ALASKA LEGISLATURE COMMITTEE FILES, 2001-2006 8672
11755 SENATE HEALTH,EDUCATION & SOCIAL SERVICES

And as Elliot Valenstein, Professor Emeritus of Psychology and Neuroscience at the University of Michigan stated, "There are no tests available for assessing the chemical status of a living person's brain."

Most children who are psychiatrically labeled end up on psychiatric drugs. That's why the psychiatric drugging of children is skyrocketing.

A January 2006 study in *Psychiatric Services* reported that the prescription of stimulants and antidepressants to teens has increased over 200% since 1994. The use of other psychiatric drugs, such as antipsychotics, has increased 385%.

Lawrence Diller, M.D., a well-known behavioral pediatrician at the University of California, San Francisco, and author of the book *Running on Ritalin,* cites IMS Health, a company that compiles prescribing statistics for the pharmaceutical industry, for his finding that between 1995 and 1999 the use of Prozac-like drugs for children under 6 increased 580% and the use of new antipsychotic drugs for children under 18 grew by nearly 300%.

The FDA has recently issued an unprecedented series of warnings about psychiatric drugs. Here are just a few of their findings.

September 15, 2004: The (FDA) reports that a causal role for antidepressants in inducing suicidality has been established in pediatric patients, and children given such drugs are twice as likely to commit suicide as those given a placebo. The FDA orders drug manufacturers to place a Black-Box warning on all antidepressants. The warning came 13 years after a panel composed mostly of psychiatrists with extensive financial ties to the pharmaceutical industry, rejected the evidence of published studies, testimony from victims, and the FDA's own adverse reaction reporting system and told the FDA there was no credible evidence linking antidepressants to suicidality.

June 28, 2005: The FDA issues a statement saying that it would make labeling changes to methylphenidate products such as Ritalin and Concerta describing "psychiatric events" such as suicidal ideation, hallucinations, aggression and violent and psychotic behavior.

September 29, 2005: The FDA orders new Black Box warnings for the ADHD drug Strattera, which was linked in clinical trials to suicidal thinking, suicidal behaviors, as well as agitation and irritability.

February 8, 2006: An FDA advisory panel warns ADHD drugs increase the risk of sudden death and serious cardiovascular problems. Dr. Steven Nissen, a cardiologist at the Cleveland Clinic and a panel member said, "I must say that I have grave concerns about the use of these drugs and grave concerns about the harm they may cause."
Dr. David Graham, a medical officer in the FDA's Office of Drug Safety, described the agency's preliminary analysis of millions of medical records that suggested an increased risk of strokes and arrhythmias. "The number of arrhythmia hospitalizations really struck us as surprising," Dr. Graham said. "Arrhythmia is believed to be the pathway for sudden unexplained death."

March 23, 2006: Another FDA panel reports that 2 – 5% of children who take stimulants for over a year "will suffer serious psychotic episodes like hallucinations." With an estimated six million children taking stimulants that translates into as many as 300,000 psychotic children.

The other problem with the drugs is their lack of effectiveness.

For example, in April 18, 2004 the *Washington Post* reported,

> Of 15 trials conducted among depressed children, 10 failed to show antidepressants were better than dummy pills. Two were inconclusive, and three showed positive results. The negative results have mostly been withheld from public scrutiny by the pharmaceutical companies that paid for the trials, which say that the data are proprietary.

Regarding two Prozac studies that appeared to demonstrate the drug worked better than dummy pills, the Post noted. "But an FDA internal analysis of the trials found Prozac failed on the statistical measure that researchers had originally chosen as their primary benchmark: 'The evidence for efficacy based on the pre-specified endpoint is not convincing.'"

The inefficacy of antidepressants has been known for some time. A 1996 study published in the *Journal of Nervous and Mental Diseases* referred to the "unanimous literature of double-blind studies indicating that antidepressants are no more effective than placebos in treating depression in children and adolescents...."

Conclusion

There is absolutely no justification for the state being involved in forcing a parent to give their child a drug which has been proven to be ineffective and can cause such serious health consequences. A parent's decision not to submit their child to an unscientific labeling procedure which is regularly ridiculed by psychiatrists themselves, or a parent's decision not to play psychiatric Russian roulette with the brain of their child should never be grounds for any action by the state. Over the course of its entire history the psychiatric industry has proven continually that it cannot be trusted to tell the public the actual effects of its drugs and treatments.

Sections 2 and 3 of this bill, which deal with the circumstances under which the state may intervene in the lives of families, should therefore be strengthened. It should state that the refusal of a parent to consent to the psychiatric evaluation and/or psychiatric drugging of a child shall never be considered grounds or evidence for a finding that a child is in need of aid.

Attachmen. #1

Psychiatric Diagnosis and Psychiatric Drugs

Psychiatry's diagnostic manual is the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Herb Kutchins, a professor of social work at California State University and Stuart A. Kirk, the Marjorie Crump Endowed Chair in Social Welfare in the School of Public Policy and Social Research at UCLA, have written two books on the DSM. In *Making Us Crazy*, they reported,

Mental health clinicians independently interviewing the same person in the community are as likely to agree as disagree that the person has a mental disorder and are as likely to agree as disagree on which of the over 300 DSM is present.[1]

Psychiatric disorders are simply lists of human traits fashioned together by committees that allow a clinician to label virtually anyone, particularly any child, mentally ill if they so choose. Paula Caplan, a psychologist who attended one DSM committee meeting, said, "The low level of intellectual effort was shocking. Diagnoses were developed by majority vote on the level we would use to choose a restaurant."[2]

The DSM itself admits, "In DSM-IV [the latest edition] there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or no mental disorder."[3]

Imagine a doctor saying there are no absolute boundaries dividing cancer from diabetes, an infection, or perfect health and you begin to understand the problem. Psychiatry's own diagnostic manual admits it can't distinguish a mental disorder from no mental disorder! This is one of many reasons why the DSM has become the laughingstock of its own profession, regularly criticized by psychiatrists themselves. In the April 2003 issue of *Psychiatric Times*, psychiatrist Paul Genova wrote that the DSM "is so intellectually incoherent as to raise eyebrows among the well-educated, critical thinkers in our own psychotherapy clientele."[4] In a January 2006 column in the *Los Angeles Times*, UCLA psychiatrist Irwin Savodnik accused the American Psychiatric Association of "inventing mental illnesses for the past 50 years" by "turning ordinary human frailty into disease."[5] Loren Mosher, the former Chief of the Center for Studies of Schizophrenia at The National Institute of Mental Health, called the DSM-IV a "fabrication upon which psychiatry seeks acceptance by medicine in general."[6]

Making matters worse, there is no biological or physiological basis to psychiatric diagnosis. The Surgeon General's 1999 report on mental health stated, "...there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness,"[7] and referred to the "lack of objective, physical symptoms."[8] Dr. Harold Pincus, the vice chairman of the DSM-IV task force, writing in the January 2000 issue of *Clinical Psychiatry News*, stated, "There has never been any criterion that psychiatric diagnoses require a demonstrated biological etiology. In fact, virtually no mental disorder except those that are substance induced or due to a general medical condition, has one."

Then why do "experts" claim that mental illnesses are the result of a chemical imbalance? Short of greed, expedience, or ignorance, there is no good explanation. Harvard psychiatrist Joseph Glenmullen has written, "In recent decades, we have had no shortage of alleged biochemical imbalances for psychiatric conditions. Diligent though these attempts have been, not one has been proven. Quite the contrary. In every instance where such an imbalance was thought to have been found, it was later proven false."[9]

Moreover, as Elliot Valenstein, Professor Emeritus of Psychology and Neuroscience at the University of Michigan stated, "There are no tests available for assessing the chemical status of a living person's brain."[10] Last year the President of the American Psychiatric Association (APA), Steven Sharfstein, confirmed Valenstein's statement. He said,"We do not have a clean-cut lab test" to detect chemical imbalances.[11] Dr. Mark Graff, Chair of the Committee of Public Affairs for the APA, confessed, "Chemical imbalance ... it's a shorthand term, really, it's probably drug industry derived."[12]

Psychiatry's diagnostic manual is called a manual of "disorders," not diseases. But even the term "disorder" is misleading. The diagnostic criteria for these "disorders" are normal human behaviors and emotions. The disorders are literally voted into existence at conventions, with arbitrary criteria and arbitrary cutoff points (e.g., requiring someone to meet 5 of 9 diagnostic criteria). According to psychiatrist Nancy Andreasen, the Editor-in-Chief of the *American Journal of Psychiatry*, the boundaries of duration (diagnostic criteria requiring that symptoms last a certain period of time) and severity used in psychiatric diagnosis are "boundaries of convenience ... not boundaries with any inherent biological meaning."[13]

Thus, psychiatric diagnosis is not diagnosis at all. It is simply the employment of medical jargon for the purpose of promoting the notion that individuals experiencing difficulty in life are sick and need "medication."

Attention deficit hyperactivity disorder is a perfect example this. In 1998 the National Institutes of Health held a "Consensus Development Conference on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder." The final Consensus Statement of the conference, presented to the press on Nov. 18, 1998, stated, "...we do not have an independent, valid test for ADHD, and there are no data to indicate that ADHD is due to a brain malfunction." (Actual video from this conference can be viewed at www.cchr.org. Just click on the link, "Video of psychiatrists and doctors admitting that ADHD has no science," to view the shocking ineptitude of the panel of "experts" the NIH assembled. It must be seen to be believed.)

Though psychiatrists use medical terms it is clear that this is primarily a marketing facade. How else could millions of children have been "diagnosed" and "medicated" for an "illness" that, without a valid test or evidence of pathology, has not and, more importantly, *cannot* be shown to exist?

Psychiatric Drugs

The most common treatment for children who are given psychiatric labels is psychiatric drugs. A survey of early-career child and adolescent psychiatrists published in the *Journal of the American Academy of Child and Adolescent Psychiatry* found that 91% prescribed psychiatric drugs.[14] The skyrocketing number of children being prescribed psychiatric drugs indicates that pediatricians and primary care doctors are following psychiatry's lead.

A January 2006 study in *Psychiatric Services* reported that the prescription of stimulants and antidepressants to teens has increased over 200% since 1994. The use of other psychiatric drugs, such as antipsychotics, has increased 385%.[15]

Lawrence Diller, M.D., a well-known behavioral pediatrician at the University of California, San Francisco, and author of the book *Running on Ritalin*, cites IMS Health, a company that compiles prescribing statistics for the pharmaceutical industry, for his finding that between 1995 and 1999 the use of Prozac-like drugs for children under 6 increased 580% and the use of new antipsychotic drugs for children under 18 grew by nearly 300%.[16]

But while the psychiatric and pharmaceutical industries have been relentless in selling their drugs to children, they have been much less eager to reveal the truth about the drugs' effects. It is simply an historical fact that the truth about psychiatric drugs comes only after years, and in many cases decades, of lawsuits, Freedom of Information Act requests, and pressure put on the Food and Drug Administration.

The demand for the truth has recently resulted in an unprecedented series of warnings about psychiatric drugs from the FDA. Here are just a few of their findings.

September 15, 2004: The (FDA) reports that a causal role for antidepressants in inducing suicidality has been established in pediatric patients, and children given such drugs are twice as likely to commit suicide as those given a placebo. The FDA orders drug manufacturers to place a Black-Box warning on all antidepressants. The warning came 13 years after a panel composed mostly of psychiatrists with extensive financial ties to the pharmaceutical industry, rejected the evidence of published studies, testimony from victims, and the FDA's own adverse reaction reporting system and told the FDA there was no credible evidence linking antidepressants to suicidality.

June 28, 2005: The FDA issues a statement saying that it would make labeling changes to methylphenidate products such as Ritalin and Concerta describing "psychiatric events" such as suicidal ideation, hallucinations, aggression and violent and psychotic behavior.

September 29, 2005: The FDA orders new Black Box warnings for the ADHD drug Strattera, which was linked in clinical trials to suicidal thinking, suicidal behaviors, as well as agitation and irritability.

