	School district employee may not recommend student use a psychotropic drug or have a psychiatric evaluation, or use refusal by a parent to consent to administration of a psychotropic drug or psychiatric evaluation for a student as grounds	2/27/03	Through both the House and Senate and sent to the Governor 6/03/03	

	for prohibiting the child from attending class or a school-related activity.			
Vermont SB 30	No school shall require a child to take psychiatric drugs as a requisite for attending school; parent or guardian may agree or disagree to allow the child to take psychiatric drugs; prohibits the unlawful possession of methylphenidate (Ritalin), with up to one year in prison or fines of up to $2,000.	1/23/03	To Senate Committee on Education 1/24/03	
West Virginia SB 122	Requires public schools to comply with provisions of federal law governing release and elicitation of certain information concerning students and their families in connection with mental or health care services. No student may be required to submit to counseling, psychiatric or psychological treatment and experimental procedures, including surveys or tests, without the parents' informed consent. Parents have the right to exclude child from such tests/surveys based on religious, cultural, moral or political beliefs or affiliations.	1/10/03	To Senate Committee on Education 1/10/03	
West Virginia HB 2111	Prohibits teachers and other school personnel from recommending that a pupil is in need of psychiatric treatment or evaluation or psychotropic, mood altering or other mind-altering drugs.	1/10/03	To House Committee on Education 1/10/03	
Arizona HB 2024	A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered to be an abused, neglected or dependent child for that reason alone.		PASSED	12/18/03

2004:

State	Description	Introduced	Active	Passed
United States H.R. 1350	Prohibits State and local educational personnel from requiring a child to obtain a prescription for substances covered by the Controlled Substances Act as a condition of attending school, receiving an evaluation under IDEA, or receiving services.	20/3/03	PASSED	19/11/04
New Hampshire HB 551	A committee to study the prescription and use of psychotropic drugs in childcare centers, preschools, and public schools. Unless otherwise ordered by the court, the refusal of a parent or other person having control of a child to administer or consent to the administration of any psychotropic drug to such child shall not, in and of itself, constitute grounds for a child to be taken into custody.	7/01/04	PASSED	15/06/04
United States H.R. 1350	Prohibits State and local educational personnel from requiring a child to obtain a prescription for substances covered by the Controlled Substances Act as a condition of attending school, receiving an evaluation under IDEA, or receiving services.	20/3/03	PASSED	19/11/04

2005:

State	Description	Introduced	Active	Passed
Florida SB 1090	Creates safeguards for parents in Florida from being coerced to put their children on dangerous psychotropic drugs or from being psychologically evaluated.	March, 2005	PASSED	May 27, 2005
Minnesota SF 2277	Provides that a parent's refusal to consent to the administration of a psychotropic drug or a psychiatric examination of a student shall not be used as grounds, by itself, for prohibiting the child from attending class or participating in a school-related activity. Further, the school district must not recommend that a student use a psychotropic drug.	28/04/05	PASSED	5/5/05

Print this page

Close Window

© 2002-2004 Citizens Commission on Human Rights® International - All Rights Reserved - Webmaster

SB 48

Background Information

Methylphenidate: Pros and Cons

What is methylphenidate?

Methylphenidate, usually known by the trade names Ritalin, Concerta, Metadate and others is one medicine used to treat the symptoms of Attention Deficit Hyperactivity Disorder (ADHD). Some children with ADHD do well using behavior training methods, and may not need a medicine. For other children, this medicine can improve attention, focus, goal-directed behavior, and organizational skills. As with any medicine, there are pros and cons to its use.

How does it work?

Methylphenidate is a stimulant medicine. Since children with ADHD are already over-stimulated, it is hard to understand how a stimulant drug will help to calm them down. Researchers think that the area of the brain that controls when to pay attention to certain activities and when to ignore other ones is immature and works poorly in people with ADHD. The medicine stimulates those areas of the brain so that the child can better pay attention and focus on his activities.

What are the pros?

The medicine works quickly so you'll know if it will help or not. The dosage may have to be adjusted by your health care provider. It is fairly inexpensive and has been used for many years. If your child is having problems with attention, focus, and being overactive in school, stimulant medicine may provide some relief. Benefits of this medicine often include:

- less trouble finishing classwork and homework
- less fidgeting or squirming
- better control of emotions
- less impatience and impulsiveness
- better relationship with family and friends
- increased self-esteem.

What are the cons?

Many parents do not like the idea of medicating their child for any length of time. As with any medicine, it can have side effects. Some children will have few or no side effects. Other children may have to stop using it because of the side effects.

Some common side effects include:

- decrease in appetite
- headaches

- difficulty falling asleep
- irritability
- stomachaches.

Some children may become more active in the evening after the medicine has worn off. This can be an ordeal for families who are tired and stressed out at the end of the day. Some children will have problems sleeping.

Rarely, this medicine causes high blood pressure, weight loss, growth delays, or aggressive behavior. One to two percent of children on this medicine have facial twitches called tics. If your child already had tics, the medicine may make them worse. The tics get better if the medicine is stopped. A few children don't like the way the medicine makes them feel. Most, however, like being better able to concentrate on schoolwork and control their activity level.

About 25% of children with ADHD do not respond to methylphenidate, although some of these children will benefit from other ADHD medicines.

Should my child take methylphenidate?

There are several treatment approaches for ADHD other than medicine, such as:

- changes to the child's education program
- cognitive-behavioral therapy
- parent education
- social skills training.

Discuss the decision to medicate your child with your child's health care providers, school counselors, and teachers. Decide with your doctor if your child's symptoms are causing enough problems that a trial of this medicine is needed.

The medicine is not a cure. There is no cure for ADHD, though medicine can help manage some of the symptoms. If you decide to try medicine, plan a 1 to 4 week trial period. Your child is usually given a small dose at first, so it may be necessary to increase the dose. Be sure to have several people that interact with your child complete rating scales that relate to ADHD behavior after your child has been on the medication for a few weeks. Even if you do decide to try medicine, be sure to get an educational evaluation and use behavioral training methods to help your child as well.

This content is reviewed periodically and is subject to change as new health information becomes available. The information is intended to inform and educate and is not a replacement for medical evaluation, advice, diagnosis or treatment by a healthcare professional.

Copyright © 2005 McKesson Corporation and/or one of its subsidiaries. All Rights Reserved.

Vernon Coleman

This article gives general material and opinions for information only and is not to be considered an alternative to professional medical advice. Readers should consult their family doctors or other qualified medical advisers on any matter relating to their health and wellbeing.

Ritalin: Child Abuse On Prescription?

Family doctors are these days frequently under pressure (usually from teachers and social workers who know nothing about drug therapy and probably understand nothing about the way the international drug industry operates) to prescribe the drug called Ritalin for children who are accused of behaving badly behaved, reported as not doing well at school and 'diagnosed' as suffering from something called Attention Deficit Hyperactivity Disorder (known as ADHD).

For several decades now Ritalin, and other amphetamine type drugs, have been prescribed for children diagnosed as suffering from various types of brain dysfunction and hyperactivity. (Other psychostimulants which have, at one time or another, been regarded as competitors to Ritalin have included Dexedrine).

In my view the first problem is that Attention Deficit Hyperactivity Disorder (and other variations on the hyperactivity theme) is a rather vague diagnosis which is often leapt upon by teachers, social workers and parents to excuse and explain any unacceptable or uncontrollable behaviour.

Parents of children whose behaviour is in any way regarded as different or unusual are often encouraged to believe that their child is suffering from a disease for two simple reasons. First, it is more socially acceptable to give a child a pseudoscientific label than to have to admit that he or she may simply be badly behaved.

Second, when a child has been given a label it is possible to offer a treatment. Commonly it will be one, such as a drug, which offers someone a profit.
ADHD, which is also known as Attention Deficit Disorder (or ADD), hyperkinetic child syndrome, minimal brain damage, minimal brain dysfunction in children, minimal cerebral dysfunction and psycho-organic syndrome in children, is a remarkably non specific disorder. The symptoms which characterise the disorder may include: a chronic history of a short attention span, distractibility, emotional lability, impulsivity, moderate to severe hyperactivity, minor neurological signs and abnormal EEG. Learning may or may not be impaired.

Read that rather nonsensical list of symptoms carefully and you'll find that just about any child alive could probably be described as suffering from ADHD.

What child isn't impulsive occasionally? What child doesn't cry and laugh (that's what emotional lability means)? What child cannot be distracted?

One big worry I have is that Ritalin could be recommended for any child who seemed bored and

restless or who exhibited unusual signs of intelligence or skill. Read the biographies of geniuses and you may wonder what we are doing to our current generation of most talented individuals.

`Is Ritalin a drug in search of a disease?' wrote one author, and it isn't difficult to see why.

First Used In The 1960s

Ritalin has been recommended as a treatment for functional behaviour problems since the 1960s. When CIBA first suggested this in 1961 they were turned down by the FDA but in 1963 approval was given for this use of the drug.

By 1966 the `experts' had come up with a definition of the sort of child for whom Ritalin could useful be prescribed. Children suffering from Minimal Brain Dysfunction (MBD), the first syndrome for which Ritalin was recommended, were defined as `children of near average, average or above average general intelligence with certain learning or behavioural disabilities ranging from mild to severe, which are associated with deviations of function of the central nervous system. These deviations may manifest themselves by various combinations of impairment in perception, conceptualization, language, memory and control of attention, impulse or motor function'.

Other symptoms which children might exhibit and which could be ascribed to MBD included: being sweet and even tempered, being cooperative and friendly, being gullible and easily led, being a light sleeper, being a heavy sleeper and so on and on.
Given that sort of list to work with it is difficult to think of a child who wouldn't benefit from Ritalin - though the official estimate seemed to be that only around 1 in 20 children were real MBD sufferers.

A Convenient Diagnosis

The bottom line is that it has become easy for social workers and teachers to define any children who misbehaves or doesn't learn `properly' as suffering from MBD or ADHD. Its a convenient diagnosis which excuses parents, teachers and social workers from responsibility or any sense of guilt. How can the parents or the teacher be accused of failing when the child is ill?

The head of the task force which identified and labelled MBD allegedly subsequently joined the company making Ritalin and produced their handbook for doctors on the condition. Commercially Ritalin and MBD became a huge success. By 1975 around a million children in the U.S. were diagnosed as suffering from MBD. Half of these were being given drugs and half of those on drugs were on Ritalin.

For the sake of completeness I should point out that Ritalin has not always been used exclusively in the treatment of badly behaved children.

When Dr Andrew Malleson wrote his book `Need Your Doctor Be So Useless' in 1973 he reported that the CIBA Pharmaceutical Company had suggested `to doctors the use of their habit forming drug Ritalin for `environmental depression' caused by `NOISE: a new social problem'.