February 8, 2006: An FDA advisory panel warns ADHD drugs increase the risk of sudden death and serious cardiovascular problems. Dr. Steven Nissen, a cardiologist at the Cleveland

Clinic and a panel member said, "I must say that I have grave concerns about the use of these drugs and grave concerns about the harm they may cause."
Dr. David Graham, a medical officer in the FDA's Office of Drug Safety, described the agency's preliminary analysis of millions of medical records that suggested an increased risk of strokes and arrhythmias. "The number of arrhythmia hospitalizations really struck us as surprising," Dr. Graham said. "Arrhythmia is believed to be the pathway for sudden unexplained death."[17]

March 23, 2006: Another FDA panel reports that 2 – 5% of children who take stimulants for over a year "will suffer serious psychotic episodes like hallucinations."[18] With an estimated six million children taking stimulants that translates into as many as 300,000 psychotic children.

These warnings only touch the surface of what has been revealed about these drugs over the past few months and more dangers appear every day. A recent study in *Cancer Letters*, for example, found that treatment with Ritalin (methylphenidate) produced significant chromosome aberrations and called for further investigations "in view of the well-documented relationship between elevated frequencies of chromosome aberrations and increased cancer risk."[19] Duke University researchers recently presented the results of a study which "found heart patients taking antidepressants had a 55 percent higher risk of dying than those not taking antidepressants."[20]

A February 9, 2006 study published in the *New England Journal of Medicine* found an association between maternal exposure to SSRI antidepressants during late pregnancy and persistent pulmonary hypertension (PPHN) in newborns. PPHN is a life-threatening condition in which babies do not receive enough oxygen in the blood and require intensive-care treatment to survive.[21] An April 2006 study in the *American Journal of Obstetrics and Gynecology* has reported, "The use of selective serotonin reuptake inhibitors in pregnancy may increase the risks of low birth weight, preterm birth, fetal death, and seizures."[22]

The other problem with the drugs is their lack of effectiveness.

On April 18, 2004 the *Washington Post* reported,

Of 15 trials conducted among depressed children, 10 failed to show antidepressants were better than dummy pills. Two were inconclusive, and three showed positive results. The negative results have mostly been withheld from public scrutiny by the pharmaceutical companies that paid for the trials, which say that the data are proprietary.[23]

Regarding two Prozac studies that appeared to demonstrate the drug worked better than dummy pills, the Post noted, "But an FDA internal analysis of the trials found Prozac failed on the statistical measure that researchers had originally chosen as their primary benchmark: 'The evidence for efficacy based on the pre-specified endpoint is not convincing.'"[24]

The inefficacy of antidepressants has been known for some time. A 1996 study published in the *Journal of Nervous and Mental Diseases* referred to the "unanimous literature of double-

blind studies indicating that antidepressants are no more effective than placebos in treating depression in children and adolescents...."[25]

A study published in the *British Medical Journal* last year found,

Recent meta-analyses show selective serotonin reuptake inhibitors have no clinically meaningful advantage over placebo.
Evidence that antidepressants are more effective in more severe conditions is not strong, and data on long term outcome of depression and suicide do not provide convincing evidence of benefit.[26]

Stimulants and antipsychotics are equally ineffective. According to psychiatrist Peter Breggin, "Ritalin's lack of effectiveness has been proven by hundreds of studies but has not been revealed to doctors, teachers or parents."[27] Instead, the dubious results of flawed studies are trumpeted to the public while the authors keep quiet about their negative findings. The 1999 Multimodal Treatment Study for Attention-Deficit Hyperactivity Disorder is a classic case of this. Widely touted, it was neither placebo controlled nor double blind (parents and teachers knew which children were on stimulants), although one group of blind classroom observers found no superiority of drugs over behavioral approaches.[28] Moreover the children themselves did not feel benefited and 64% experienced adverse drug reactions.

Increasing numbers of children are being prescribed antipsychotics, arguably the most powerful and dangerous psychiatric drugs. A recent study in *The New England Journal of Medicine* that compared a conventional antipsychotic with four newer "atypical" antipsychotics found, "...74 percent of patients discontinued the study medication before 18 months.... The majority of patients in each group discontinued their assigned treatment owing to inefficacy or intolerable side effects or for other reasons.[29]

The vast majority of patients in this study discontinued treatment within 3 – 5 months. The "Duration of successful treatment" was 3 months for one drug and 1 month for all the others.

It is impossible to convey in a few pages the amount of damage these drugs have produced. But we should mention that many of the teen school shooters had been prescribed these drugs, which are known to cause violent, psychotic states. In 1999 Dr. Malcolm Bowers of Yale University reported in *Clinical Psychiatry News* that psychosis induced by the newer antidepressants (known as selective serotonin reuptake inhibitors or SSRIs) accounted for 8% of all general psychiatric hospital admissions over one 14-month period.[30]

Here is a partial list of teen shooters over the past few years:

Jeff Weise, Red Lake, MN, **Prozac**
Eric Harris, Columbine High School, Littleton, CO, **Luvox**
Jason Hoffman, Granite Hills High School, CA, **Effexor, Celexa**
Thomas Soloman, Conyers, GA, **Ritalin**
Kip Kinkle, Springfield, OR, **Prozac, Ritalin**

Cory Baadsgaard, Mattawa, WA, **Paxil, Effexor**. Held 23 students hostage with rifle. No one killed.
Michael Carneal, West Padukah, KY. Reportedly on **Ritalin**.
Luke Woodham, Pearl, MI, reportedly on **Prozac**
Elizabeth Bush, Williamsport, PA, **antidepressants**
Dominick Maldonado, Tacoma, WA, **Ritalin**
Andrew Golden, Jonesboro, AK, **Ritalin**
Unnamed 13 year-old killer of Louise Frazier, Seattle, WA, **Prozac**

1. Herb Kutchins and Stuart A. Kirk, *Making Us Crazy*, The Free Press, 1997, p. 52.
2. Paula Caplan, *They Say You're Crazy*, Addison Wesley, New York, 1995, p. 90.
3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, DSM-IV, p. xxii.
4. Paul Genova, "Dump the DSM!" *Psychiatric Times*, April 1, 2003, p. 72.
5. Irwin Savodnik, "Psychiatry's Sick Compulsion: turning weaknesses into diseases," *Los Angeles Times*, January 1, 2006.
6. Loren Mosher, Letter of Resignation from the American Psychiatric Association, 4 Dec. 1998, available at: http://www.moshersoteria.com/resig.htm.
7. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, p. 44.
8. Ibid., p. 48.
9. Joseph Glenmullen, *Prozac Backlash*, 2000, p. 196.
10. Elliot Valenstein, *Blaming the Brain*, 1998.
11. Steven Sharfstein, "All Fired Up," *People*, 11 July 2005, p. 87.
12. Mark Graff, CBS 2 News Interview, July 10, 2005.
13. Marcia Andreasen, "Linking Mind and Brain in the Study of Mental Illnesses: A Project for a Scientific Psychopathology," *Science*, 14 March 1997: 1586-1593.
14. Dorothy Stubbe and W. John Thomas, "A Survey of Early-Career Child and Adolescent Psychiatrists: Professional Activities and Perceptions," *Journal of the American Academy of Child and Adolescent Psychiatry*, 41:2, February 2002, pp. 123- 130.
15. Cindy Thomas, Peter Conrad, Rosemary Casler, et al., "Trends in the Use of Psychotropic Medications Among Adolescents, 1994 to 2001," *Psychiatric Services*, January 2006, Vol. 57, No. 1, pp. 63-69.
16. Lawrence Diller, "Kids on Drugs," salon.com, March 9, 2000. URL: http://dir.salon.com/health/feature/2000/03/09/kid_drugs/index.html.
17. Gardiner Harris, "Warning Urged on Stimulants Like Ritalin," *New York Times*, February 8, 2006.
18. Gardiner Harris, "Panel Advises Discloser of Drugs' Psychotic Effects," *New York Times*, March 23, 2006.
19. El-Zein et al., "Cytogenic effects in children treated with methylphenidate," *Cancer Letters*, Volume 230, Issue 2, 18 December 2005, Pages 284-291.

20. Amanda Gardner, "Antidepressants Boost Heart Patients' Death Risk."MedicineNet.com, http://www.medicinenet.com/script/main/art.asp?articlekey=60314.
21. Chambers et al., "Selective Serotonin-Reuptake Inhibitors and Risk of Persistent Pulmonary Hypertension of the Newborn," *New England Journal of Medicine*, 354;6, February 9, 2006, pp. 579-587.
22. Wen et al., "Selective Serotonin Reuptake Inhibitors and adverse pregnancy outcomes," *American Journal of Obstetrics and Gynecology* (2006), 194(4),961-966.
23. Shankar Vedantam, "Antidepressant Use in Children Soars Despite Efficacy Doubts," *Washington Post*, April 18, 2004, p. A01.
24. Ibid.
25. Fisher et al., "Antidepressants for Children," *The Journal of Nervous and Mental Diseases*, 1996, v. 184, no.2.
26. Joanna Moncrief, Irving Kirsch, "Efficacy of antidepressants in adults," *British Medical Journal* 2005; 331:155-157.
27. Dr. Peter Breggin, "Psychiatrist Discloses Ritalin's Hidden Dangers to Children" http://www.breggin.com/Ritalinprnews.html.
28. Breggin, "A Critical Analysis of the NIMH Multimodal Treatment Study for Attention-Deficit/Hyperactivity Disorder (The MTA Study)," http://www.breggin.com/mta.html.
29. Lieberman et al, "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia," *New England Journal of Medicine*, Vol. 353, No. 12, September 22, 2005, p. 1209.
30. Quoted by Todd Zwillich, Senior Writer, *Clinical Psychiatry News*, 27(6):34, 1999.

24-LS0208\L
Mischel
4/11/06

CS FOR SENATE BILL NO. 48( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children."

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

* **Section 1.** AS 14.30 is amended by adding new sections to read:

Article 2A. Psychiatric and Behavioral Evaluations and Treatments.

Sec. 14.30.171. Prohibited actions. Except as provided in AS 14.30.172 - 14.30.176, school personnel may not, unless otherwise authorized by law,

(1) recommend to a parent or guardian that a child take or continue to take a psychotropic drug as a condition for attending a public school;

(2) require that a child take or continue to take a psychotropic drug as a condition for attending a public school;

(3) conduct a psychiatric or behavioral health evaluation of a child;

(4) recommend a specific licensed physician, psychologist, or other health specialist to a parent or guardian for a child;

(5) recommend that a parent or guardian seek or use for a child

(A) a psychotropic medication; or

(B) a psychiatric or psychological treatment; or

(6) except when refusal of consent causes a child to suffer mental injury or neglect, as defined in AS 47.17.290, make a report of suspected child abuse or neglect to authorities, including the Department of Health and Social Services, based solely on the fact that a parent or guardian refuses to give signed consent for

(A) the administration of a psychotropic drug to a child;

(B) a psychiatric, psychological, or behavioral treatment of a child; or

(C) a psychiatric or behavioral health evaluation of a child.

Sec. 14.30.172. Communication not prohibited. (a) Nothing in AS 14.30.171 may be construed to prohibit school personnel from

(1) consulting or sharing classroom-based observations with parents or guardians regarding a student's academic and functional performance, behavior in the classroom or school, or regarding the need for evaluation for special education or related services as long as school personnel do not

(A) make an assertion or recommendation that violates AS 14.30.171; or

(B) denigrate, criticize, punish, or attempt to denigrate, criticize, or punish, a parent, guardian, or child for a decision made by the parent or guardian pertaining to whether the child takes, does not take, or discontinues taking a psychotropic medication; or

(2) exercising their authority relating to the placement within the school or readmission of a child who may be or has been suspended or expelled for a violation of a school disciplinary and safety program adopted under AS 14.33.110 - 14.33.140.

(b) Nothing in AS 14.30.171 may be construed to prevent teachers or other school personnel from complying with the requirements of AS 47.17.020.

Sec. 14.30.174. Compliance with federal education law. (a) Notwithstanding AS 14.30.171(3) and (5), a behavioral or mental health professional working within a

public school system may, for the sole purpose of complying with federal education law,

(1) recommend, but not require, a psychiatric or behavioral health evaluation of a child;

(2) recommend, but not require, psychiatric, psychological, or behavioral treatment for a child; and

(3) conduct a psychiatric or behavioral health evaluation of a child with the consent of the child's parent or guardian.

(b) In this section,

(1) "behavioral health professional" means a person who has a master's degree in psychology, social work, counseling, or a related field with specialization or experience in working with children experiencing behavioral, physical, and emotional disabilities, and is working within the scope of the person's training and experience; "behavioral health professional" does not include a person employed as a teacher;

(2) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools and Communities Act of 1994), 29 U.S.C. 794 (nondiscrimination under federal grants and programs), and 42 U.S.C. 12101 - 12213 (equal opportunity for individuals with disabilities);

(3) "mental health professional" has the meaning given in AS 47.30.915.

Sec. 14.30.176. List of community resources. Notwithstanding AS 14.30.171(4), a school district may make available to an interested parent or guardian a list of community resources, including mental health services if the list conspicuously states the following: "This list is provided as a resource to you. The school neither recommends nor requires that you use this list or any of the services provided by individuals or entities on the list. It is for you to decide what services, if any, to use and from whom you wish to obtain them."

Sec. 14.30.177. Violations. (a) A violation of AS 14.30.171 - 14.30.176 constitutes substantial noncompliance with a school law of the state for purposes of dismissal of a teacher under AS 14.20.170 or nonretention of a teacher under

AS 14.20.175.

(b) Each school board shall adopt a bylaw under AS 14.14.100 that provides that violation of AS 14.30.171 - 14.30.176 is grounds for disciplinary action against a person employed by the school district.

Sec. 14.30.179. Definition. In AS 14.30.171 - 14.30.179, "public school" means a school operated by publicly elected or appointed school officials in which the program and activities are under the control of those officials and that is supported by public funds.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/12/05

FURTHER: Judiciary

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4.12.06

Health, Education and Social Services Committee considered

SENATE BILL NO. 48

SB 48 PSYCH. EVALUATION/TREATMENT FOR STUDENTS

"An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children."

and recommends:

[X] be rep'aced with _____ CS fav. SB 48 (HES)

[ ] adopt **previous** _____ CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[x] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
EED	3/31		X		
HSS	3/31			X	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
~~EED~~			X		

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
K. L. Gees	✓			
Gary Wilson			✓	
Grace Cole			✓	
CHAIR: Fred Thayn	✓			

SB

49

Senator Hollis French

Capitol Room 504
465-3892
465-6595 fax

MEMORANDUM

Date: February 3, 2005

To: Senator Fred Dyson, Chair
Senate Health and Social Services Committee

From: Senator Hollis French

RE: Request for Hearing on SB 49 – "An Act relating to listing certain anabolic steroids as controlled substances"

This is a request that you schedule a HESS Committee hearing on SB 49 – – "An Act relating to listing certain anabolic steroids as controlled substance" at the earliest possible time. The bill has been referred to your committee, with a further reference to the Judiciary Committee.

I have attached a copy of the bill for your information. Additional materials will be made available to the committee aide next week.

Attachment

ALASKA STATE LEGISLATURE

Senate
Judiciary
Committee
•
Senate
Labor & Commerce
Committee
•
Senate
Administrative
Regulation Review
Committee

SENATOR HOLLIS FRENCH

Senator_Hollis_French@legis.state.ak.us
www.akdemocrats.org

While in Session
State Capitol
Juneau, Alaska 99801
(907) 465-3892
1 (866) 465-3892
Fax: (907) 465-6595
•
While in Anchorage
716 West 4th Avenue
Anchorage, Alaska 99501
(907) 269-0234
Fax: (907) 269-0238

SB 49 – OUTLAWING THE DISTRIBUTION AND USE OF ANABOLIC STEROIDS

Sponsor Statement

Alaska is one of only two states in the nation that do not outlaw anabolic steroids. SB 49 is meant to correct this oversight. While there is no strong evidence of rampant steroid abuse in Alaska, 20 percent of the state athletic directors recently surveyed indicated that they suspected steroid use among the young people they coached directly or those who played on other sports teams at their schools.

Anabolic steroid use is on the rise. While several recent allegations of steroid use by professional and Olympic athletes have garnered widespread media attention, less publicized but no less important is the rise in use by young people. Research supported by the National Institute of Drug Abuse indicates that steroid use among the nation's twelfth graders nearly doubled between 1991 and 2002, from 2.1 percent to 4 percent.

Despite recurring reports on the negative consequences of steroid abuse, many bodybuilders, athletes, and fitness buffs use anabolic steroids in the belief that the substances give them a competitive advantage and improve their physical performance. Young people who use anabolic steroids are particularly at risk. Some of the physical symptoms of steroid abuse include liver disorders, severe acne, high blood cholesterol levels, and sexual and reproductive disorders. Possible psychological disturbances include mood swings, depression, extreme irritability, hostility, and aggression.

Anabolic steroids are currently legal under Alaska law. Under SB 49, simple possession of anabolic steroids without a prescription would be a misdemeanor, and distribution or sale of anabolic steroids would be a felony. Please join me in supporting this bill, which is intended to make certain that athletes in Alaska do not yield to the temptation of steroids.

February 4, 2005

Alaska State Legislature
Senator Hollis French
Representative Ethan Berkowitz

WEB: http://www.akdemocrats.org
CONTACT: Minta Montalbo
PHONE: (907) 465-3892
FAX: (907) 465-6595
EMAIL: french@akdemocrats.org
ROOM: #504 State Capitol Bldg.

FOR IMMEDIATE RELEASE · February 4, 2005

French, Berkowitz Target Anabolic Steroids

Right now, there's no state law against use, possession

JUNEAU -- Sen. Hollis French and Rep. Ethan Berkowitz, both D-Anchorage, have filed bills to make the possession and use of anabolic steroids illegal in Alaska. Alaska is one of only two states in which steroids are still legal.

Anabolic steroid use is on the rise. Several recent allegations of steroid use by professional and Olympic athletes have gotten widespread media attention, but use by young people is also up. Research supported by the National Institute of Drug Abuse indicates that steroid use among the nation's 12th graders nearly doubled between 1991 and 2002, from 2.1 percent to 4 percent.

Despite recurring reports of the negative consequences of steroid abuse, many bodybuilders, athletes, and fitness buffs use anabolic steroids in the belief the substances give them a competitive advantage and improve their physical performance.

"While I have not found strong evidence of rampant steroid abuse in Alaska," said Senator French, "20 percent of the state athletic directors recently surveyed indicated that they suspected steroid use among the young people they coached directly or those who played on other teams at their schools. In good conscience, we cannot continue the loophole in our laws that allows our youth access to these dangerous substances."

Young people who use anabolic steroids are particularly at risk, although abuse of steroids can harm users of any age. Some of the physical symptoms of steroid abuse include liver disorders, severe acne, high blood cholesterol levels, and sexual and reproductive disorders. Possible psychological disturbances include mood swings, depression, extreme irritability, hostility, and aggression.

Under SB 49 and HB 80, simple possession of anabolic steroids without a prescription would be a misdemeanor under state law, and distribution or sale of anabolic steroids would be a felony. Federal law also outlaws the distribution, use, and sale of anabolic steroids.

#####

Steroid Abuse in Today's Society

A Guide for Understanding Steroids and Related Substances

March 2004

A Guide for Understanding Steroids and Related Substances

Once viewed as a problem strictly associated with body builders, fitness "buffs," and professional athletes, the abuse of steroids is prevalent in today's society. This is an alarming problem because of increased abuse over the years, and the ready availability of steroids and steroid related products. The problem is widespread throughout society including school-age children, athletes, fitness "buffs," business professionals, etc. The National Institute on Drug Abuse (NIDA) estimates that more than a half million 8th and 10th grade students are now using these dangerous drugs, and increasing numbers of high school seniors don't believe steroids are risky. Another study indicated that 1,084,000 Americans, or 0.5 percent of the adult population, said that they had used anabolic steroids. These are just a couple of examples of how widespread the problem has become.

Some people are taking dietary supplements that act as steroid precursors without any knowledge of the dangers associated with their abuse. Dietary supplements are sold in health food stores, over the internet, and through mail order. People may believe that these supplements will produce the same desired effects as steroids, but at the same time avoid the medical consequences associated with using steroids. This belief is dangerous. Supplements may also have the same medical

consequences as steroids.

This guide will help you understand why steroids are being abused, and how you can educate athletes and others about the dangers of these drugs. This guide will also discuss the dangerous medical effects of illegal use of steroids on health. The short-term adverse physical effects of anabolic steroid abuse are fairly well known. However, the long-term adverse physical effects of anabolic steroid abuse have not been studied, and as such, are not known. In addition, abuse of anabolic steroids may result in harmful side-effects as well as serious injury and death. The abuser in most cases is unaware of these hidden dangers. By working together we can greatly reduce the abuse of anabolic steroids and steroid related products. It is important to recognize this problem and take preventive measures to protect athletes and other users.

WHAT ARE ANABOLIC STEROIDS?

Anabolic steroids are synthetically produced variants of the naturally occurring male hormone testosterone. Both males and females have testosterone produced in their bodies: males in the testes, and females in the ovaries and other tissues. The full name for this class of drugs is **androgenic** (promoting masculine characteristics) **anabolic** (tissue building) **steroids** (the class of drugs). Some of the most abused steroids include Deca-Durabolin® , Durabolin ® , Equipoise® , and Winstrol® . The common street (slang) names for anabolic steroids include arnolds, gym candy, pumpers, roids, stackers, weight trainers, and juice.

The two major effects of testosterone are an androgenic effect and an anabolic effect. The term androgenic refers to the physical changes experienced by a male during puberty, in the course of development to manhood. Androgenic effects would be similarly experienced in a female. This property is responsible for the majority of the side effects of steroid use. The term anabolic refers to promoting of anabolism, the actual building of tissues, mainly muscle, accomplished by the promotion of protein synthesis.

WHY ARE STEROIDS ABUSED?

Anabolic steroids are primarily used by bodybuilders, athletes, and fitness "buffs" who claim steroids give them a competitive advantage and/or improve their physical performance. Also, individuals in occupations requiring enhanced physical strength (body guards, construction workers, and law enforcement officers) are known to take these drugs. Steroids are purported to increase lean body mass, strength and aggressiveness. Steroids are also believed to reduce recovery time between workouts, which makes it possible to train harder and thereby further improve strength and endurance. Some people who are not athletes also take steroids to increase their endurance, muscle size and strength, and reduce body fat which they believe improves personal appearance.

WHERE DO YOU GET STEROIDS?

Doctors may prescribe steroids to patients for legitimate medical purposes such as loss of function of testicles, breast cancer, low red blood cell count, delayed puberty and debilitated states resulting from surgery or sickness. Veterinarians administer steroids to animals (e.g. cats, cattle, dogs, and horses) for legitimate purposes such as to promote feed efficiency, and to improve weight gain, vigor, and hair coat. They are also used in

veterinary practice to treat anemia and counteract tissue breakdown during illness and trauma. For purposes of illegal use there are several sources; the most common illegal source is from smuggling steroids into the United States from other countries such as Mexico and European countries. Smuggling from these areas is easier because a prescription is not required for the purchase of steroids. Less often steroids found in the illicit market are diverted from legitimate sources (e.g. thefts or inappropriate prescribing) or produced in clandestine laboratories.

HOW ARE STEROIDS TAKEN?

Anabolic steroids dispensed for legitimate medical purposes are administered several ways including intramuscular or subcutaneous injection, by mouth, pellet implantation under the skin and by application to the skin (e.g. gels or patches). These same routes are used for purposes of abusing steroids, with injection and oral administration being the most common. People abusing steroids may take anywhere from 1 to upwards of a 100 times normal therapeutic doses of anabolic steroids. This often includes taking two or more steroids concurrently, a practice called "stacking." Abusers will often alternate periods (6 to 16 weeks in length) of high dose use of steroids with periods of low dose use or no drug at all. This practice is called "cycling." Another mode of steroid use is called "pyramiding." With this method users slowly escalate steroid use (increasing the number of drugs used at one time and/or the dose and frequency of one or more steroids), reach a peak amount at mid-cycle and gradually taper the dose toward the end of the cycle. Please see "Appendix A" for additional information on patterns of anabolic steroid abuse.

Doses of anabolic steroids used will depend on the particular objectives of the steroid user. Athletes (middle or high school, college, professional, and Olympic) usually take steroids for a limited period of time to achieve a particular goal. Others such as bodybuilders, law enforcement officers, fitness buffs, and body guards usually take steroids for extended periods of time. The length of time that steroids stay in the body varies from a couple of days to more than 12 months.