Does Ritalin Work?

The next question which has to be asked is: `Does Ritalin work?'

Well, I'm afraid that I can't answer that question. And I honestly don't think anyone else can either.

Novartis, the drug company which is now responsible for Ritalin in the UK, admits that 'data on...efficacy of long term use of Ritalin are not complete'.
With one in twenty children said to be suffering from MBD (or ADHD or ADD or whatever else anyone wants to call it), with Ritalin having been on the market and used for this condition for over three decades, and with some experts saying that a million children a year are given Ritalin in the U.S. alone you might find this a trifle disappointing.

Just how long does it take to find out whether or not a drug works? Am I being horribly cynical in suggesting that it might be against the drug company's interests to find out whether or not Ritalin really works? After all, if long term studies found that Ritalin didn't work a very profitable drug would, presumably, lose some of its appeal.
Some research has been done. One five year study of hyperactive children who were given Ritalin at Montreal Children's Hospital found that the children did not differ in the long term from hyperactive children who were not given the drug. At least one investigator has reported that drugs like Ritalin may produce a deterioration in learning new skills at school and parents have reported that the symptoms of MBD have miraculously disappeared during school holidays.

The picture is confused by the fact that there may be a short term improvement in behaviour among children given Ritalin. But is this a real improvement? Or is the child simply drugged? Amphetamine type drugs reduce the variety of behaviour exhibited by children. A child taking Ritalin might have more focused behaviour. But although that might mean less disruption in the classroom does it really help the child? And should we give a child a powerful and potentially hazardous drug because they it keeps him quiet?

There is evidence suggesting that children who are genuinely hyperactive may have been poisoned by food additives or by lead breathed in from air polluted by petrol fumes. If this is so then is giving another potentially toxic drug really the answer to this problem?

Potentially Toxic

The next problem is that I believe that Ritalin can reasonably be described as potentially toxic. Ritalin has been described as 'very safe' but for the record here is a list of some of the possible side effects which may be associated with Ritalin: nervousness, insomnia, decreased appetite, headache, drowsiness, dizziness, dyskinesia, blurring of vision, convulsions, muscle cramps, tics, Tourette's syndrome, toxic psychosis (some with visual and tactile hallucinations), transient depressed mood, abdominal pain, nausea, vomiting, dry mouth, tachycardia, palpitations, arrhythmias, changes in blood pressure and heart rate, angina pectoris, rash, pruritus, urticaria, fever, arthralgia, alopecia, thrombocytopenia purpura, exfoliative dermatitis, erythema multiforme, leucopenia, anaemia and minor retardation of growth during prolonged therapy in children.

Doctors who prescribe Ritalin, and who have the time and the inclination to read the warnings issued with the drug, will discover that Ritalin should not be given to patients suffering from marked anxiety, agitation or tension since it may aggravate these symptoms.

Ritalin is contraindicated in patients with tics, tics in siblings or a family history or diagnosis of Tourette's syndrome. It is also contraindicated in patients with severe angina pectoris, cardiac arrhythmias, glaucoma, thyrotoxicosis, or known sensitivity to methylphenidate and it should be used cautiously in patients with hypertension (blood pressure should be monitored at appropriate intervals).
Ritalin should not be used in children under six years of age, should not be used as treatment for severe depression of either exogenous or endogenous origin and may exacerbate symptoms of behavioural disturbance and thought disorder if given to psychotic children.

The company selling it claims that although available clinical evidence indicates that treatment with Ritalin during childhood does not increase the likelihood of addiction chronic abuse of Ritalin can lead to marked tolerance and psychic dependence with varying degrees of abnormal behaviour.

Ritalin, it is warned, should be employed with caution in emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase the dosage on their own initiative.

Ritalin should also be used with caution in patients with epilepsy since there may be an increase in seizure frequency.

And height and weight should be carefully monitored in children as prolonged therapy may result in growth retardation. (A child might lose several inches in possible height - though if treatment is stopped there is a generally a growth spurt). It is perhaps worth mentioning here my view that if a drug is powerful enough to retard growth it does not seem entirely unreasonable to suspect that the chances are high that it may be having other powerful effects upon and within the body.

Doctors are also warned that careful supervision is required during drug withdrawal, since depression as well as renewed overactivity can be unmasked. Long term follow up may be needed for some patients.

There have also been reports that children have committed suicide after drug withdrawal. And one study has shown that children who are treated with stimulants alone had higher arrest records and were more likely to be institutionalised.
Long term use of Ritalin has been said to cause irritability and hyperactivity (these are, you may remember, the problems for which the drug is often prescribed). In a study published in Psychiatric Research and entitled *Cortical Atrophy in Young Adults With A History of Hyperactivity* brain atrophy was reported in more than half of 24 adults treated with psychostimulants (though I don't think anyone can say for sure whether or not the psychostimulants caused the brain atrophy the possible link should make prescribers, teachers and parents who are fans of Ritalin stop and think for a moment).

In Johannesburg a study of 14 children is said to have produced a response in only 2 children. One child showed some deterioration and another showed marked deterioration.

The final insult is, surely, the fact that the company selling Ritalin tells doctors that `Data on safety and efficacy of long term use of Ritalin are not complete.' For this reason they recommend that patients requiring long term therapy should be monitored carefully with periodic complete and differential blood counts, and platelet counts.
I regard this as an insult because Ritalin is not a new drug.

I have not, at the time of writing this, been able to find out exactly when it was first introduced but I have been able to trace it back to 1961.

Now, maybe I'm being rather demanding but it does seem to me that when a drug has been on the market for well over a quarter of a century it isn't entirely unreasonable for the drug company involved to have completed studying the data on whether or not it works and is safe.

Cancer In Mice

When early safety tests were done on mice researchers found that the drug caused an increased in hepatocellular adenomas and, in male mice only, an increase in hepatoblastomas (described as `a relatively rare rodent malignant tumour type').

`The significance of these results to humans is unknown' say Novartis, the company selling Ritalin.

Here, once again, is yet more proof of the total worthlessness of animal experiments and the ruthless and cynical attitude shown by drug companies and those government departments which allegedly exist to protect the public from unsafe drugs.
I have frequently argued that when drug companies perform pre clinical tests on animals they do so knowing that if the tests show that a drug doesn't cause any problems when given to animals they can use the results to help convince the authorities that the drug is safe.

On the other hand when a drug does cause a problem when given to animals the results can be ignored on the grounds that `the significance of these results to humans is unknown'.

The question here is a very simple one: if the experiments on mice which showed that Ritalin causes cancer were of value why is the drug still available on prescription for children? And if the experiments can safely be ignored (on the grounds that animals are so different to human beings that the results are irrelevant) why the hell were the tests done in the first place?

Ignorance And Misplaced Trust

My own feeling is that the people who told you that Ritalin is 'very safe' are either unable to read or too lazy to do any research into the safety of a product which they are recommending with such enthusiasm.

Years of experience mean that I am not in the slightest bit surprised to find such crass stupidity exhibited by social workers. I am, however, more surprised to find school teachers showing such a potent mixture of ignorance and misplaced trust. Some observers claim that Ritalin can be considered for a children when tests and clinical examinations have shown the existence of a clear neurological disorder - with abnormal brain wave patterns.

Psychiatrist, psychologist, health visitor, teachers, GP and parents should, it is said, all be considered before considering treatment.

Even the company selling Ritalin says that `Ritalin treatment is not indicated in all children with this syndrome and the decision to use the drug must be based on the physician's evaluation of the child's history and the duration and severity of symptoms'.
However, despite this, when a team of researchers from the United Nationals International Narcotics Control Board examined the records of nearly 400 paediatricians who had prescribed Ritalin they found that half the children who had been diagnosed as suffering from MBD (or ADD or whatever) had not been given psychological or educational testing before being given the drug. The United Nations concluded that frustrated parents, teachers and doctors were too quick to stick a label of ADD onto children with behavioural problems (or, to be more accurate, to children whose behaviour was annoying the parents, teachers and doctors).

Less Than Enthusiastic

I am less than enthusiastic about this drug. In my view, the world would be a healthier place if all supplies of this wretched drug were wrapped in concrete and buried in the rubble of the headquarters of the company making the damned stuff.

You might have guessed by now that I wouldn't prescribe Ritalin for anyone - for anything.

But other doctors clearly don't agree with me. Some observers have described Ritalin as a drug

that can unlock a child's potential. And although estimates about the number of children taking Ritalin vary in the U.S. alone it has been claimed that up to 12 % of all American boys aged between 6 and 14 are being prescribed Ritalin to treat various behavioural disorders. In 1990 the world wide production of the drug was less than three tonnes. By 1994 production of the drug had virtually trebled. It is now not unknown for schools to arrange for children to be treated with Ritalin without obtaining parental permission.

It is worth remembering that although doctors, parents and teachers have for over thirty years now been enthusiastically recommending the use of Ritalin (and similar drugs) in the treatment of MBD there are still a number of unanswered questions.
We still do not know whether the drug works and nor do we know whether it causes any permanent long term damage. We do not know whether the listed potential side effects do more damage than any possible good the drug might do. And, perhaps most astonishing of all, despite the fact that millions of children have been diagnosed as suffering from ADHD, ADD or MBD, and treated with powerful drugs, we do not even know whether any of these conditions - or hyperactivity - really exist.

Back in 1970 the Committee on Government Operations of the U.S. House of Representatives studied the use of behaviour modification drugs on children. At that time around 200,000 to 300,000 children a year in the U.S. were being given these drugs and the point was then made that hyperactivity is considered a disease because it makes it difficult for schools to be run `like maximum security prisons, for the comfort and the convenience of the teachers and administrators who work in them...'.
Since then the only thing that has changed is that the popularity of Ritalin has continued to rise and rise and rise inexorably.

Prescribing Ritalin is, in my view, authorised child abuse on a massive, global scale.
But it is clear that the prescribing of powerful mind altering drugs for small children is big business.

In the US the use of antidepressants and stimulants among toddlers aged between two and four tripled between 1991 and 1995. The period between birth and four years of age is a time of great change in the human body. Most importantly it is a time when the brain is maturing. Heaven knows what effect these drugs have on those tiny developing brains.

Ritalin is now widely prescribed for toddlers. So are many other antidepressants, stimulants and other powerful drugs. Remember: typical symptoms of this alleged disease include `restlessness' and `inattentiveness'.

I am delighted that my protests and complaints about these absurd and obscene prescribing habits have drawn a number of vicious complaints from doctors.
In my view every doctor who prescribes such drugs for children with alleged ADHD should be defrocked, given a good thrashing with genetically engineered stinging nettles and forced to emigrate to the USA.