Examples of oral and injectable steroids are as follows:

Oral Steroids	Injectable Steroids
• Anadrol® (oxymetholone) • Oxandrin® (oxandrolone) • Dianabol® (methandrostenolone) • Winstrol® (stanozolol)	• Deca-Durabolin® (nandrolone decanoate) • Durabolin® (nandrolone phenpropionate) • Depo-Testosterone® (testosterone cypionate) • Equipoise® (boldenone undecylenate) (veterinary product) ®

PHYSICAL & PSYCHOLOGICAL DANGERS

There is increasing concern regarding possible serious health problems that are associated with the abuse of steroids, including both short-term and long-term side effects (see Appendix B). The short-term adverse physical effects of anabolic steroid abuse are fairly well known. Short-term side effects may include sexual and reproductive disorders, fluid retention, and severe acne. The short-term side effects in men are reversible with discontinuation of steroid use. Masculinizing effects seen in women, such as deepening of the voice, body and facial hair growth, enlarged clitoris, and baldness are not reversible.

The long-term adverse physical effects of anabolic steroid abuse in men and in women, other than masculinizing effects, have not been studied, and as such, are not known. However, it is speculated that possible long-term effects may include adverse cardiovascular effects such as heart damage and stroke.

POSSIBLE PHYSICAL SIDE EFFECTS INCLUDE THE FOLLOWING:

- High blood cholesterol levels - high blood cholesterol levels may lead to cardiovascular problems
- Severe acne
- Thinning of hair and baldness
- Fluid retention
- High blood pressure
- Liver disorders (liver damage and jaundice)
- Steroids can affect fetal development during pregnancy
- Risk of contracting HIV and other blood-borne diseases from sharing infected needles
- Sexual & reproductive disorders:

Males	Females
• Atrophy (wasting away of tissues or organs) of the testicles • Loss of sexual drive • Diminished or decreased sperm production • Breast and prostate enlargement • Decreased hormone levels • Sterility	• Menstrual irregularities • Infertility • Masculinizing effects such as facial hair, diminished breast size, permanently deepened voice, and enlargement of the clitoris.

POSSIBLE PSYCHOLOGICAL DISTURBANCES INCLUDE THE FOLLOWING:

- Mood swings (including manic-like symptoms leading to violence)
- Impaired judgment (stemming from feelings of invincibility)
- Depression
- Nervousness
- Extreme irritability
- Delusions
- Hostility and aggression

LAWS AND PENALTIES FOR ANABOLIC STEROID ABUSE

The Anabolic Steroids Control Act of 1990 placed anabolic steroids into Schedule III of the Controlled Substances Act (CSA) as of February 27, 1991. Under this legislation, anabolic steroids are defined as any drug or hormonal substance chemically and pharmacologically related to testosterone (other than estrogens, progestins, and corticosteroids) that promotes muscle growth.

The possession or sale of anabolic steroids without a valid prescription is illegal. Simple possession of illicitly obtained anabolic steroids carries a maximum penalty of one year in

prison and a minimum $1,000 fine if this is an individual's first drug offense. The maximum penalty for trafficking is five years in prison and a fine of $250,000 if this is the individual's first felony drug offense. If this is the second felony drug offense, the maximum period of imprisonment and the maximum fine both double. While the above listed penalties are for federal offenses, individual states have also implemented fines and penalties for illegal use of anabolic steroids. State executive offices have also recognized the seriousness of steroid abuse and other drugs of abuse in schools. For example, The State of Virginia enacted a new law that will allow student drug testing as a legitimate school drug prevention program. Some other states and individual school districts are considering implementing similar measures.

The International Olympic Committee (IOC), National Collegiate Athletic Association (NCAA), and many professional sports leagues (e.g. Major League Baseball, National Basketball Association, National Football League (NFL), and National Hockey League) have banned the use of steroids by athletes, both because of their potential dangerous side effects and because they give the user an unfair advantage. The IOC, NCAA, and NFL have also banned the use of steroid precursors (e.g. androstenedione) by athletes for the same reason steroids were banned. The IOC and professional sports leagues use urine testing to detect steroid use both in and out of competition.

COMMON TYPES OF STEROIDS ABUSED

The illicit anabolic steroid market includes steroids that are not commercially available in the U.S. as well as those which are available. Steroids that are commercially available in the U.S. include fluoxymesterone (Halotestin®), methyltestosterone, nandrolone (Deca-Durabolin® , Durabolin ®), oxandrolone (Oxandrin®), oxymetholone (Anadrol®), testosterone, and stanozolol (Winstrol®). Veterinary steroids that are commercially available in the U.S. include boldenone (Equipoise®), mibolerone, and trenbolone (Revalor®). Other steroids found on the illicit market that are not approved for use in the U.S. include ethylestrenol, methandriol, methenolone, and methandrostenolone.

STEROID ALTERNATIVES

A variety of non-steroid drugs are commonly found within the illicit anabolic steroid market. These substances are primarily used for one or more of the following reasons: 1) to serve as an alternative to anabolic steroids; 2) to alleviate short-term adverse effects associated with anabolic steroid use; or 3) to mask anabolic steroid use. Examples of drugs serving as alternatives to anabolic steroids include clenbuterol, human growth hormone, insulin, insulin-like growth factor, and gamma-hydroxybutyrate (GHB). Examples of drugs used to treat the short-term adverse effects of anabolic steroid abuse are erythropoietin, human chorionic gonadotropin (HCG), and tamoxifen. Also, diuretics and uricosuric agents may be used to mask steroid use. The following chart illustrates how masking is accomplished:

Drug Group	Drug or Effect	How drug masks steroid use
Uricosuric Agents	Probenecid	Decreases entry of steroids into the urine
Diuretics	Spironolactone, Furosemide	Dilutes steroid concentration in the urine
Epitestosterone	Decreases Testosterone to	Reduces detection of

Epitestosterone ratio	testosterone usage

Over the last few years, a number of metabolic precursors to either testosterone or nandrolone have been marketed as dietary supplements in the U.S. These dietary supplements can be purchased in health food stores without a prescription. Some of these substances include androstenedione, androstenediol, norandrostenedione, norandrostenediol, and dehydroepiandtrosterone (DHEA), which can be converted into testosterone or a similar compound in the body. Whether they promote muscle growth is not known.

ARE ANABOLIC STEROIDS ADDICTIVE?

An undetermined percentage of steroid abusers may become addicted to the drug, as evidenced by their continuing to take steroids in spite of physical problems, negative effects on social relations, or nervousness and irritability. Steroid users can experience withdrawal symptoms such as mood swings, fatigue, restlessness, and depression. Untreated, some depressive symptoms associated with anabolic steroid withdrawal have been known to persist for a year or more after the abuser stops taking the drugs.

HOW WIDESPREAD IS THE PROBLEM?

In today's society people are willing to take great risk to excel in sports and perform their jobs better. Also, we live in a society where image is paramount to some people. Therefore, the popularity of performance enhancing drugs such as anabolic steroids and anabolic steroid substitute products are the choice of some people to achieve these goals. Steroid abuse is still a problem despite the illegality of the drug and the banning of steroids by various sports authorities and sports governing bodies. The following examples indicate how diverse this problem is and how widespread it is across all age groups.

General Public

The Substance Abuse and Mental Health Services Administration's National Household Survey on Drug Abuse determined 1,084,000 Americans, or 0.5 percent of the adult population, said that they had used anabolic steroids. In the 18 to 34 age group, about 1 percent had ever used steroids.

School-Age Children

The "Monitoring the Future" study conducted in 2002 determined that since 1991 there has been a significant increase of steroid use by school age children. This annual study, supported by the NIDA and conducted by the Institute for Social Research at the University of Michigan, surveys drug use among eighth, tenth, and twelfth graders in the United States. The first year data was collected on younger students was in 1991. Since 1991 there has been a significant increase in reported steroid use by teenagers. For all three grades, the 2002 levels represent a significant increase from 1991. The following chart illustrates the increase of steroid abuse among teenagers who reported using steroids at least once in their lifetime:

Percent of Students Reporting Steroid Use 1991 - 2002

Year	Eighth grade	Tenth Grade	Twelfth Grade
1991	1.9%	1.8%	2.1%
1999	2.7%	2.7%	2.9%
2002	2.5%	3.5%	4.0%

The 2002 survey also indicated additional data related to steroid abuse by school age children:

Percent of Students Reporting Steroid Use in 2002

Student Steroid Use	Eighth grade	Tenth Grade	Twelfth Grade
Past month use	0.8%	1.0%	1.4%
Past year use	1.5%	2.2%	2.5%
Lifetime use	2.5%	3.5%	4.0%

In addition, the 2002 survey also determined how easy it was for school aged children to obtain steroids. The survey indicated 22% of eighth graders, 33.2% of tenth graders, and 46.1% of twelfth graders surveyed in 2002 reported that steroids were "fairly easy" or "very easy" to obtain. More than 57% of twelfth graders surveyed in 2002 reported that using steroids was a "great risk." Also, another study indicated that steroids are used predominately by males. The survey determined the annual prevalence rates were two to four times as high among males as among females.

The "Monitoring the Future" study also determined that misuse and abuse of steroids is a major concern among school aged children. Some of their findings are alarming and indicate a need for concern:

- A survey in 1999 determined that 479,000 students nationwide, or 2.9 percent, had used steroids by their senior year of high school.
- A survey in 2001 determined the percentage of 12th graders who believed that taking these drugs causes "great risk" to health declined from 68 percent to 62 percent.

The Center for Disease Control and Prevention (CDC) conducts the Youth Risk Behavior Surveillance Study, a survey of high school students across the United States. A survey conducted in 2001 indicated that 5% of all high school students reported lifetime use of steroid tablets/injections without a doctor's prescription. The survey also indicated that 5.8% of ninth graders, 4.9% of tenth graders, 4.3% of eleventh graders, and 4.3% of twelfth graders reported lifetime illegal use of steroids.

A majority of the studies performed on steroid abuse indicate males are twice as likely to abuse steroids as females.

Professional & College Sports

The NFL suspended running back Mike Cloud of the New England Patriots, defensive

back Lee Flowers of the Denver Broncos, and Keith Newman of the Atlanta Falcons for violating the league's steroid policy. All three players tested positive for steroids and received a four game suspension without pay during the regular season. Three members of the Norwick University (located in Northfield, Vermont) football team were arrested for possession of 1,000 anabolic steroid tablets. During interviews with the three football players they advised authorities that several other students and football players were using steroids. In professional baseball it is widely believed that steroid abuse is rampant. The news media has reported countless instances where players were taking steroids or other performance enhancing drugs. There is also continuous debate about steroid testing and other drug testing in professional baseball.

Law Enforcement

Despite the illegality of steroids without a prescription and the known dangers of steroid abuse the problem continues to grow in the law enforcement community. In Minneapolis, a police sergeant was charged for possession of steroids. He admitted to being a user of steroids. In Miami, a police officer was arrested for the purchase of human growth hormone kits (HGH) from a dealer. The dealer had also informed Federal officials that the police officer had purchased anabolic steroids from him on four other occasions. In Tampa, a police officer was sentenced to 70 months in jail for exchanging 1,000 ecstasy tablets from police custody for steroids.

HOW CAN WE CURTAIL THEIR ABUSE?

The most important aspect to curtailing abuse is education concerning dangerous and harmful side effects, and symptoms of abuse. Athletes and others must understand that they can excel in sports and have a great body without steroids. They should focus on getting proper diet, rest, and good overall mental and physical health. These things are all factors in how the body is shaped and conditioned. Millions of people have excelled in sports and look great without steroids. For additional information on steroids please see our website at www.DEAdiversion.usdoj.gov

Back to top

APPENDIX A: FACTS ABOUT STEROIDS AND ATHLETIC PERFORMANCE ENHANCEMENT[1]

Patterns of Anabolic Steroid Abuse

Cycling

- Alternating periods of anabolic steroid use (on cycle) with periods of either no use or the use of low doses of anabolic steroids (off cycle)
- Cycling periods usually last from 6 to 16 weeks
- Anecdotal reasons for cycling
    - Reduction of tolerance development
    - Reduction of adverse effects
    - Prevent detection of steroid use
    - Insure peak performance during competition

Stacking

- Never done in medical practice
- Concurrent use of two or more steroids together
- Injectables may be stacked with oral preparations
- Short acting steroids may be stacked with longer acting steroids

Stacking the Pyramid

- A stacking regimen wherein there is a progressive increase in the doses and types of steroids used in the initial part of the cycle and a gradual reduction in the doses and types of steroids used in the latter half of the cycle
- This regimen is believed to give the optimal, desired steroid effects while decreasing the likelihood of detection of anabolic steroid use

Alternatives to Anabolic Steroids

- Human chorionic gonadotropin
- Human growth hormone
- Insulin-like growth factor
- Insulin
- Clenbuterol
- Erythropoietin (EPO)
- Gamma-hydroxybutyrate (GHB)
- Vitamins and amino acids

Doses of Anabolic Steroids Abused

Steroid abusers select doses depending upon their particular objectives. For athletes, the doses selected are to some extent determined by the sporting event.

- **Endurance athletes**: At or slightly below replacement levels of 5 to 10 mg/day.
- **Sprinters**: 1.5 to 2 times replacement levels.
- **Weightlifters & body builders**: 10 to 100 times normal doses.
- **Women**: Regardless of sport tend to use lower doses than men.

Back to Top

APPENDIX B: PHYSICAL & MENTAL EFFECTS OF STEROID ABUSE ON MALES AND FEMALES[1]

Short-Term Adverse Physical Effects of Anabolic Steroids in Men

- Acne
- Skin tissue damage at the site of injection
- Shrinkage of the testicles
- Decreased sperm production and motility
- Decreased semen volume
- Frequent or continuing erections

- Enlargement of the breast (gynecomastia)
- Elevated blood pressure
- Increased LDL cholesterol levels
- Decreased HDL cholesterol levels
- Fluid retention leading to swelling
- Abnormal liver function
- Prostate enlargement
- Bleeding (usually nose)

Short-Term Adverse Physical Effects of Anabolic Steroids in Prepubertal Boys

- Precocious sexual development
- Penis enlargement
- Painful, prolonged penile erections
- Increased frequency of penile erections
- Premature closure of the growth plates in long bones resulting in a decrease in the total height achieved
- Fluid retention leading to swelling

Short-Term Adverse Physical Effects of Anabolic Steroids in Women

- Acne
- Oily skin
- Tissue damage at injection site
- Deepening of the voice
- Increased body and facial hair growth
- Enlargement of the clitoris
- Male pattern baldness
- Decreased breast size
- Menstrual irregularities (missed periods or no periods)
- Fluid retention leading to swelling

Adverse Cardiovascular Effects of Anabolic Steroids in Men and Women

- Increased blood pressure ------> potential coronary artery disorder
- Increased LDL cholesterol ------> potential coronary artery disorder
- Enlargement of the heart
- Actual death of heart cells
- Heart attacks (cardiac infraction)
    - o - Spasms of the coronary arteries
    - o - Increased blood clotting
- Stroke

Possible Long-Term Consequences of Anabolic Steroid Abuse in Men and Women

- Adverse cardiovascular effects
- Liver dysfunction
- Liver tumors
- Liver cancer
- Cancer of the prostate (men only)

Other Potential Risks Faced by Anabolic Steroid Abusers in Men and Women

- Skin infections
- HIV infection (needle sharing) --------> AIDS
- Hepatitis infections
- Violent trauma

Psychological Effects of Anabolic Steroid Abuse in Men and Women

Psychotic and Manic Reactions (rare occurrence)

- Most likely seen in people with prior mental illness

Anger, Hostility, Aggression and/or Violent Behavior

- Occurs in some but not all anabolic steroid users
- Unpredictable who will respond
- Increased likelihood with higher doses
- Minor provocations evoke exaggerated responses
- Presents danger to spouse, family, and friends
- Presents danger to law enforcement

[1] Dr. James Tolliver (Pharmacologist), DEA, Drug and Chemical Evaluation Section (ODE)

Presented as a public service by:
Drug Enforcement Administration
Office of Diversion Control
Washington, D.C. 20537

Back to Top

NIDA Community Drug Alert Bulletin - Anabolic Steroids

Steroid abusers often do not realize that over time, these drugs can take a heavy toll on their health.

Dear Colleague;

Since the 1950s, some athletes have taken anabolic steroids to build muscles and boost their athletic performance. Increasingly, other segments of the population also have been taking these synthetic substances. The Monitoring the Future study, an annual survey of drug abuse among middle and high school students across the country, showed a significant increase from 1998 to 1999 in anabolic steroid abuse among middle schoolers. During the same year, the percentage of 12th-graders who believed that taking these drugs causes "great risk" to health declined from 68 percent to 62 percent.

Studies show that, over time, anabolic steroids can indeed take a heavy toll on a person's health. Abuse of oral or injectable anabolic steroids is associated with increased risk for heart attacks and strokes, and the abuse of most oral anabolic steroids is associated with increased risk for severe liver problems, including hepatic cancer. People who share needles or use nonsterile injection techniques put themselves at risk for contracting dangerous infections, such as HIV/AIDS, hepatitis B and C, and bacterial endocarditis.

Anabolic steroid abuse can also cause undesirable body changes. Men may develop enlarged breasts and women's bodies may become masculinized. Both sexes can develop acne and hair loss.

This Community Drug Alert Bulletin summarizes some of the latest scientific information on anabolic steroids. NIDA also has established a Web site to provide scientific information about anabolic steroids: http://www.steroidabuse.org. As research produces new information, NIDA will continue to make every effort to quickly disseminate these findings via the Web site and subsequent Alerts. Our objective is to keep the Nation's communities up-to-date concerning the risks of abusing anabolic steroids and science-based approaches to preventing and treating such abuse.

Sincerely,

Alan I. Leshner, Ph.D.
Director

COMMUNITY DRUG ALERT BULLETIN
CDAB Home

Information on Anabolic Steroids

- Anabolic Steroic
- Anabolic Steroic
- How Steroids Ar
- Health Consequ Steroid Abuse
- Discouraging Yo Abusing Steroid

More Information Steroids

SteroidAbuse.org Web Site

Anabolic steroids are:

- Synthetic substances related to the male sex hormones (androgens). They promote growth of skeletal muscle (anabolic effect) and the development of male sexual characteristics (androgenic effects), and also have other effects. (The term "anabolic steroids" will be used throughout this bulletin because of its familiarity, although the proper term for these compounds is "anabolic/androgenic" steroids.)

- Used by doctors to treat conditions that occur when the body produces abnormally low amounts of testosterone, such as delayed puberty and some types of impotence, and also to treat body wasting in patients with AIDS and other diseases.

- Legally available in the United States only by prescription. Anabolic steroid abusers obtain drugs that have been made in clandestine laboratories (sometimes with poor quality control standards), smuggled from other countries, or diverted illegally from U.S. pharmacies.

- Distinct from steroidal supplements. In the United States, supplements such as dehydroepiandrosterone (DHEA) and androstenedione (street name Andro) can be purchased legally without a perscription through many commercial sources including health food stores. They are often taken because the user believes they have anabolic effects.

Anabolic steroid abuse is:

- Increasing among adolescents, and most rapidly among females. The 1999 Monitoring the Future study, a NIDA-funded survey of drug abuse among middle school and high school students across the United States, recorded that 2.7 percent of 8th-graders, 2.7 percent of 10th-graders, and 2.9 percent of 12th-graders reported having taken anabolic steroids at least once in their lives. These figures represent increases since 1991 of approximately 50 percent among 8th- and 10th-graders and 38 percent among 12th-graders.

- Probably widespread among athletes and would-be sports competitors at all levels, although few data are available to provide exact estimates of prevalence. Many anabolic steroid abusers are unwilling to report the practice, because the International Olympic Committee and many other amateur and professional sports organizations have banned anabolic steroids.

- Motivated in most cases by a desire to build muscles and improve sports performance. Some individuals are motivated by erroneous perceptions of their own bodies (that is, a mistaken belief that they look underweight or obese) and others by a desire to prevent recurrence of physical or sexual attacks they have experienced.

Anabolic steroids are taken:

- Orally as tablets or capsules (Anadrol® [oxymetholone], Oxandrin® [oxandrolone], Dianabol® [methandrostenolone], Winstrol® [stanozolol], and others); by injection into muscles (Deca-Durabolin® [nandrolone decanoate], Durabolin® [nandrolone phenpropionate], Depo-Testosterone® [testosterone cypionate], Equipoise® [boldenone undecylenate], and others); or by ointment preparations rubbed into the skin. Doses taken by abusers can be up to 100 times more than the doses used for treating medical conditions.

- In combinations, a practice called "stacking." Abusers frequently take two or more anabolic steroids together, mixing oral and/or injectable types, sometimes adding drugs such as stimulants or painkillers. The rationale for stacking is a belief-which has not been tested by science-that the different drugs interact to produce a greater effect on muscle size than could be obtained by simply increasing the dose of a single drug.

- In cyclic dosage regimens, a practice called "pyramiding." At the beginning of a

cycle, the person starts with low doses of the stacked substances and then gradually increases the doses for 6 to 12 weeks. In the second half of the cycle, the doses are slowly decreased to zero. This is sometimes followed by a second cycle during which the person continues to train, but without drugs. Abusers believe that pyramiding allows the body time to adjust to the high doses, and the drug-free cycle allows time for the body's hormonal system to recuperate. As with stacking, the perceived benefits of pyramiding have not been substantiated scientifically.

Health consequences associated with anabolic steroid abuse include:

- *In boys and men*, reduced sperm production, shrinking of the testicles, impotence, difficulty or pain in urinating, baldness, and irreversible breast enlargement (gynecomastia).
- *In girls and women*, development of more masculine characteristics, such as decreased body fat and breast size, deepening of the voice, excessive growth of body hair, and loss of scalp hair, as well as clitoral enlargement.
- *In adolescents of both sexes*, premature termination of the adolescent growth spurt, so that for the rest of their lives, abusers remain shorter than they would have been without the drugs.
- *In males and females of all ages*, potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension, each of which can promote heart attack and stroke; and acne. Although not all scientists agree, some interpret available evidence to show that anabolic steroid abuse-particularly in high doses-promotes aggression that can manifest itself as fighting, physical and sexual abuse, armed robbery, and property crimes such as burglary and vandalism. Upon stopping anabolic steroids, some abusers experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, reduced sex drive, headache, muscle and joint pain, and the desire to take more anabolic steroids.
- *In injectors*, infections resulting from the use of shared needles or nonsterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

To encourage youths to avoid anabolic steroid abuse:

- Present a balanced picture of what these drugs can do for them and to them. Most adolescents know that anabolic steroids build muscles and can increase athletic prowess. Research has shown that failure to acknowledge these potential benefits creates a credibility problem and can actually make youths more likely to try the drugs.
- Make use of the authority of coaches and the team ethos. In the most promising program currently under study, coaches and team leaders are trained to educate team members about the effects of anabolic steroid abuse, both desirable and adverse, in the general context of training. They also provide information about nutrition and, of course, exercise and other training techniques for improving performance without the steroid abuse by as much as 50 percent and also reduces alcohol abuse among teammates.
- It is uncertain whether drug testing programs can discourage anabolic steroid abuse. However, the first scientific studies of this practice are currently under way.

Contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or Web site: http://www.health.org/ for free NIDA publications. For

faxed drug abuse information in Spanish and English, call NIDA's INFOFAX line at 1-888-NIH-NIDA or, for those with impaired hearing, 1-888-TTY-NIDA.

Access NIDA's specialized Web site, http://www.steroidabuse.org/. Additional information on other illicit drugs can be accessed through NIDA's home page on the World Wide Web: http://www.drugabuse.gov/.

This page accessed **190546** times since 4/17/00.