Home

SB 48

Articles

Fairbanks Daily News-Miner

FYI

Councilman backs bill affecting psychotropic drugs in schools

By CHRIS ESHLEMAN
Staff Writer

Monday, April 10, 2006 - A Fairbanks City Council member is asking the council to support a bill in Juneau that seeks to bar employees in public schools in Alaska from recommending the use of psychotropic drugs by students.

While he thinks it is rare that schools would require children to take drugs like Ritalin or Adderall as a prerequisite of attending, Councilman Lloyd Hilling said he is concerned that school employees in Alaska can recommend parents put their children on the drugs without enough understanding of the possible and proven side effects psychotropics can have.

"Let's let scientific research prove these psychotropic drugs," Hilling said. "Meanwhile, let's not be pushing them."

Hilling has put forward a resolution to the council that, if approved, would support a bill introduced last year in the Alaska Legislature. The bill, sponsored by state Sen. Bettye Davis, D-Anchorage, would, in part, prohibit school employees from recommending that a child take a psychotropic drug as a condition for attending a public school.

The bill has not moved from the Senate since it was introduced over a year ago, but a Senate committee plans to hold a public hearing on it Wednesday.

In a sponsor statement on her bill, Davis said it is important that only physicians suggest the use of psychiatric medication. Davis said the use of the drugs in schools has increased rapidly in recent years, and points to parents' concern regarding the issue of diagnosis.

"There are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline," Davis' statement reads.

Hilling said the roles of schools in the prescription of psychiatric drugs has been a concern of his for years. A teacher at the University of Alaska Fairbanks and former teacher's aide, Hilling said he supports Davis' bill in part because it would help require parents around the state to go to doctors for advice without being biased through conversations with school employees.

Chris Eshleman can be reached at 459-7582 or ceshleman@newsminer.com .

The New York Times
nytimes.com

PRINTER-FRIENDLY FORMAT SPONSORED BY THANI FOR SM

March 23, 2006

Panel Advises Disclosure of Drugs' Psychotic Effects

By GARDINER HARRIS

GAITHERSBURG, Md., March 22 — Stimulants like Ritalin lead a small number of children to suffer hallucinations that usually feature insects, snakes or worms, according to federal drug officials, and a panel of experts said on Wednesday that physicians and parents needed to be warned of the risk.

The panel members said they hoped the warning would prevent physicians from prescribing a second drug to treat the hallucinations caused by the stimulants, which one expert estimated affect 2 to 5 of every 100 children taking them. Instead, they said, the right thing to do in such cases was to stop prescribing the stimulants.

On Feb. 9, a different advisory committee voted 8 to 7 to recommend that the Food and Drug Administration place its most serious warning label, a so-called black box, on the labels of stimulants to warn that they could have dangerous effects on the heart, particularly in adults. That recommendation grew out of reports that 25 people, mostly children, had died suddenly while taking the drugs.

Since Ritalin was first approved in the 1950's, stimulants to treat attention deficit disorder and hyperactivity have become among the most widely prescribed medicines in the world. In the United States alone, about 2.5 million children and 1.5 million adults take them; as many as 10 percent of boys ages 10 to 12 do

In addition to Ritalin, two other stimulants, Adderall and Concerta, are popular.

The drugs have been studied in hundreds of trials over five decades and have proven to be extremely effective. But they have always been controversial, with some experts saying they are overprescribed. It is a measure of the difficulty of uncovering the physiological effects of medicines that experts are only now grappling with some of the drugs' serious, though rare, physical and mental effects.

Dr. Thomas B. Newman, an epidemiologist at the University of California, San Francisco, who is a member of the pediatric advisory committee, estimated that out of 100 patients treated for a year with stimulants, 2 to 5 will suffer serious psychotic episodes like hallucinations.

"It's a small number, but it's real," said Dr. Robert M. Nelson, an intensive-care physician at Children's Hospital of Philadelphia and chairman of the committee.

Dr. Kate Gelperin, an F.D.A. drug-safety specialist, told the committee that the agency had discovered a surprising number of cases in which young children given stimulants suffered hallucinations. Most said that they saw or felt insects, snakes or worms, Dr. Gelperin said.

Dr. Gelperin described the case of a 12-year-old girl who said that insects were crawling under her skin. Another child was found by his parents crawling on the ground and complaining that he was surrounded by cockroaches. In both cases, the hallucinations disappeared after drug therapy was stopped. The boy's doctor persuaded his parents to give the stimulants again, and his hallucinations reappeared.

F.D.A. officials made clear to the advisory panel that they considered the reports of hallucinations a problem that deserved a label warning.

"We were struck by the hallucinations," said Dr. Rosemary Johann-Liang, deputy director of the division of drug-risk evaluation at the F.D.A. "We felt it was a drug effect."

The agency does not have to follow the conclusions of its advisory panels, but it usually does. Dr. Robert Temple, director of the Office of Medical Policy at the agency, said after the meeting that the agency would "turn quite quickly to implementing the recommendations we've gotten."

Dr. Temple added, "The area of uncertainty is what to do about the black-box warning on cardiovascular risks in adults."

After the advisory committee meeting in February, agency officials said they had no intention in the near future of placing such warnings on stimulant labels about their potential heart risks.

Wednesday's panel, made up mostly of experts in pediatric medicine and psychiatry, discussed only the potential risks of the drugs among children, while February's group focused mostly on the risks to adults. The pediatric panel agreed with the earlier group that children who have heart problems should probably not be given stimulants. But most children who die suddenly from heart ailments never knew they were at risk, and most children put on stimulant therapy are not given thorough heart evaluations.

"You can't screen 2.5 million children" with intensive heart evaluation tests, Dr. Neison said.

Copyright 2006The New York Times Company | Home | Privacy Policy | Search | Corrections | XML | Help | Contact Us | Work for

SignOnSanDiego.com
THE SAN DIEGO UNION-TRIBUNE

PRINT THIS

Uncle Sam wants you – well, not everyone in prime recruiting age group

By Pauline Jelinek
ASSOCIATED PRESS

9:33 a.m. March 12, 2006

WASHINGTON – Uncle Sam wants YOU, that famous Army recruiting poster says. But does he really?

Not if you're a Ritalin-taking, overweight, Generation Y couch potato – or some combination of the above.

As for that fashionable "body art" that the military still calls a tattoo, having one is grounds for rejection, too.

With U.S. casualties rising in wars overseas and more opportunities in the civilian work force from an improved U.S. economy, many young people are shunning a career in the armed forces. But recruiting is still a two-way street – and the military, too, doesn't want most people in this prime recruiting age group of 17 to 24.

Of some 32 million Americans now in this group, the Army deems the vast majority too obese, too uneducated, too flawed in some way, according to its estimates for the current budget year.

"As you look at overall population and you start factoring out people, many are not eligible in the first place to apply," said Doug Smith, spokesman for the Army Recruiting Command.

Some experts are skeptical.

Previous Defense Department studies have found that 75 percent of young people are ineligible for military service, noted Charles Moskos of Northwestern University. While the professor emeritus who specializes in military sociology says it is "a baloney number," he acknowledges he has no figures to counter it.

"Recruiters are looking for reasons other than themselves," said David R. Segal, director of the Center for Research on Military Organization at the University of Maryland. "So they blame the pool."

The military's figures are estimates, based partly on census numbers. They are part of an elaborate analysis the military does as it struggles each year to compete with colleges and companies for the nation's best and brightest, plan for future needs and maintain diversity.

The Census Bureau estimates that the overall pool of people who would be in the military's prime target age has shrunk as American society ages. There were 1 million fewer 18- to 24-year olds in 2004 than in 2000, the agency says.

The pool shrinks to 13.6 million when only high school graduates and those who score in the upper half on a military service aptitude test are considered. The 30 percent who are high school dropouts are not the top choice of today's professional, all-volunteer and increasingly high-tech military force.

Other factors include:

- the rising rate of obesity; some 30 percent of U.S. adults are now considered obese.
- a decline in physical fitness; one-third of teenagers are now believed to be incapable of passing a treadmill test.

- a near-epidemic rise in the use of Ritalin and other stimulants to treat attention deficit hyperactivity disorder. Potential recruits are ineligible for military service if they have taken such a drug in the previous year.

- Doctors prescribe these drugs to about 2 million children and 1 million adults a month, according to a federal survey. Many more are believed to be using such stimulants recreationally and to stay awake longer to boost academic and physical performance.

Other potential recruits are rejected because they have criminal histories and too many dependents. Subtract 4.4 million from the pool for these people and for the overweight.

Others can be rejected for medical problems, from blindness to asthma. The Army estimate has subtracted 2.6 million for this group.

That leaves 4.3 million fully qualified potential recruits and an estimated 2.3 million more who might qualify if given waivers on some of their problems.

The bottom line: a total 6.6 million potential recruits from all men and women in the 32 million-person age group.

In the budget year that ended last September, 15 percent of recruits required a waiver in order to be accepted for active duty services – or about 11,000 people of some 73,000 recruited.

Most waivers were for medical problems. Some were for misdemeanors such as public drunkenness, resisting arrest or misdemeanor assault – prompting criticism that the Army is lowering its standards.

This year the Army is trying to recruit 80,000 people; all the services are recruiting about 180,000.

And about the tattoos: They are not supposed to be on your neck, refer to gang membership, be offensive, or in any way conflict with military standards on integrity, respect and team work. The military is increasingly giving waivers for some types of tattoos, officials said.

■ On the Net:
Defense Department career and aptitude exploration site: **www.asvabprogram.com**

Find this article at:
http://www.signonsandiego.com/news/military/20060312-0933-unclesamwantsyou.html

☐ Check the box to include the list of links referenced in the article.

Sun-Sentinel.com
http://www.sun-sentinel.com/news/nationworld/ats-ap_health12mar16,1,3869296.story?ctrack=1&cset=true

More Kids Are Getting Anti-Psychotic Drugs

By LINDSEY TANNER
AP Medical Writer

March 16, 2006, 8:07 PM EST

CHICAGO -- Soaring numbers of American children are being prescribed anti-psychotic drugs -- in many cases, for attention deficit disorder or other behavioral problems for which these medications have not been proven to work, a study found.

The annual number of children prescribed anti-psychotic drugs jumped fivefold between 1995 and 2002, to an estimated 2.5 million, the study said. That is an increase from 8.6 out of every 1,000 children in the mid-1990s to nearly 40 out of 1,000.

But more than half of the prescriptions were for attention deficit and other non-psychotic conditions, the researchers said.

The findings are worrisome "because it looks like these medications are being used for large numbers of children in a setting where we don't know if they work," said lead author Dr. William Cooper, a pediatrician at Vanderbilt Children's Hospital.