NIDA Community Alert Bulletin on Steroid Abuse was published in April, 2000

Big Picture Local Focus
Daily Herald
Suburban Chicago's Information Source

Sports
- Arlington Park
- Bears
- Blackhawks
- Bulls
- College Teams
- Cougars
- Cubs
- Fire
- Flyers
- Rush
- White Sox
- Wolves

E-mail Us
- General Sports
- High School
- Neighbor/Youth

7 day search Go

FIND A JOB
FIND A HOME
FIND A CAR
News/Home
- Cook County
- DuPage County
- Kane County
- Lake County
- McHenry County
- Illinois
- Nation/World

Ads/Classifieds
- Place an ad
- Ads Online
- Autos
- Jobs
- Homes
- Personals

Obituaries
Business
Sports
Prep Sports
Entertainment
- TV listings
- Movie times
- Events
- Comics
- Crossword

Opinion/Editorial
Commitments
- Engagements
- Weddings
- Anniversaries
- Place a commitment
- Recipes
- Coupons

Health & Fitness

This steroids stuff just gets more scary

Posted Thursday, December 09, 2004


Barry Rozner

By Barry Rozner

Put down your coffee, stow your muffins and place your bagel in its upright and locked position.

You might want to sit down and fasten your seat belt, because this is the sort of turbulent moment that shakes you off of every preconceived notion.

According to the Centers for Disease Control, the group with the highest use of anabolic steroids today is ... freshman girls.

Yes, high school freshman girls.

About 7.3 percent have admitted to using steroids, and that figure is thought to be two or three times higher.

"Unlike many other drugs, kids don't admit it because it's not cool to be on steroids, not to mention the fact that it makes you paranoid," explained Linn Goldberg, professor of medicine at Oregon Health & Science University in Portland. "The girls believe it helps them shape their bodies, and the boys believe it helps them hit home runs, and so that's their identity.

"The body builders I've treated say it's really about shallow egos and lack of self-confidence, so you can see why kids are so at risk, especially since kids are, by nature, risk-takers."

Goldberg, a fellow of the American College of Sports Medicine and United States Olympic Committee Crew Chief for Drug Surveillance, says there can be no doubting the short- and long-term effects of steroid use.

"Some people will say there isn't enough evidence yet and that we haven't proven a thing," Goldberg said. "Those are the same people who said it about asbestos and cigarettes.

"We know steroids will raise your bad cholesterol, lower your good cholesterol, raise your blood pressure, promote clotting of the blood and increase the risk of tumors, especially liver tumors.

"Those are just a few things and those all lead to other things."

But in young people, it's much worse. They get all of the above, and more. Let's take, for example, a 13-year-old male on steroids.

"We do know that he won't get any taller," Goldberg said. "It rewires his brain and tricks it into thinking he's much older than he is.

"You're giving a powerful hormone to the receptors in the brain that want to go at a slow pace, but steroids trick the receptors into thinking this boy is fully grown, so he

Recent Columns
- Schwass prefers to count blessings, not hardships (12/25)
- Sandberg talks about Fame, what it should take to get there (12/21)
- Cubs haven't been as quiet as you think (12/15)
- Good start for Sox, but holes remain (12/14)
- This steroids stuff just gets more scary (12/9)
- What's next big scandal? Genetic doping (12/8)

To contact Barry Rozner send email to brozner@dailyherald.com

Homes & Garden
Suburban Living
Travel
Special Reports
Sources
- EZ Links
- 7 day search
- Photo archives
- Site map

Contact us
- Subscribe
- About us
- Your TIPS
- Subscriber services
- N.I.E.

stops growing and instead of being 6-foot, or 6-foot-3, he'll stop at 5-5 or 5-6.

"The heightened aggression that comes on might persist forever, as will changes in personality. As if adolescence wasn't tough enough, it heightens adolescence.

"About 10 years down the road, he can expect to start experiencing liver problems and heart problems.

"There's female breast enlargement and his testis will shrink and he could become sterile. Then, there's the prostate, which grows with testosterone. Prostate cancer loves testosterone. It can't get enough of the stuff.

"A 13-year-old boy is basically inviting prostate cancer by using steroids."

And a 13-year-old girl?

"Her brain is rewired as well and in many ways she will become an adolescent male, and the changes are mostly permanent," Goldberg said. "It lowers her voice, she'll grow facial hair and body hair and the genitalia will grow.

"This doesn't even take into account all the changes in cardiovascular risk factors and cancer risk factors."

That all sounds very pleasant. What about the so-called legal supplements?

"They could be taking something that's not manufactured with any standards or safety controls," Goldberg said. "The FDA is excluded from analyzing supplements that are sold in your local stores, but the IOC studied supplements sold in the U.S. and found 18 percent were spiked with true anabolic steroids, though the label said nothing about it.

"Creatine has never been studied among kids, but in short studies there have been problems with elevations in markers of kidney function.

"Kids can get the actual steroids pretty easily from local gyms. The body builders get them off the Internet or from Mexico. And in the last two years, major steroid rings were broken up at high schools in Utah and Arizona."

It also is the only drug increasing in use while even alcohol and tobacco are dropping.

So if 6.1 percent of high school students admit to using anabolic steroids, and the real number may be two to three times that, why is it happening?

"Steroid users believe that parents are more accepting of it than typical drugs of abuse, since the drugs aren't for getting high," Goldberg said. "Kids may think parents want them to get a college scholarship no matter what the cost, or maybe even a pro contract.

"Girls may be doing it for sports or just for body-shaping. So these substances have a 'pro-social' effect and may mean parents are unwittingly encouraging children to use them.

"Parents who have unrealistic expectations are partially responsible for the emphasis placed on sports in middle school, high school and college, and the reaction of kids to that emphasis.

"Taking steroids, the pharmacy approach to looking better or performing better, is a bad idea. You alter nature and the reaction is highly unpredictable.

"In essence, taking steroids is Russian roulette."

Sen. Hollis French

From: raymond.sawyer@AKANCH.ANG.AF.MIL
Sent: Wednesday, February 09, 2005 2:37 PM
To: Sen. Hollis French
Subject: RE: 2004 Anabolic Steroid Control Act

Senator Hollis,
Please use his letter as you need. I have coached youth sports for over twenty years, and it was not until three years ago that I saw a shift in the attitude of steroid use. In the past, steroids was a taboo subject, even by those taking it. Now, I have kids coming up to me bragging of the supplements they purchased on the internet, mind you the kids are thirteen and fourteen year olds. What ever you can do to stop kids from ruining their lives you have my support. Again, thank you.

Raymond Sawyer

-----Original Message-----
From: Sen. Hollis French
[mailto:Senator_Hollis_French@legis.state.ak.us]
Sent: Wednesday, February 09, 2005 2:15 PM
To: SAWYER, RAYMOND, CIV, 176 WG, 6070
Subject: RE: 2004 Anabolic Steroid Control Act

Dear Mr. Sawyer,
Thank you for writing, and for including your son's invaluable perspective on this issue. His experience comports with what we are hearing from some athletic directors: that there is more steroid useage out there than most folks are aware of.
With your permission, I would like to include your son's letter in the materials we circulate to other legislators by way of informing them about this particular issue. Please let me know if that would be OK.
Yours,
Hollis French

-----Original Message-----
From: raymond.sawyer@AKANCH.ANG.AF.MIL
[mailto:raymond.sawyer@AKANCH.ANG.AF.MIL]
Sent: Wednesday, February 09, 2005 12:28 PM
To: Sen. Hollis French
Cc: Rep. Vic Kohring; Sen. Charlie Huggins; Sen. Lyda Green
Subject: 2004 Anabolic Steroid Control Act

Honorable Senator French,

I am forwarding a letter from my son, Shannon Keola Sawyer, in regards to your efforts of combating this "allowed" drug. Before you read his letter, please allow me to personally thank you for taking on this beast of a task.

Sincerely,

Raymond Sawyer
1204 S Frontier Dr
Palmer, AK 99645

Senator,

My name is Shannon Sawyer, and I heard you are working on a problem I have been battling with for sometime. You see I am a very hard working athlete.
I won the 2004 Tanana Wrestling State Championship 160 lb bracket when I weighed only 148 lbs. This year I started high school football, and not only made the varsity team, but was their starting varsity linebacker.
Two years ago I entered my first bodybuilding competition at the 2003 Mr.

Alaska, and I competed in the twenty year old and under class. I placed fifth. Last year I placed third. My GPA is 3.85 (I got a B in Spanish).
Last year I was class president, member of the MATSU Youth Advisory Board, and voted on as the Alaska DARE youth advisor. I just turned fifteen, and I do not use any drug, alcohol, or supplement that is identified as banned.
You see I am a natural athlete.

I initially saw steroids as a way people could cheat the system, or more appropriately, how to get what took me years to accomplish in a matter of months. However, after witnessing friends and teammates go through this evil change after taking over the counter prohormone, I started to voice my concerns. The changes I witnessed included violent mood changes, hostile outburst, physical changes that included Gynocomastia (male breast), and due to my own physic I have been accused of taking this garbage. I initially went to coaches who played the "I didn't know that" game. The Athletic Advisor was the same. It wasn't until I met Mr. Bob Sanders, State Program Director, Dare Alaska, who was willing to listen. Since becoming a member last year, I have talked about this problem to several members in government to include Governor Swarzenegger of California.

Steroids do enhance the strength and size of the user, but at what cost?
Having a 250 pound enraged individual coming at me does not sound like a sporting event, or not one that the majority of Alaskan want to participate in. The health concerns to those who use steroids are not a concern to the user. They what to get big, strong, and they want it now. They do not see the rage, violent outburst, skin problems, enlarged breast on males, or the countless other internal problems that I am not aware of. The bottom line is, these drugs are banned, made illegal, however still out in our playgrounds (yes, reports of steroid use by elementary kids), school boys and girl locker rooms, and gyms.
Alaska now has a champion in you to help further put a damper on the flow of this poison. What ever I can do to assist in getting information out to the youth of Alaska, please let me
know.

Shannon Sawyer
Palmer AK

SB

51

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

January 28, 2004

Honorable Fred Dyson, Chairman
Senate Health, Education and
Social Services Committee
Alaska State Capitol; Rm. 121
Juneau, AK 99801

Dear Senator Dyson,

The Department of Health and Social Services respectfully requests a hearing in the Senate Health, Education and Social Services Committee on Senate Bill 51"An Act relating to contracts for the provision of state public assistance to certain recipients in the state; providing for regional public assistance plans and programs in the state; relating to grants for Alaska Native family assistance programs; relating to assignment of child support by Alaska Native family assistance recipients; relating to paternity determinations and genetic testing involving recipients of assistance under Alaska Native family assistance programs; and providing for an effective date."

This bill would reauthorize the Alaska Native Family Assistance Grant Program established in Chapter 96, SLA 2000 as a temporary pilot program. In addition to reauthorizing the pilot program on a permanent basis in statute, the bill also would allow the remaining nine Alaska native nonprofit organizations authorized in federal law to participate in the program.

The bill was previously heard by the Senate (CRA) Committee and moved from committee without amendment. All members present signed the committee report "do pass."

A copy of Governor Murkowski's transmittal letter providing additional information on the proposal and the associated fiscal notes should be on file with the committee.

Your favorable consideration of this request will be appreciated.

Sincerely,

Sherry Hill, Special Assistant
Office of the Commissioner

cc: Kevin Jardell, Legislative Director
Office of the Governor

Katherine Farnham, Director
Division of Public Assistance

SB 51

FRANK H. MURKOWSKI
GOVERNOR
GOVERNOR@GOV.STATE.AK.US

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

P.O. BOX 110001
JUNEAU, ALASKA 99811-0001
(907) 465-3500
FAX (907) 465-3532
WWW.GOV.STATE.AK.US

January 11, 2005

The Honorable Ben Stevens
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Stevens:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to the Alaska Native family assistance grant program. This bill would reauthorize the Alaska Native family assistance grant program, which was enacted in ch. 96, SLA 2000 as a temporary pilot program.

The federal Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (P.L.104-193) (PRWORA) gave Alaska Native and American Indian tribes the authority to assume responsibility for providing public assistance and self-sufficiency services by administering the Temporary Assistance for Needy Families program (TANF) independent of state welfare agencies. The law also set out the methodology for federal financing of tribal TANF programs, but did not address state financing or any state maintenance-of-effort provisions. In response, ch. 96, SLA 2000 was enacted into law, authorizing the Department of Health and Social Services (department) to award and administer federally authorized tribal TANF providers in Alaska with Native Family Assistance Program (NFAP) grants on a pilot program basis. The financing was limited to only four of the 13 Alaska Native nonprofit organizations authorized in PRWORA: Tanana Chiefs Conference, Tlingit-Haida Central Council, Association of Village Council Presidents, and the Metlakatla Indian Community of the Annette Islands Reserve. Each of these organizations, except Metlakatla, is now operating a tribal TANF program and receiving financing from the department in the form of an Alaska Native family assistance grant. This temporary law program will sunset on June 30, 2005.