The increasing use of anti-psychotics since the mid-1990s corresponds with the introduction of costly and heavily marketed medications such as Zyprexa and Risperdal. The packaging information for both says their safety and effectiveness in children have not been established.

Anti-psychotics are intended for use against schizophrenia and other psychotic illnesses.

However, attention deficit disorder is sometimes accompanied by temper outbursts and other disruptive behavior. As a result, some doctors prescribe anti-psychotics to these children to calm them down - a strategy some doctors and parents say works.

The drugs, which typically cost several dollars per pill, are considered safer than older anti-psychotics -- at least in adults -- but they still can have serious side effects, including weight gain, elevated cholesterol and diabetes.

Anecdotal evidence suggests similar side effects occur in children, but large-scale studies of youngsters are needed, Cooper said.

The researchers analyzed data on youngsters age 13 on average who were involved in annual national health surveys. The surveys involved prescriptions given during 119,752 doctor visits. The researchers used that data to come up with national estimates.

Cooper said some of the increases might reflect repeat prescriptions given to the same child, but he said that is unlikely and noted that his findings echo results from smaller studies.

The study appears in the March-April edition of the journal Ambulatory Pediatrics.

Heavy marketing by drug companies probably contributed to the increase in the use of anti-psychotic drugs among children, said Dr. Daniel Safer, a psychiatrist affiliated with Johns Hopkins University, who called the potential side effects a concern.

Safer said a few of his child patients with behavior problems are on the drugs after they were prescribed by other doctors. Safer said he has let these children continue on the drugs, but at low doses, and he also does periodic tests for high cholesterol or warning signs of diabetes.

Dr. David Fassler, a University of Vermont psychiatry professor, said more research is needed before anti-psychotics should be considered standard treatment for attention deficit disorders in children.

"Given the frequency with which these medications are being used, there's no question that we need additional studies on both safety and efficacy in pediatric populations," Fassler said.

Copyright © 2006, The Associated Press

SB 48

Resolution

Introduced by: Council Member Hilling
Date: April 10, 2006

RESOLUTION NO. 4208

A RESOLUTION IN SUPPORT OF SENATE BILL 48, WHICH WOULD PROHIBIT SCHOOL PERSONNEL FROM RECOMMENDING OR REQUIRING PRECRIPTIONS OF PSYCHOTROPIC DRUGS FOR SCHOOL CHILDREN

WHEREAS, the family of psychotropic drugs, such as the Amphetamine-type Ritalin and Adderall, are often prescribed for school age children in Alaska; and

WHEREAS, school personnel often require or recommend to parents that these drugs be prescribed to ameliorate their children's behavior; and

WHEREAS, such drugs pose significant risk for a multitude of proven negative side effects, including negative transformations of personality and even death; and

WHEREAS, Alaska Senate Bill No. 48, "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children," is currently being debated in the Alaska State Legislature; and

WHEREAS, the SB 48 would amend the Alaska Statutes by adding 14.30.171, which reads in part "school personnel may not recommend..." [or require that a parent or guardian obtain a prescription for] "...a child to take or continue to take a psychotropic drug..." (a full copy of the Bill is attached);

NOW, THEREFORE, BE IT RESOLVED that the City Council of the City of Fairbanks supports adoption of SB 48 and encourages the public to review the Bill and provide input to the legislature.

Passed and Approved this 10th day of April, 2006.

_____
STEVE M. THOMPSON, MAYOR

ATTEST:

_____
Carol L. Colp CMC, City Clerk

APPROVED AS TO FORM

_____
Herbert P. Kuss, City Attorney

SB

150

IOUSE COMMITTEE REPO

5.4.05

(7)

Date Referred to Committee: April 27, 2005 **FURTHER REFERRALS: Finance**

Date of Committee Action: May 3, 2005

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **CSSB 150(HES)**

CS FOR SENATE BILL NO. 150(HES) **ALASKA CHILDREN'S TRUST FUND GRANTS**

"An Act relating to the Alaska children's trust grant awards."

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____(_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] 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
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

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

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

Signing with recommendations	Printed Last Name	DP (4)	DNP	NR	AM
Cissna	Cissna	✓			
Berta Gardner	Gardner	✓			
Paul K Seaton	SEATON	X			
Chair					
Chair: K Pedro Wilson	Wilson	X			

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 150
(S) Publish Date: 4/18/05

Revision Date/Time (Note if correction): 04/06/2005 Corrected

Dept. Affected: Health & Social Services

Title: REPEALING LIMITS ON GRANTS AWARDED BY THE ALASKA CHILDREN'S TRUST FUND

RDU: Children's Services

Component: Children's Trust Programs

Sponsor: SENATE (HES)

Requester: SENATE (HES)

Component No.: 2251

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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)						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

The intent of Senate Bill 150 is to allow the Alaska Children's Trust (ACT) more flexibility in grant awards to benefit abused and neglected children. It's goal is to eliminate the cap or limit of dollars that can be awarded to any one grantee through the grant process. The bill also eliminates the current funding formula which is designed to allocate percentages of the cost of the program to be dispersed out over time.

Prepared by: Sherry Hill, Special Assistant to the Commissioner — Phone 465-1618
Division: Office of the Commissioner — Date/Time 04/06/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 04/05/2005
Agency: Department of Health and Social Services

(Revised 9/23/2004 OMB)

SENATOR FRED DYSON

MEMORANDUM

April 27, 2005

To: Representative Peggy Wilson, Chair
House H.E.S.S. Committee

From: Senator Fred Dyson

RE: Request for Hearing SB 150

SB 150 is a Senate H.E.S.S. Committee bill entitled "*An Act relating to the Alaska children's trust grant awards.*" I respectfully request that SB 150 be heard in the House H.E.S.S. Committee as soon as possible. In addition to the attached materials, I would be glad to answer any questions that may arise, as would my staff, Jason Hooley (ext. 3762). Thank you for your consideration. The attached packet contains:

- Sponsor Statement
- CS SB 150 (HES)
- Zero Fiscal Note
- Current Statutes
- 2004 Alaska Children's Trust Annual Report

During Session (January-May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 FAX
During Interim (June-December): 10928 Eagle River Road • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 FAX
Senator.Fred.Dyson@Legis.state.ak.us • www.akrepublicans.org

Health, Education, and Social Services Committee
Alaska State Senate

SPONSOR STATEMENT
CS SB 150 (HES)—*"An Act relating to the Alaska children's trust grant awards."*

The Alaska Children's Trust was created by the Legislature in 1988 to help fund programs around the state aimed at preventing child abuse and neglect. Under current law, the trust may spend the net income earned by the trust to fund community based prevention programs. However, current statute limits the size of grants to $50,000 and provides a specific formula for funding grants. The Board of Trustees has requested additional flexibility in awarding grants. SB 150 removes the $50,000 cap and refines the funding formula. The changes proposed by the bill will allow trustees flexibility in setting grant awards, authority to reduce grants and enforce requirements for program performance, and authority to require applicants to include self-sustainability plans in their proposals. There will be a four-year limit on grant awards. A chart describing the funding formula is provided below.

Grant year	Previous funding amount	New funding amount
1	up to 75% of costs	up to 75% of 1st year costs
2	up to 75% of costs	up to 50% of 1st year costs
3	up to 50% of costs	up to 25% of 1st year costs
4	up to 50% of costs	up to 25% of 1st year costs
5+	up to 25% of costs	N/A

Ensuring a

Bright Future

for all of

Alaska's Children

Alaska's children deserve to grow up in a safe and nurturing environment. The mission of the Alaska Children's Trust is to improve the status of children in Alaska by generating funds and committing resources to eliminate child abuse and neglect.

ALASKA
CHILDREN'S
TRUST


Never fear spoiling children by making them too happy:
Happiness is the atmosphere in which all good

Alaska Children's Trust

Trustees

Joel Gilbertson, Commissioner
Dept. of Health and Social Services

Roger Sampson, Commissioner
Dept. of Education & Early Development

Karen Rehfeld, Deputy Commissioner
Dept. of Education & Early Child Development

Ramy Brooks

Margo McCabe, Chair

Andrea Gelvin

Kaye Saxon

Diane Kaplan

Friends of ACT

Tlisa Northcutt, FACT Chair

State of Alaska

Marcia Kennai, Deputy Commissioner
Office of Children Services
Dept. of Health and Social Services


We worry about what a child will become tomorrow, yet we forget that he is someone today.
Stacia Tauscher

Message from the Chair

Financially, it has been an exciting year for the Alaska Children's Trust (ACT). Assets held by the Trust now exceed $10 million. In Fiscal Year 2005, the ACT awarded a total of approximately $217,314 to 16 grantees in 12 communities around the state. For the first time in history, the ACT also received a $600,000 federal appropriation to develop and implement a social marketing campaign aimed at preventing child abuse in Alaska. A special recognition goes to Senator Ted Stevens and Lisa Sutherland for this grant.

Though the rate of child abuse remains higher in Alaska than anywhere else in the country, the ACT is deeply grateful for an improving financial position to help address this problem. Over the next five years, the ACT will remain focused on its strategic priorities including:

- Implementing a social marketing campaign aimed at preventing child abuse in Alaska;
- Continuing to fund community-based child abuse prevention programs that deliver measurable results;
- Working with the Friends of the Alaska Children's Trust to develop a long-term funding strategy for the ACT;
- Further developing the organizational structure of the Board and related committees/entities to carry out the mission of the ACT.

The Board is committed to building on the hard work of Carol Brice (outgoing chair), the entire past Board and all of its supporters. We welcome two new board members, Andrea Gelvin, an educator from Fairbanks, and Diane Kaplan, president of the Rasmuson Foundation to help us accomplish our mission of preventing child abuse in Alaska. We remain dedicated to our work and to making a difference in the lives of our children.

Margo S. McCabe
Chair

Carol Brice


There are no seven wonders of the world in the eyes of a child.
There are seven million.
Walt Streightiff

Message from the FACT Chair

The Friends of the Alaska Children's Trust (FACT) is comprised of a dedicated Board of Directors that has overseen the fund raising for the Alaska Children's Trust since its inception. In 2004, it raised more than $100,000 for the Children's Trust through special events. In all, it has raised more than $1 million to help eliminate child abuse and neglect.

2004 "Mush for Kids" underwritten by Flint Hills Resources Alaska, LLC.

In April of 2004, the Fairbanks community raised nearly $25,000 at the annual "Mush for Kids." Alaska's popular Iditarod sled dog racer, Ramy Brooks from Healy who serves as a Trustee for the Alaska Children's Trust, signed autographs and had pictures taken with the families alongside his mother, famous sprint musher Roxy Wright. Ramy was joined by Carol Brice, founding member and former chair of the Alaska Children's Trust and long-time community leader who was honored for her many years of service.