In addition to reauthorizing the pilot program on a permanent basis in statute, this bill also would include the other nine Alaska native nonprofit organizations authorized in federal law to operate tribal TANF programs: Arctic Slope Native Association, Kawerak, Inc., Maniilaq Association, Cook Inlet Tribal Council, Bristol Bay Native Association, Aleutian and Pribilof Island Association, Chugachmiut, Kodiak Area Native Association, and Copper River Native Association.

COMMITTEE COPY

From the outset, the State of Alaska has supported the establishment and development of the tribal TANF programs. The NFAP program affirms the state's interest in promoting regional responsibility and local control for public assistance programs in Alaska. Families served by tribal TANF programs have been successful in moving families from welfare to work. The local presence and familiarity with village and community life puts the tribal administrators in the best position to implement the program and to successfully promote self-sufficiency for their clients.

Since enactment of ch. 96, SLA 2000, three Alaska Native groups not currently authorized to receive Alaska Native family assistance grants are either actively planning a tribal TANF program or have expressed interest in beginning the planning process. Cook Inlet Tribal Council plans to begin operating a tribal TANF program in July 2005 and is currently receiving technical support from the department. The Bristol Bay Native Association has submitted a letter of intent to begin operating a tribal TANF program in July 2005, and Chugachmiut has also advised the department of its interest in developing a tribal TANF program.

Funding for tribal TANF program operations comes from the federal TANF block grant and is supplemented by state grant funds that would otherwise be spent to serve the same number of Alaska Native families receiving assistance from the state's temporary assistance program. Enacting this bill will not take away the state oversight of TANF program operations. Tribal providers who receive NFAP grants enter into a contractual agreement with the State of Alaska to provide timely and accurate cash assistance, eligibility services, case management and other welfare-to-work services, supportive services, child care assistance, and administrative support to all eligible families living within their service area. Furthermore, the contract requires tribal providers to report monthly to the Division of Public Assistance (DPA) and allows DPA to monitor and evaluate the tribal program to assure grant money is being used to serve eligible families.

I urge your prompt and favorable action on this measure.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 51
(S) Publish Date: 1/12/05
Dept. Affected: Health & Social Services
RDU: Public Assistance
Component: Tribal Assistance
Component No: 2336

Revision Date/Time (Note if correction):
Title: REAUTHORIZATION OF NATIVE FAMILY ASSISTANCE GRANTS PROGRAM
Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: GOVERNOR

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	4,093.8	4,093.8	4,093.8	4,093.8	4,093.8	4,093.8
Miscellaneous						
TOTAL OPERATING	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match	3,685.8	3,685.8	3,685.8	3,685.8	3,685.8	3,685.8
1004 GF						
1037 GF/Mental Health						
1007 Interagency Receipts	408.0	408.0	408.0	408.0	408.0	408.0
Other(Specify Type - do not abbreviate)						
TOTAL	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**	**4,093.8**

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)*

Under federal law, 12 Alaska Native regional non-profits and the village of Metlakatla are authorized to receive federal funds for the administration of tribal TANF programs. This legislation reauthorizes the Alaska Native family assistance grant program established under Chapter 96, SLA 2000, and gives the Department of Health & Social Services the ability to award and administer state grants to Native non-profit organizations to supplement their federally approved Tribal TANF Assistance programs. Approval of this legislation would maintain support for the three organizations currently running Tribal TANF programs and receiving state supplemental Native family assistance grant funds: TANF - Tanana Chiefs Conference (TCC), Central Council of Tlingit & Haida Indian Tribes of Alaska (T&H) and Association of Village Council Presidents (AVCP). In addition to reauthorizing the existing programs this bill would also include the other nine Alaska native non-profit organizations authorized in federal law to operate tribal TANF programs. Cook Inlet Tribal Council (CITC) plans to begin operating a tribal TANF program in July 2005. The fiscal note assumes implementation of the CITC

Prepared by: Katherine Farnham
Division: Public Assistance
Phone: 269-7930
Date/Time: 12/07/2004

Approved by: Joel S. Gilbertson, Commissioner
Agency: Department of Health and Social Services
Date: 12/10/2004

(Revised 9/23/2004 OMB)

COMMITTEE COPY

FISCAL NOTE
FN # 1

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB 51

ANALYSIS CONTINUATION
Analysis Continued:

program as planned and reflects the associated budget impacts.

State supplemental grant to CITC to operate tribal TANF in the Anchorage service area:
Funding for Native TANF program operation comes from the federal TANF block grant and is supplemented by state grant funds that would otherwise be spent to serve the same Native welfare recipients. This fiscal note reflects the 'transfer' of $4,093.8 state funding to the Tribal Assistance component from the ATAP component to supplement the federal TANF for the operation of tribal TANF by CITC. Funds provided by this state grant will be used for the purpose of providing temporary assistance benefits to eligible families through CITC's tribal TANF program.

Summary of all component impacts for CITCs NFAP	Total	Federal	GFM	I/A
ATAP component	(6,727.0)	(563.2)	(5,755.8)	(408.0)
Tribal Assistance	4,093.8		3,685.8	408.0
Work Services component	(1,346.4)	(1,346.4)	-	-
Child Care Benefits component	(931.5)	(931.5)	-	-
Total net fiscal impact for CITC Native TANF	(4,911.1)	(2,841.1)	(2,070.0)	-

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 51
(S) Publish Date: 1/12/05
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction)

Title: REAUTHORIZATION OF NATIVE FAMILY ASSISTANCE GRANTS PROGRAM
RDU: Public Assistance
Component: Work Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: GOVERNOR
Component No.: 2337

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	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)
Miscellaneous						
TOTAL OPERATING	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)	(1,346.4)
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**	**(1,346.4)**

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)*

This legislation reauthorizes the Department of Health and Social Services (DHSS) to award and administer state funds under the Alaska Native family assistance grant program to support the operation of federally approved Tribal TANF programs. In addition to reauthorizing the existing programs this bill would also allow DHSS to provide grants to the other nine Alaska native non-profit organizations authorized in federal law to operate tribal TANF programs. Cook Inlet Tribal Council (CITC) plans to begin operating a tribal TANF program in July 2005.

The fiscal note assumes implementation of the CITC program as planned and reflects the budget impacts. Work Services is a budget category for case management staff and supportive service payments that assist TANF clients from welfare to work. This fiscal note deletes $1,346.4 federal authority for the decline in Work Services component expenditure due to the transfer of the existing Native Temporary Assistance caseload in Anchorage to CITC.

Prepared by: Katherine Farnham
Phone 269-7930
Division: Public Assistance
Date/Time 12/07/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 12/10/2004
Agency: Department of Health and Social Services

(Revised 9/23/2004 OMB)

COMMITTEE COPY

FISCAL NOTE
FN # 2

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB 51

ANALYSIS CONTINUATION
Analysis Continued: Work Services

Summary of all component impacts for CITCs NFAP	Total	Federal	GFM	I/A
ATAP component	(6,727.0)	(563.2)	(5,755.8)	(408.0)
Tribal Assistance	4,093.8		3,685.8	408.0
Work Services component	(1,346.4)	(1,346.4)	-	-
Child Care Benefits component	(931.5)	(931.5)	-	-
Total net fiscal impact for CITC Native TANF	(4,911.1)	(2,841.1)	(2,070.0)	-

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 51
(S) Publish Date: /12/05
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: REAUTHORIZATION OF NATIVE FAMILY ASSISTANCE GRANTS PROGRAM
RDU: Public Assistance
Component: ATAP

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: GOVERNOR
Component No.: 220

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	(6,727.0)	(6,727.0)	(6,727.0)	(6,727.0)	(6,727.0)	(6,727.0)
Miscellaneous						
TOTAL OPERATING	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(563.2)	(563.2)	(563.2)	(563.2)	(563.2)	(563.2)
1003 GF Match	(5,755.8)	(5,755.8)	(5,755.8)	(5,755.8)	(5,755.8)	(5,755.8)
1004 GF						
1037 GF/Mental Health						
1007 Interagency Receipts	(408.0)	(408.0)	(408.0)	(408.0)	(408.0)	(408.0)
Other(Specify Type-do not abbreviate)						
TOTAL	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**	**(6,727.0)**

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)*

This legislation reauthorizes the Department of Health & Social Services (DHSS) to award and administer state funds under the Alaska Native family assistance grant program to support the operation of federally approved Tribal TANF programs. The three organizations currently running programs and receiving Native family asssistance grants ,e: Tanana Chiefs Conference (TCC) in the interior Doyon region, Central Council of Tlingit & Haida Indian Tribes of Alaska (T&H) in SE Alaska , and the Association of Village Council Presidents in the YK Delta. Approval of this legislation maintains state support for these programs at the current, status quo level (no fiscal impact or change for existing Native family assistance programs). In addition to reauthorizing the existing programs this bill would also allow DHSS to provide grants to the other nine Alaska native non-profit organizations authorized in federal law to operate tribal TANF programs. Cook Inlet Tribal Council (CITC) plans to begin operating a tribal TANF program in July 2005. This fiscal note assumes implementation of the CITC program on July 1, 2005 and reflects the associated budget impacts.

Prepared by: Katherine Farnham
Phone 269-7930
Division: Public Assistance
Date/Time 12/07/2004
Approved by: Joel S. Gilbertson, Commissioner
Date 12/10/2004
Agency: Department of Health and Social Services

(Revised 9/23/2004 OMB)

TEE COPY

FISCAL NOTE
FN # 3

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB 51

ANALYSIS CONTINUATION
Analysis Continued:

State supplemental grant to CITC to operate tribal TANF in the Anchorage service area:
Funding for tribal TANF program operations comes from the federal TANF block grant and is supplemented by state grant funds that would otherwise be spent to serve the same number of Native families receiving assistance from the State's temporary assistance program. This fiscal note reflects the 'transfer' of $4,093.8 in state funding from the ATAP component to the Tribal Assistance component to support the operation of tribal TANF administered by CITC. Funds provided by this state grant supplement CITC's federal TANF block grant and will be used for purpose of providing temporary assistance payments to eligible families through the CITC tribal TANF program.

Native Operated TANF programs & Changes in MOE
The state maintenance of effort (MOE) requirement for TANF is based on the state share of AFDC expenditures in FFY1994. In order to earn the annual TANF block grant, states must spend at least 75-80 percent of their FFY 1994 spending. Federal law allows designated Native organizations to operate their own TANF programs and to receive TANF grants directly from the federal government. The federal grants for Native TANF reduce the state block grant amount dollar for dollar. In addition, the required state maintenance of effort (MOE) is reduced.

State general funds savings of roughly $25 million have been previously deleted from the ATAP budget to a level equal to the minimum 75% MOE amount. Due to CITC implementing a new tribal TANF program, DHSS can reduce the required MOE by an additional $2,070.0 million GF. This fiscal note changes ATAP component funding sources by deleting $2,070.0 GF (MOE) and replacing with federal TANF authority. The change in fund source assumes a reduction in state TANF MOE amount due to the implementation of the CITC tribal TANF program.

Delete excess Federal TANF - ATAP caseload transfers to CITC
This fiscal note deletes $2,633.2 federal budget authority for the projected decline in ATAP component formula payments due to the transfer of the existing Native Temporary Assistance caseload in Anchorage to CITC.