Volunteer mushers gave more than 800 children free dog sled rides on a track constructed by volunteers from Brice Inc. and Great Northwest. Inside Pike's Waterfront Lodge, crowds were entertained by Celtic Confusion, Lousiaska, the Johnson-O'Malley Dancers, Randy Smith Middle School Jazz Band and Slightly Askew. Many of Fairbanks' non-profit agencies that provide services to children conducted fun family activities and handed out information about their programs. Outside, three-time Iditarod champion Jeff King signed autographs and talked to children and their parents about mushing. The Fairbanks Police Department, Alaska State Troopers and local fire departments gave children tours of their vehicles. The day also featured ice carving and weight-pull demonstrations, the Musher's Olympics, a hockey shoot and puppy petting pens.

Once again we thank Jeri Wigdahl from Flint Hills Resources Alaska, who joined a cadre of volunteers and organizers to make this a fun and successful day for all. And a special thanks goes to our event coordinator, Lin Gale.

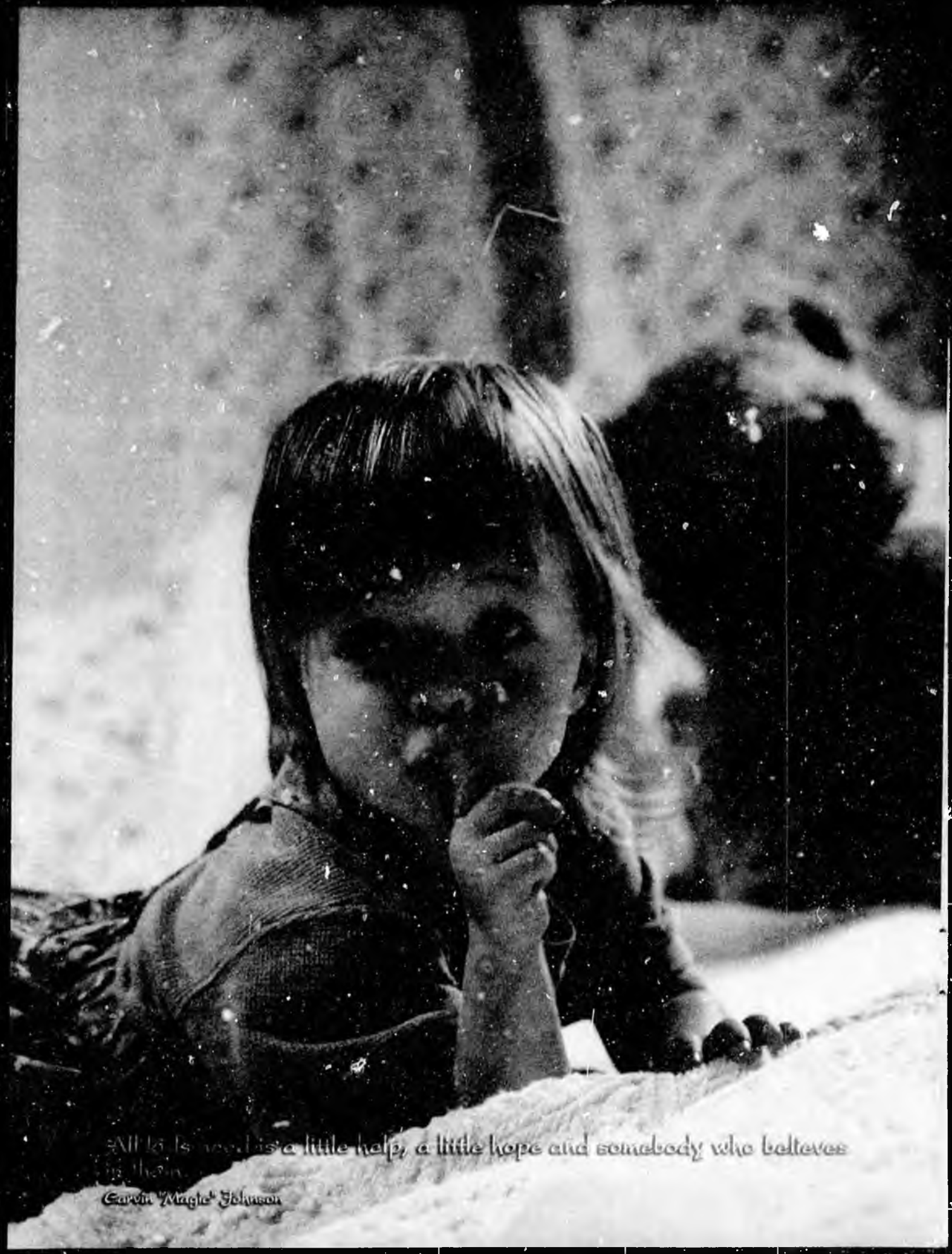
Seventh Annual Golf Classic sponsored by Alyeska Pipeline Service Company.

In August, nearly 100 supporters came out on a chilly Saturday morning to golf for kids. This year, FACT raised $80,000 for the Alaska Children's Trust. The ongoing success of this tournament is due in large part to the support that we receive from Alyeska Pipeline Service Company and its many employees. I would like to thank Alyeska's president David Whyte, Janie Leask, director of Public Affairs, and all of the sponsors and volunteers that help to make this event such a success.

As we look to the new year, FACT will be joining the Alaska Children's Trust to roll out a major campaign to eliminate child abuse and neglect in Alaska. Please join us as we continue our efforts on behalf of Alaska's children.

Tlisa A. Northcutt

Chair


All kids need is a little help, a little hope and somebody who believes
in them.
Earvin "Magic" Johnson

Alaska Children's Trust Overview

The Alaska Children's Trust was established in 1988 with the goal of preventing child abuse and neglect throughout the state. The first legislative appropriation was made in 1996 for $6.8 million. Today, the Alaska Children's Trust boasts a total of $10.3 million dollars.

Seven Trustees, appointed by the Governor, oversee the fiduciary and grant making functions of the Alaska Children's Trust.

The Alaska Children's Trust operates as a savings account. The Fund's principal continues to grow through grants and donations, while the interest from the earnings fund small grants of $30,000 or less to small nonprofits providing prevention programs for child abuse and neglect.

In 2004, the Trustees awarded a total of $217,314 to 16 nonprofits in 12 communities across the state. In all, more than $2 million has been granted to prevention programs and projects.

In 1997, a nonprofit arm of the Trust was formed - the Friends of the Alaska Children's Trust (FACT). The FACT fundraises solely for the Alaska Children's Trust, and annually contributes proceeds in excess of $100,000.

To make a gift, please make check payable to:

The Friends of the Alaska Children's Trust (FACT)

P.O. Box 240249

Anchorage, AK 99524-0249

www.friendsofact.org

(907-248-7676

FACT Tax ID #91-1765129


Good parents give their children roots and wings. Ro
where home is wings to fly away and exercise what's be
Jonas Salk

Financial Statements

(Amounts rounded to nearest thousand)

Statement of Invested Assets

June 30, 2004	
Cash and Equivalents	$ 266,0000
Marketable Debt Securities	5,593,0000
Equity Securities	4,424,0000
Interest and Dividends Receivable	18,0000
Total Investments	**$ 10,301,0000**

Statement of Investment Income and Changes in Invested Assets

June 30, 2004	
Investment Income	$ 812,0000
Total Invested Assets, Beginning of Year	9,595,0000
Net Contributions (Withdrawals)	(106,0000)
Total Invested Assets, End of Year	**$ 10,301,0000**

NOTE: *The June 30, 2004, audited financial statements are available from the Department of Revenue, Treasury Division, by calling Betty Martin, Comptroller, at (907) 465-2350.*

Grantees

Alaska Legal Services Corporation

Anchorage $18,000

Through its Children At Risk program, Alaska Legal Services helps empower parents and children to use the legal system to increase family safety, stability and self-sufficiency.

Bartlett Regional Hospital

Juneau $6,688

The Fathers Project provides support for new fathers and encourages their involvement in child care.

Center for Community

Sitka $20,000

Teach Your Children Well is a parent support project featuring a radio program promoting parent and child health. The project also provides prenatal and parenting classes.

Covenant House Alaska

Anchorage $7,000

Project Nurture offers support services for young new mothers between the ages of 16 and 20.

Fairbanks Counseling & Adoption

Fairbanks $3,333

Responsible Fathers is a program aimed at helping teen fathers increase their involvement with--and responsibility for—their children. Services include parenting education, supervised playtime and teen parent mediation.

Homer Children's Services, Inc.

Homer $4,902

The Birth 2 Three Project is a prenatal and early childhood family education and support program.

Hoonah City Schools

Hoonah $19,810

Parents as Teachers provides primary prevention services including parenting education and support, home visits and assistance to all families seeking Denali KidCare health benefits.

Juneau Family Birth Center

Juneau $7,110

The Young Families Program supports teen families through the pregnancy and parenting experience with a combination of pregnancy and parenting education, labor and birth support, home-based support and referral services.

Resource Center for Parents & Children (RCPC)

Fairbanks $20,000

RCPC is the coordinator for parent education, information and support in the northern region of Alaska. Program grants include the RCPC Community Outreach Video Project, a series of parenting videos focusing on promoting culturally respectful and appropriate parenting skills in rural villages and small communities

REACH, Inc.

Juneau $18,650

The Family Support Project provides behavioral and infant mental health training and consultation to community outreach programs throughout Juneau.

Safe & Fear-Free Environment, Inc. (S.A.F.E.)

Dillingham $7,483

SAFE for LIFE provides children and their families with the tools and information they need to prevent domestic violence and child abuse.

Saxman/Gateway Center

Ketchikan/Saxman $15,000

The Youth Breakfast and Homework Club offers kids a nutritious morning snack at the center before they go to school . Students participate in a variety of activities and discussions that teach them skills to handle conflicts and build confidence. In addition, they receive after school assistance with school projects and homework.

SeaView Community Services

Seward $18,381

SeaView's Incest Awareness Campaign employs education and prevention programs, and early intervention strategies to raise awareness about sexual abuse in families.

Sutton Elementary School

Sutton $10,957

The Eagle's Nest Transitional Preschool, which shares its learning environment with the kindergarten class at Sutton Elementary School, is a unique family resource center that focuses on abuse prevention by promoting early intervention and parental involvement.

Talkeetna Elementary School

Talkeetna $20,000

The Early Childhood Initiative is a program designed to target at-risk children and their families, offering support through home visits and parenting classes.

Tundra Women's Coalition (TWC)

Bethel $20,000

The TWC Children's Program provides after-school group activities for at-risk K–6 children, in addition to a support group for teen girls, parenting sessions with shelter residents, and the Talking About Touching child sexual abuse prevention curriculum.

Total Amount Awarded = $217,314

SB

177

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 24, 2006 **FURTHER REFERRALS: Labor and Commerce**

Date of Committee Action: April 11, 2006

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **CSSB 177(HES)**

CS FOR SENATE BILL NO. 177(HES) **PRACTICE OF PSYCHOLOGY**
"An Act eliminating the prohibition on the use by certain licensed professionals of titles or descriptions of services that incorporate the terms 'psychoanalysis,' 'psychoanalyst,' psychotherapy,' 'psychotherapeutic,' or 'psychotherapist.'"

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____(_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] 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
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

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

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
CED	1			X
HSS	2			X

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
Sylvia McCanna	CISSNA			V	
Berta Gardner	Gardner			X	
Tom Anderson	ANDERSON	X			
Chair: Kegan Wilson		X			
Chair:					

Health, Education, and Social Services Committee
Alaska State Senate

SPONSOR STATEMENT

CS SB 177 (HES)—*"An Act eliminating the prohibition on the use by certain licensed professionals of titles or descriptions of services that incorporate the terms 'psychoanalysis,' 'psychoanalyst,' psychotherapy,' 'psychotherapeutic,' or 'psychotherapist."*

AS 08.86.180 prohibits professionals—except for licensed psychologists and clinical social workers—from using certain terms to describe their services or their titles. These terms include: "psychology," "psychological," "psychologist," "psychometry," "psychotherapy," "psychotherapeutic," "psychotherapist," "psychoanalysis," and "psychoanalyst." This statute was written prior to the licensure of professional counselors (LPC's) and marital and family therapists (LMFT's), who also provide these types of psychological services. LPC's and LMFT's constitute a large portion of Alaska's licensed mental health professional workforce, and are an even larger percentage of professionals working in state funded community mental health centers.

CS SB 177 (HES) was composed with the collaboration of the Alaska Board of Licensed Professional Counselors, the Alaska Psychological Association, the Alaska Board of Psychologist and Psychological Associate Examiners, the Alaska Chapter of the National Association of Social Workers, the Alaska Board of Marital and Family Therapists, and the Alaska Board of Social Work Examiners.

SB 177 updates these statutes to reflect current practice and training as well as maintaining a degree of protection to the public. The language affects licensed clinical social workers, licensed marital and family therapists, and licensed professional counselors.

Sec. 08.86.170. Use of title.

(a) Unless licensed under this chapter, a person may not use the title "psychologist" or a title, designation, or device indicating or tending to indicate that the person is a psychologist or practices psychology.

(b) Unless licensed under this chapter, a person may not use the title "psychological associate" or a title, designation, or device indicating or tending to indicate that the person is a psychological associate or practices counseling or psychometrics.

Sec. ⏭08.86.180⏮. Practice of psychology.

(a) Unless licensed under this chapter, a person may not practice psychology or hold out publicly as a psychologist or as practicing psychology. A person holds out as a psychologist by using a title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychometry," "psychotherapy," "psychotherapeutic," "psychotherapist," "psychoanalysis," or "psychoanalyst" or when holding out publicly to be trained, experienced, or qualified to render services in the field of psychology.

(b) This section does not apply to

(1) a person employed by a governmental unit, educational institution or private agency who may be required to engage in some phase of work of a psychological nature in the course of the person's employment, if the employer maintains appropriate supervision of psychological activities and professional conduct, and if the person is performing the psychological activities as part of the duties for which the person was employed, is performing the activities solely within the facilities of the organization in which the person is employed or under the supervision of the organization in which the person is employed, and does not render or offer to render psychological services to the public for compensation in addition to the salary the person receives from the organization;

(2) a student, intern, or resident in psychology pursuing a course of study approved by the board as qualifying training and experience for a psychologist, if that person's activities constitute a part of that person's supervised course of study and that person is designated by titles such as "psychology intern" or "psychology trainee";

(3) a qualified member of another profession, in doing work of a psychological nature consistent with that person's training and consistent with the code of ethics of that person's profession, if the person does not hold out to the public by a title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychometry," "psychotherapy," "psychotherapeutic," "psychotherapist," "psychoanalysis," or "psychoanalyst" or represent to be trained, experienced, or qualified to render services in the field of psychology.

(4) *[Repealed, Sec. 15 ch 65 SLA 1973].*

(5) a physician engaged in the normal practice of medicine for which the physician is licensed under AS 08.64.

(c) Nothing in this chapter authorizes a person licensed as a psychologist to engage in the practice of medicine, as defined by the laws of the state.

(d) Nothing in this section prohibits a clinical social worker from holding out to the public by a title or description of services incorporating the words "psychotherapy," "psychotherapist," or "psychotherapeutic."

Sec. 08.86.185. Practice of counseling and psychometrics. [Repealed, Sec. 24 ch 58 SLA 1980. For current law, see AS 08.86.180].

Repealed or Renumbered

Psychotherapy means:

the treatment of mental or emotional problems by psychological means

the treatment of psychological disorders or maladjustments by a psychological technique, as psychoanalysis, group therapy, or behavioral therapy. Psychotherapy does not include physiological interventions, such as drug therapy or electroconvulsive therapy, although it may be used in combination with such methods. Behavior therapy aims to help the patient eliminate undesirable habits or irrational fears through the use of principles of conditioning

a set of techniques believed to cure or to help solve behavioral and other psychological problems in humans. The common part of these techniques is direct personal contact between therapist and patient, mainly in the form of talking. Due to the nature of these communications, there are significant issues of patient privacy and/or client confidentiality.

A generic term for the treatment of mental illness or emotional disturbances primarily by verbal or nonverbal communication.

The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth.

(Partial) List of Psychotherapeutic Modalities

- Analytical psychology
- Autogenic psychotherapy
- Behavior therapy
- Biodynamic psychotherapy
- Bioenergetic analysis
- Biosynthesis
- Jungian psychotherapy
- Rogersian psychotherapy
- Cognitive analytic psychotherapy
- Cognitive behavioural psychotherapy
- Concentrative movement therapy
- Core proces psychotherapy
- Daseins analytic psychotherapy
- Encounter groups
- Existential analysis
- Family therapy
- Freudian psychotherapy
- Gestalt therapy
- Group therapy
- Humanistic psychology
- Logotherapy
- Neuro-Linguistic Programming
- Person centred psychotherapy
- Personal construct psychology (PCP)
- Positive psychotherapy
- Postural integration
- Primal integration
- Primal therapy
- Psychoanalysis
- Psychodrama
- Psychodynamic psychotherapy
- Psycho-Organic analysis
- Psychosynthesis
- Pulsing
- Rational emotive behaviour psychotherapy
- Reichian psychotherapy
- Rolfing
- Sophia analysis
- Systemic therapy
- T Groups
- Transactional analysis
- Transpersonal psychotherapy

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 177(HES)
(S) Publish Date: 2/6/06

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Practice of Psychology
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Health, Education & Social Services
Requester: Health, Education & Social Services
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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 ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

SB177 eliminates certain titles or description of services from requiring licensure by the Board of Psychologist and Psychological Associate Examiners. New funds are not required to implement the provisions of this bill.

Prepared by: Jennifer Strickler, Chief
Phone (907) 465-2144
Division: Corporations and Licensing
Date/Time 1/24/06 4:44 PM
Approved by: William C. Noll, Commissioner
Date 1/24/2006
Agency: Commerce, Community and Economic Development

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 177(HES)
(S) Publish Date: 2/15/06
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: USE OF THE TERMS PSYCHOTHERAPY, PSYCHOTHERAPEUTIC, C PSYCHOTHERAPIST

RDU: Health Care Services

Component: Medicaid Services

Sponsor: SENATE (HES) BY REQUEST

Requester:

Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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)						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This bill eliminates the prohibition on the use of the terms 'psychoanalysis', 'psychoanalyst', 'psychotherapy', 'psychotherapeutic' or 'psychotherapist' in descriptions of services or titles by licensed clinical social workers, licensed marital and family therapists, or licensed professional counselors.

This bill is not expected to have an effect on any aspect of the Medicaid program.

Prepared by: Dwayne Peeples, Director — Phone 907-465-5830
Division: Health Care Services — Date/Time 02/02/2006
Approved by: Karleen Jackson, Commissioner — Date 02/07/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

Dear Legislator:

An issue has been brought up to me again by members of the Community Mental Health Center (CMHC) providers association. They are concerned because one of the primary services that they provide is "psychotherapy". There is confusion among them and others because the statutes regarding licensed psychologists says that only they and social workers may call themselves "psychotherapists", and use the terms "psychotherapy" and "psychotherapeutic" to describe the work that they do. This statute was written prior to the licensing of professional counselors (LPC) and marital and family therapists (LMFT) who currently make up close to half of the licensed mental health professionals practicing in the state and an even larger percentage working in state funded community mental health centers (CMHC).

The problem is that "psychotherapy" is a generic term much like "physical therapy". There are many modes of therapy that fall under the umbrella of this generic term and they all have to do with working with people's minds to improve health or alter behavior. Attached are several definitions of psychotherapy easily found on the internet at medical dictionary sites. Also attached is the statutory language limiting the use of the psychotherapy terms and the definition of the practice of psychology.

When billing for services at a CMHC, Medicaid recognizes "psychotherapy" as a service and Medicaid regulations allow all of the four mental health professions to bill for it. However, there is currently confusion and fear that service providers could be found to be billing fraudulently if they have LMFT or LPC staff sign and bill for those services.

It is clear that legislators in the past recognized that psychologists were not the only mental health professionals to practice psychotherapy. Before the licensing of LMFT and LPC clinicians, they amended the psychology statutes to include:

> Sec. 08.86.180. (d) Nothing in this section prohibits a clinical social worker from holding out to the public by a title or description of services incorporating the words "psychotherapy," "psychotherapist," or "psychotherapeutic."

In a survey that I did two years ago, I found that there were only 8 licensed psychologists working in community mental health centers across the state. The rest of the clinical staff were mostly social workers and LPCs with a few MFTs. These numbers help to demonstrate the necessity to make changes to current law in order to recognize the reality of the current workforce, the actual practice of clinical staff, and the need to support clinical staff on whom many rely for mental health services.

Should you wish to contact me to discuss this bill, my email address is alhenry@alaska.net, and my phone numbers are: (H) 272-0816, (cell) 250-5244.

Thank you very much for considering this.
Respectfully,
Anne L. Henry
LPC Board Chair

DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT
Division of Corporations, Business and Professional Licensing

Frank H. Murkowski, Governor
William Noll, Commissioner
Rick Urion, Director

JASW

RECEIVED
JAN 17

January 13, 2006

The Honorable Fred Dyson
Alaska State Senate
State Capitol, Room 121
Juneau, AK 99801-1182

Dear Senator Dyson:

The Board of Social Work Examiners has met and discussed the merits of Senate Bill 177. After discussion and consideration of the Statutes and Regulations governing the licensing of social workers, we are in agreement that the statutory changes proposed in the amended version of SB177 (below) are consistent with the mission of the Board. The amended bill will protect the public safety while better defining the work of the practitioners who serve them.

Amend SB177 to: *Delete proposed changes to Sec. 08.86.180(a) and (b). This maintains the restrictive language currently in Statute, which will prevent unlicensed individuals from using the restricted terminology. This protects the public while remedying the confusion about who is permitted to use the generic terminology to describe the work that is done by all four disciplines.*

Add a change to Sec. 08.86.180: (d) Nothing in this section prohibits a licensed clinical social worker, licensed marital and family therapist or licensed professional counselor from holding out to the public by a title or description of services incorporating the words "psychotherapy", "psychotherapist", "psychotherapeutic", "psychoanalysis", or "psychoanalyst".

Thank you for your sponsorship of SB177.

Respectfully,

Denny Patella

Denny Patella, LCSW, Chairperson
Board of Social Work Examiners

PO Box 110806, Juneau, AK 99811-0806
Telephone: (907) 465-2534 Fax: (907) 465-2974 Website: www.commerce.state.ak.us/occ

JBSAN
SB 177

DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT
Division of Corporations, Business and Professional Licensing

Frank H. Murkowski, Governor
William Noll, Commissioner
Kick Urion, Director

January 10, 2006

The Honorable Fred Dyson
Alaska State Senate
10928 Eagle River Road
Eagle River, AK 99577

Dear Senator Dyson:

This letter is in support of Senate Bill 177, which references the use of words such as "psychotherapy/psychotherapeutic" by licensed mental health professionals. As you know, currently terms such as "psychotherapy", "psychotherapeutic" and "psychotherapist" that are used by Psychologists may not be used by other mental health professionals. We would like to eliminate the requirement that only Psychologists licensed by their Board can use those terms.

The Webster's Dictionary defines "psychotherapy" as "the treatment of psychological disorders or maladjustments"... In the Statutes for Licensed Marriage and Family Therapists, (LMFT) Sec. 08.63.900, the "practice of marital and family therapy" (#5) is defined as (A) "the professional application of assessments and treatments of psychotherapeutic services to individuals, couples and families for the purpose of treating the diagnosed emotional and mental disorders". Therefore, the term "psychotherapeutic" is already being used and is in the Statutes for LMFTs.

In order that the public understand that all licensed mental health professionals are qualified to provide psychotherapeutic services, we need to ensure passage of Senate Bill 177. Currently, there is apparent contradictory information in the Statutes.

The Marriage and Family Therapy licensing Board is in support of Senate Bill 177.

Thank you for your attention to this matter.

Sincerely,

Vivian C. Finlay

Vivian C. Finlay, Chair
Marital & Family Therapists Board

PO Box 110806, Juneau, AK 99811-0806
Telephone: (907) 465-2534 Fax: (907) 465-2974 Website: www.commerce.state.ak.us/occ

April 20, 2005

Senator Fred Dyson, Chair
& Members of Senate H&SS Committee
State Capitol Building
Juneau, Alaska

Re: Senate Bill 177

Senator Dyson,

I am writing to you in support of Senate Bill 177, which seeks to remove the unintentional, discriminatory language that was inserted into state statutes prior to the licensing of LPC and LMFT clinicians in the state of Alaska.

My strong support for the bill stems in part from the shortage of mental health professionals licensed to legally provide services to Alaska's village communities and adolescent populations, given the current wording of the statute. I lend further support given the fact that many clients take comfort in being able to choose from qualified multidisciplinary mental health providers when attempting to obtain needed services; however, due to the language in the current statute, health insurance companies may choose to limit subscriber's coverage to psychologists or clinical social workers only.

Senate Bill 177 would update the statutory language necessary to include licensed professional counselors to provide mental health services that they are clearly schooled and qualified to provide and it would also promote unity among the four professions (psychology, social work, counseling and marriage and family therapy) that are vital in providing access to behavioral healthcare for all Alaskans.

As we rapidly interface with the 21st century, so do our social challenges as a community. I thank you for your support, as one of the many professionals, who is dedicated to moving Alaska forward and supporting quality mental health clinicians and understanding their inclusive scope of practice.

In appreciation of your efforts,
Ann M. Ginn, M.Ed., LPC, LBSW

April 16, 2005

Senator Fred Dyson, Chair, and
Members of Senate HE&SS Committee
State Capitol
Juneau, Alaska

Dear Senator Dyson:

Senate Bill 177 serves a very important purpose to the public, by allowing mental health and related behavioral health professionals to legally provide the services they either already offer mentally ill Alaskans, or could offer them, if this bill is passed.

Many mental health professionals in community mental health centers, and other behavioral health agencies are technically not allowed to use some of the "psychology-related" language, or provide services referred to in this legislation, even though they are trained and qualified to do so. SB 177 would correct that situation.

For Alaskans, this would mean greater access to needed services, often at less cost to them than they currently might pay. They could receive mental health services, and have greater opportunity to use their own insurance to cover those services provided by agencies and providers qualified to perform them.

I strongly encourage you and the Committee to support this legislation, in the best interests of our state and communities.

Thank you,

Pamela Watts, Administrator
Rainforest Recovery Center (formerly Juneau Recovery Hospital)

January 26, 2006

Dear Senator,
As an LPC therapist I do support the passage of bill SB177 but do *not* want to see anything about combining LPC and LMFT boards attached to the bill.

LPC and LMFT disciplines and orientations and often, clients are different. LMFT therapists, as their initials state, specialize in work with families, marriages and couples. LPC's serve a broader base of clientele and our specialties within the field of counseling are diverse. My own specialty is PTSD (post traumatic stress disorder).

As an LPC I want to be responsible for the legal and other expenses in my own area of work. I do not want to take on past, current, or future debt of LMFT's and have my own licensure expense penalized.

I understand the legislature's interest in combining boards to simplify and save State money. But, this does not benefit LPC's in any way and in fact creates more liability for us.

Please do not add anything about combining boards to bill SB177.

Thank you.

Micki Halloran, MA, LPC
2605 Denali Street #203
Anchorage, Alaska 99503
State of Alaska, LPC #329
907-279-1393

Jason Hooley

From: Sen. Fred Dyson
Sent: Monday, January 30, 2006 9:13 AM
To: Jason Hooley
Subject: FW: Hess Committee

From: Ellen Cole [mailto:ecole@alaskapacific.edu]
Sent: Thursday, January 26, 2006 11:30 PM
To: Sen. Fred Dyson; Sen. Gary Wilken; Sen. Donny Olson; Sen. Lyda Green; Sen. Kim Elton
Subject: Hess Committee

Dear Senators,

I am writing to you as director of the Master of Science in Counseling Psychology (MSCP) program at Alaska Pacific University. While I am a psychologist, myself, I and my APU colleagues are responsible for training the next generation of Alaska's Licensed Professional Counselors. We support the passage of SB177 but do not support the combining of the LPC licensing board and the Marriage and Family Therapist licensing board.

We do not think combining the boards would serve either profession well, nor (above all) would it serve the clients with whom we work. There is already enough confusion about the differences between the two professions. Combining the boards would only add to that confusion.

The fact of the matter is that LMFT's specialize in one very particular and focused arena of the counseling world. LPC's practice across a broader range of specialties and have very different training, theoretical orientations, and internship requirements. To become an LPC in Alaska, a graduate student must complete a 60-credit graduate program which includes a 600 hour internship. Then there are 3000 hours of post-graduate supervision and the passage of a national exam. These are rigorous requirements, and those who complete them are very proud of their accomplishments. They chose to become Professional Counselors. Marriage and Family Therapy is an equally fine profession, but it is a different one.

In addition, my understanding is that two difficulties emerge in states that have tried to combine mental health boards. First, turf wars are inevitable and create inefficiency and ill will. Second, combined boards cost more in the long run, because each discipline wants and needs to meet separately in addition to joint meetings.

I hope these comments help with your deliberations. Thank you for your attention.

Ellen Cole, Ph.D.
Professor of Psychology
Director, MSCP
Alaska Pacific University
4101 University Drive
Anchorage, Alaska 99508
tel: 907-564-8216
fax: 907-564-8396
ecole@alaskapacific.edu

Pat Crowe, LPC
PO Box 135
Kodiak, AK 99615
907-486-0846
pcrowe@ak.net

Senator Fred Dyson, Chair, and
Members of Senate HE&SS Committee
State Capitol
Juneau, Alaska

Dear Senator Dyson:

Senate Bill 177 serves a very important purpose to the public, by allowing mental health and related behavioral health professionals to legally provide the services they either already offer mentally ill Alaskans, or could offer them, if this bill is passed.

Many mental health professionals in community mental health centers, and other behavioral health agencies are technically not allowed to use some of the "psychology-related" language, or provide services referred to in this legislation, even though they are trained and qualified to do so. SB 177 would correct that situation.

For Alaskans, this would mean greater access to needed services, often at less cost to them than they currently might pay. They could receive mental health services, and have greater opportunity to use their own insurance to cover those services provided by agencies and providers qualified to perform them.

I strongly encourage you and the Committee to support this legislation, in the best interests of our state and communities.

Thank you,

Pat Crowe

Jason Hooley

om: Joan Soutar [akjbear@yahoo.com]
Sent: Sunday, January 29, 2006 2:00 PM
To: Sen. Fred Dyson; Sen. Gary Wilken; Sen. Donny Olson; Sen. Lyda Green; Senator_Kim_Elton@legis.ak.us
Subject: SB177-comments from a LPC

Ladies and Gentlemen of the Alaska Senate,

I support passage of SB177. I do NOT support combining ahd LPC and the LMFT boards.

I have had different training, different supervision and serve different clients than do LMFT's. I believe that my LPC Board membes stand up for me and my needs.
I want the board members to focus upon LPC licensed individuals.

I need to ask why seek to combine these two boards but not add in social workers, psychologists, psychiatrists and psychological associates into one hugh board? Are you trying to save LMFT individuals in some way by combining their board with the growing number of LPS's?

When I received my initial license the cost was over $800 for two years. Costs have gone progressively down to the $200 I paid in October 2005. The LPC board even adjusted the date of renewal to coincide with our receipt of our Alaska Dividends which I appreciated. I believe my board works hard for me in keeping quality up and costs down. I do not want to take on expenses of individuals who hold a different license.

incerely,

Joan Soutar MA, LPC (#52)

Do You Yahoo!?
Tired of spam? Yahoo! Mail has the best spam protection around http://mail.yahoo.com

Jason Hooley

om: F Kenneth Freedman [fken@alaska.net]
ent: Friday, January 27, 2006 10:57 PM
To: Sen. Fred Dyson
Subject: SB177

Follow Up Flag: Follow up
Flag Status: Completed

Dear Senator Dyson:

Here's my support for SB177 but I do not want to see the boards combined.

Thanks,

F. Kenneth Freedman, LPC

SB

235

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 235(FIN)
(S) Publish Date: 4/12/06

Revision Date/Time (Note if correction):
Dept. Affected: Education

Title: An act relating to school performance incentive payments
RDU: K-12 Support
Component: New -School Performance Incentive Program
Sponsor: Rules Committee
Requester: Governor
Component No.

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	5,800.0	5,800.0	5,800.0	**	**	**
Miscellaneous						
TOTAL OPERATING	5,800.0	5,800.0	5,800.0	**	**	**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	5,800.0	5,800.0	5,800.0	**	**	**
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	5,800.0	5,800.0	5,800.0	**	**	**

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) If funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation will allow the Department of Education & Early Development to establish a school performance incentive program. This program will provide an incentive payment of up to $5,500 for certified personnel and up to $2,500 for noncertified personnel if the students in their school demonstrate substantial growth in achievement on state assessments from one year to the next. Incentive payments will be based on four achievement levels. The cost of the incentive program will not exceed $5.8 million annually because the program is limited to 850 certified staff and approximately 340 non-certified staff. The program will sunset June 30, 2009. This bill also requires LB&A to review the program by December 31, 2008 and recommend whether it should be continued or not.

It is not expected that all 850 certified staff will qualify for the maximum bonus. EED prepared this fiscal note to show the legislature the maximum entitlement under this pilot program. The following page outlines the amount of the bonus for each of the achievement levels.

Prepared by: Eddy Jeans, Director
Phone
Division: School Finance
Date/Time: 2/23/06 12:00 AM
Approved by: Roger Sampson
Date: 2/23/06 12:00 AM
Agency: Commissioner

(Revised 9/23/2004 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 235(FIN)
(S) Publish Date: 4/12/06

ANALYSIS CONTINUATION

Staffing: The department will utilize existing staff, to the extent possible, to calculate the schools that qualify for the bonus at which level, the staff to be awarded the bonus and to make the actual grant payments and provide the accounting support. Depending upon the volume of payments, it may be necessary to hire staff. If so, funds would be transferred from the grant line to cover personnel costs.

The School Performance Incentive Program will have four levels: Strong; High; Excellent; Outstanding. All school staff, certified and non-certified will be eligible for the incentive payment if the students in the school meet the achievement targets. The table below outlines the levels and the amount of the incentive payment for each level:

Achievement Level	Bonus Amount for Cerified Staff	Bonus Amount for Non-Certified Staff
Strong	$2,500	$1,000
High	$3,500	$1,500
Excelent	$4,500	$2,000
Oustanding	$5,500	$2,500
Approximate # of Employees Statewide	9,000	3,700

The following chart illustrates the cost based on 850 certified staff and 340 non-certified staff that would qualify for the incentive at the highest level or $5,500 per certified staff and $2,500 for non-certified staff.

Achievement Level = Oustanding **Range of Cost - Assumptions**

	Number of Certified Staff	Number of Non-Certified Staff	Certified Cost	Non-Certified Cost	Central Office Staff may receive up to 5% of the total paid to all employees at all schools	Total
	850	340	$4,675,000	$850,000	$276,250	$5,801,250

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1 (CORRECTED)
Bill Version: SB 235
(S) Publish Date: 1/17/06

Revision Date/Time (Note if correction):
Dept. Affected: Education

Title: An act relating to school performance incentive payments
RDU: K-12 Support
Component: New -School Performance Incentive Program
Sponsor: Rules Committee
Requester: Governor
Component No.:

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	15,000.0					
Miscellaneous						
TOTAL OPERATING	15,000.0	**	**	**	**	**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	15,000.0					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	15,000.0	**	**	**	**	**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation will allow the Department of Education & Early Development to establish a school performance incentive program. This program will provide an incentive payment of up to $5,500 for certified personnel and up to $2,500 for noncertified personnel if the students in their school demonstrate substantial growth in achievement on state assessments from one year to the next. Incentive payments will be based on four achievement levels. The cost of the incentive program will vary from one year to the next based on the number of schools that qualify and at which level. Because it is not known how many schools will qualify for the incentive payments in FY2007, the deparment will seek an extended lapse date for this appropriation through June 30, 2008.

The following page outlines the amount of the bonus for each of the achievement levels. There is also an estimate of the range of costs for the program. If 5% of Alaska's school staff qualified for the incentive at the highest level, the cost would be approximately $3 million and up to $15 million if 25% qualify.

Prepared by: Barbara Thompson, Director
Phone
Division: Teaching & Learning Support
Date/Time: 1/11/06 3:00 PM
Approved by: Roger Sampson
Date: 1/12/2006
Agency: Commissioner

(Revised 9/23/2004 OMB)

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO. SB 235

ANALYSIS CONTINUATION

Staffing: The department will utilize existing staff, to the extent possible, to calculate the schools that qualify for the bonus at which level, the staff to be awarded the bonus and to make the actual grant payments and provide the accounting support. Depending upon the volume of payments, it may be necessary to hire staff. If so, funds would be transferred from the grant line to cover personnel costs.

The School Performance Incentive Program will have four levels: Strong; High; Excellent; Outstanding. All school staff, certified and non-certified will be eligible for the incentive payment if the students in the school meet the achievement targets. The table below outlines the levels and the amount of the incentive payment for each level:

Achievement Level	Bonus Amount for Cerified Staff	Bonus Amount for Non-Cerified Staff
Strong	$2,500	$1,000
High	$3,500	$1,500
Excelent	$4,500	$2,000
Oustanding	$5,500	$2,500
Approximate # of Employees Statewide	9,000	3,700

The following chart illustrates a range of costs based on estimates of the percentage of school staff that would qualify for the incentive at the highest level or $5,500 per certified staff and $2,500 for non-certified staff:

Achievement Level = Oustanding **Range of Cost - Assumptions**

Assumption % of staff that qualify for bonus	Estimate of Certified Staff that qualify (of approx. 9,000)	Estimate of Non-Certified Staff that qualify (of approx 3,700)	Range of Certified Cost Based on % of staff	Range of Non-Certified Cost Based on % of staff	Central Office Staff may receive up to 5% of the total paid to all employees at all schools	Total
5%	450	185	$2,475,000	$462,500	$146,875	$3,084,375
10%	900	370	$4,950,000	$925,000	$293,750	$6,168,750
15%	1,350	555	$7,425,000	$1,387,500	$440,625	$9,253,125
20%	1,800	740	$9,900,000	$1,850,000	$587,500	$12,337,500
25%	2,250	925	$12,375,000	$2,312,500	$734,375	$15,421,875
30%	2,700	1,110	$14,850,000	$2,775,000	$881,250	$18,506,250
40%	3,600	1,480	$19,800,000	$3,700,000	$1,175,000	$24,675,000
50%	4,500	1,850	$24,750,000	$4,625,000	$1,468,750	$30,843,750
75%	6,750	2,775	$37,125,000	$6,937,500	$2,203,125	$46,265,625
100%	9,000	3,700	$49,500,000	$9,250,000	$2,937,500	$61,687,500

SB235 – School Performance Incentive Program

April 19, 2006

What the bill does –

- Increases student achievement
- Creates the environment for every school employee to work together and focus on greatly increasing student achievement in reading, writing and mathematics
- Rewards school staff for exceeding expectations and accelerating student learning
- Implements proven private sector practice into public education
- Links student academic performance to the bonus
- If we don't see significant increases in student achievement then there is no financial liability
- When schools and kids achieve exceed expectations and more than a years worth of academic growth – Alaska benefits!

Finance CS

- Limits participation to 850 certified staff.
- Requires LB&A review and recommendations to continue beyond June 30, 2009.
- Reduces fiscal note from estimated $15 million to $5.8 million.

More details:

The School Performance Incentive Program -

- Awards bonuses to a school's teachers, administrators and support staff each year that its students show more than a year of academic growth
- Certified Staff may receive bonuses of up to $5,500
- Non-certified staff may receive bonuses of up to $2,500

The program is based on -

- Each student's scores on the state's standards based assessments are compared to his or her performance in the previous year.
- Schools earn points based on how each student does compared to last year. The points are totaled and divided by the number of students in the school to produce a school score.
- The school score is applied to an index that has several levels. There are four bonus levels: the higher the school score, the larger the bonuses.
- If no progress is shown, no bonus is earned.
- The procedures for calculating and awarding the bonus will be established by department regulation.

The benefits to Alaska are -

- Accountability: The money is directly linked to high levels of student learning.
- Effective instruction, staff collaboration, and shared responsibility.
- Enhanced Alaska teacher recruitment efforts.
- Targeting results: no progress, no financial liability to the state.

The expected results of the program are -

- Increases in student achievement.
- Instruction directly linked to outcomes.
- Incentives to work differently and create partnerships that will result in more than a year's growth in learning for students.
- Creative and effective use of instructional time in schools.
- Leveling the playing field for all schools; large or small, high or low – performing.

The changes made in the Senate Finance Committee Substitute -

- Limits the participation in the program to 850 certified staff.
- Requires a sunset review by Legislative Budget & Audit by December 31, 2008, to recommend whether or not the program should be continued beyond July 1, 2009.
- Reduced the fiscal note from estimated $15 million to $5.8 million.

Alaska School Performance Incentive Program

Measuring Individual Student Achievement

What is the Program?

Schoo' Performance Incentive Program

- Performance incentive pay for improved student achievement beyond a year's growth
- Entire staff in a school receive incentive (all or none) includes administrators, teachers, classified
- Target based on individual student growth
- Compares the same student from previous year to current year
- All schools qualify if they meet growth target
- Measurement tool is the Standards Based Assessments (SBA) given annually in April

EDUCATION & EARLY DEVELOPMENT

Benefits

School Performance Incentive Program

- Target not reached = no state financial liability
- Create a strong workforce for Alaska
- Enhance teacher recruitment efforts
- Accountability: directly linked to high levels of achievement
- Promote collaboration, effective instruction and spread responsibility across grade levels and content areas
- Requires focused instruction aligned to Alaska standards