Summary ATAP component impacts	Total	Federal	GFM	I/A
"Transfer" to Tribal Assistance component	(4,093.8)	-	(3,685.8)	(408.0)
Delete GFM to the revised MOE floor	-	2,070.0	(2,070.0)	-
Delete excess federal TANF federal authority	(2,633.2)	(2,633.2)	-	-
ATAP component net change	(6,727.0)	(563.2)	(5,755.8)	(408.0)

Summary of all component impacts for CITCs NFAP	Total	Federal	GFM	I/A
ATAP component	(6,727.0)	(563.2)	(5,755.8)	(408.0)
Tribal Assistance	4,093.8		3,685.8	408.0
Work Services component	(1,346.4)	(1,346.4)	-	-
Child Care Benefits component	(931.5)	(931.5)	-	-
Total net fiscal impact for CITC Native TANF	(4,911.1)	(2,841.1)	(2,070.0)	-

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 51
(S) Publish Date: 1/12/05
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: REAUTHORIZATION OF NATIVE FAMILY ASSISTANCE GRANTS PROGRAM
RDU: Public Assistance
Component: Child Care Benefits

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: GOVERNOR
Component No.: 1897

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	(931.5)	(931.5)	(931.5)	(931.5)	(931.5)	(931.5)
Miscellaneous						
TOTAL OPERATING	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(931.5)	(931.5)	(931.5)	(931.5)	(931.5)	(931.5)
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**	**(931.5)**

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)*

This legislation reauthorizes the Department of Health & Social Services (DHSS) to award and administer state funds under the Alaska Native family assistance program to support the operation of federally approved Tribal TANF programs. In addition to reauthorizing the existing Native Family Assistance Programs (NFAP), this bill would also allow DHSS to provide gra[illegible] to the other nine Alaska Native non-profit organizations authorized in federal law to operate tribal TANF programs. Cook Inlet Tribal Council (CITC) plans to begin operating a tribal TANF program in July 2005.

The fiscal note assumes implementation of the CITC program on July 1, 2005, and reflects the associated budget impacts. Child Care benefits are direct subsidies paid to childcare providers for TANF families. This fiscal note deletes $931.5 federal budget authority for the decline in childcare expenditures due to the transfer of the existing Native Temporary Assistance caseload in Anchorage to CITC.

Prepared by: Katherine Farnham
Phone: 269-7930
Division: Public Assistance
Date/Time: 12/07/2004
Approved by: Joel S. Gilbertson, Commissioner
Date: 12/10/2004
Agency: Department of Health and Social Services

(Revised 9/23/2004 OMB)

COMMITTEE COPY

FISCAL NOTE
FN # 4

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB 51

ANALYSIS CONTINUATION

Analysis Continued: Child Care Benefits

Summary of all component impacts for CITCs NFAP	Total	Federal	GFM	I/A
ATAP component	(6,727.0)	(563.2)	(5,755.8)	(408.0)
Tribal Assistance	4,093.8		3,685.8	408.0
Work Services component	(1,346.4)	(1,346.4)	-	-
Child Care Benefits component	(931.5)	(931.5)	-	-
Total net fiscal impact for CITC Native TANF	(4,911.1)	(2,841.1)	(2,070.0)	-

Sectional Analysis

Bill No. SB 51

"An Act relating to contracts for the provision of state public assistance to certain recipients in the state; providing for regional public assistance plans and programs in the state; relating to grants for Alaska Native family assistance programs; relating to assignment of child support by Alaska Native family assistance recipients; relating to paternity determinations and genetic testing involving recipients of assistance under Alaska Native family assistance programs; and providing for an effective date

Section 1:

Amends AS 47.27 by adding a new article authorizing the Department of Health and Social Services (DHSS) to award and administer Alaska Native family assistance program (NFAP) grants. NFAP grants and programs operated under NFAP grants need not conform to legislative provisions authorizing the state administered Alaska Temporary Assistance Program (ATAP).

Outlines requirements for eligibility for an NFAP grant by specifying:

- which entities are eligible for NFAP grants under this legislation. AS 47.27.070 references the 12 Alaska Native non-profit corporations and the Metlakatla Indian Community of the Annette Islands Reserve;
- only tribes with a federally approved tribal TANF plan and those that agree to operate a tribal family assistance program under an approved plan are eligible for grant;
- the plan approved under this section must be operated on a state fiscal year basis;
- the process the department will use for approving an NFAP grant;
- guidelines for determining the grant amount;
- standards the program must meet for plan approval by the department;
- provisions for safeguarding confidentiality record sharing, data and fiscal record collection and exchange, and termination of the program.

Specifies that a person residing in an area covered by a tribal family assistance plan will be served only through that tribal organization and outlines an appeal process.

Requires that a participant in an Alaska Native family assistance program assign to that program all rights to ongoing child support and cooperate with all CSSD enforcement activities unless the program finds the participant has good cause for refusing to cooperate.

Requires a Native family assistance program to provide CSSD with information needed to make a valid child support assignment, and specifies the applicability of AS 25.27 (Child Support Services Agency) to a recipient under an Alaska Native family assistance program.

Section 2:

Amends AS 47.27 by adding a new article establishing the authority of DHSS to develop and implement regional public assistance plans and programs and authorizes the department to award contracts for the implementation of regional assistance programs. Contracts under this section are exempt from competitive bid requirements of the state procurement code. Under this section, DHSS can only contract for the implementation of a regional public assistance program if:

- an Alaska Native organization is authorized to operate a federally approved tribal assistance program;
- the organization has been awarded an NFAP grant;
- the regional plan will serve eligible state residents not covered by the federally approved tribal assistance program;
- the organization agrees to provide state public assistance identical to that provided by the federally approved tribal family assistance plan;
- the organization provides an appeals process for applicants or recipients that uses the same methodology available under the federally approved plan.

Mandates that recipient records be kept confidential.

Section 3:

Defines "Alaska Native family assistance grant;" "Alaska Native family assistance programs;" "federally approved tribal family assistance plan.

Section 4:

Provides authority for DHSS to adopt transitional regulations

Section 5:

Provides Revisor's instructions.

Section 6

Establishes an effective date of June 30, 2005.

State of Alaska

Department of Health & Social Services

Frank H. Murkowski
Governor
P.O Box 110001
Juneau, Alaska 99811-0001

FACT SHEET

Joel Gilbertson
Commissioner
907-465-3030
FAX: 907-465-3068
www.hss.state.ak.us

January 10, 2005

Reauthorization of the Native Family Assistance Program Fact Sheet

- Federal law authorizes 13 Alaska Native regional non-profit agencies to deliver their own unique tribal TANF programs to their members. Currently, three non-profit agencies operate tribal TANF programs that serve 995 families in Alaska.

- These tribal agencies have successfully administered TANF programs that reflect the unique needs and conditions in local communities while moving tribal members from welfare to work. Tribes have the knowledge and experience to provide culturally relevant services to their members.

- Tribal TANF programs are funded with federal dollars; tribal providers receive a share of the state's TANF block grant equal to the amount formerly expended by the state to serve tribal members.

- Both Alaska state and tribal officials agree that federal funds alone are insufficient for operation of a viable tribal TANF program. Moreover, federal law requires Alaska tribal TANF programs be comparable to the state-run TANF program. In response, state law passed in 2000 authorizes the Department of Health and Social Services to supplement four of the 13 non-profit agencies with Native Family Assistance Program grants (NFAP). NFAP grants are based on the amount of state funds formerly expended by the state to serve tribal members. This law will sunset on June 30, 2005. In 2004, the three tribal TANF programs currently operating in Alaska received approximately $8 7 million in NFAP grants

- Interest in development of tribal TANF programs in Alaska is on the rise. The Division of Public Assistance reports that three additional Native non-profit organizations have formally begun the process of developing tribal TANF programs.

HB 69:

- Reauthorizes the Native Family Assistance Program and places its provisions in permanent statute.

- Expands eligibility for NFAP grants to all 13 federally authorized tribal TANF providers.

- Ensures the viability of current tribal TANF programs and supports the development of additional locally operated and culturally relevant Tribal TANF programs.

COOK INLET
TRIBAL
COUNCIL INC.

February 9, 2005

Senator Fred Dyson
HESS Committee Chairman
State Capitol
Juneau, Alaska 99801-1182

RE: SB 51

Dear Chairman Dyson & Members of the HESS Committee,

My name is Molly Merritt-Duren, Department Director of Employment & Training Services for Cook Inlet Tribal Council (CITC) in Anchorage, AK. Cook Inlet Tribal Council strongly supports the passage of SB 51. We are poised and ready to become a Tribal TANF service provider for the Alaska Native and American Indian population living within the Anchorage area (with the option to expand these TANF services to surrounding villages in the future). We are fully prepared to partner with the State of Alaska in this endeavor.

CITC has been providing TANF (Welfare to Work) case management services as a vendor for the State of Alaska since 1997 (8 years). During this tenure CITC has been a key player in the successful decline of State TANF caseloads. Over the past several years we have consistently served between 600-700 families at any given time, with the Tribal TANF estimated caseload to be 794.

The 1994 TANF caseload for Anchorage was 1,123; it is currently 692 (as of 11/2004). During this period, Anchorage experienced an increase in Native population from 12,000 (1990 *US Census*) to approx. 46,000 (*2000 US Census*); yet the TANF participant role decreased by 62%.

Allowing CITC to become a Tribal TANF service provider makes the delivery of Tribal Temporary Assistance to Needy Families service delivery uniform throughout the State, as the majority of Alaska Native and American Indians in Alaska are currently being provided TANF services at other Native regional tribal social services agencies including Tanana Chiefs Conference, Central Council of Tlingit and Haida Indian Tribes and the Association of Village Council Presidents.

CITC is a fully integrated one-stop employment, social service, and substance abuse treatment agency.

Data and financial reporting & tracking will not be an issue for CITC. CITC will be using the State of Alaska; DHSS Eligibility Management System

670 W. FIREWEED LANE, ANCHORAGE, ALASKA 99503-2578
FAX: (907) 265-7942
PHONE: (907) 265-5900

COOK INLET
TRIBAL
COUNCIL INC

interfaced with our own sophisticated information technology (IT) & accounting infrastructure for the delivery of Tribal TANF services.

CITC currently provides IT services for 5 non-profit agencies in 25 locations (413 end users) and accounting services for 39 non-profits, consistently having no financial single audit findings.

We support this bill allowing CITC & other Native regional social service agencies to become a Tribal TANF service provider because it allows us to better serve and strengthen Alaska Native and American Indian families in a culturally respectful manner and to move towards getting families independent from TANF and into work.

Respectfully Submitted,

Molly Merritt-Duren for
Molly Merritt-Duren

Molly Merritt-Duren, M.S. Ed
Department Director
Cook Inlet Tribal Council
Employment & Training Services
670 W. Fireweed Lane
Anchorage, AK 99503
(907) 265-5915
mmerrittduren@citci.com

cc: Gloria O'Neill, President/CEO
Cook Inlet Tribal Council

Dr. MJ Longley, Chief of Operations
Cook Inlet Tribal Council

670 W. FIREWEED LANE, ANCHORAGE, ALASKA 99503-2578
FAX: (907) 265-7942
PHONE: (907) 265-5900

Native Family Assistance Program

Report to the Alaska Legislature on the Pilot Projects

Department of Health and Social Services
Division of Public Assistance
January 2005

TABLE OF CONTENTS

Alaska Native Family Assistance Program Pilot Projects

Executive Summary

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) ended the individual entitlement to welfare cash benefits and established a cap on federal funding in the form of a fixed block grant. In exchange for this new method of funding, states were allowed more flexibility in the administration of their Temporary Assistance for Needy Families (TANF) programs.

PRWORA also gave American Indian and Alaska Native organizations authority, as well as access to federal funding, to operate TANF programs through their own tribal organizations. In response, 37 tribal TANF programs currently operate on behalf of 175 tribes and serve over 8,400 families nationwide. A 2001 report published by the National Congress of American Indians estimates that a third of all American Indian and Alaska Native TANF recipients received support through tribal TANF programs in 2001.

PRWORA also specifies which Native entities are eligible to operate tribal TANF programs in Alaska. These are limited to the Metlakatla Indian Community of the Annette Island Reserve and the twelve Alaska Native regional non-profit corporations.

The 21st Alaska Legislature passed Chapter 96, SLA 2000 that allows the Alaska Department of Health and Social Services to supplement four of the thirteen federally authorized tribal TANF providers in Alaska with "Native Family Assistance Program" grants (NFAP). NFAP was authorized as a pilot program with a sunset date of June 30, 2005. The legislation also required the Department of Health and Social Services to deliver a report detailing the status of the tribal TANF pilot programs operating in Alaska, and making recommendations for the reauthorization and expansion of the NFAP program.

Three tribal TANF programs are currently operating in Alaska. The Tanana Chiefs Conference in the Doyon Region, the Central Council of Tlingit and Haida Indian Tribes in the Sealaska Region of southeast Alaska, and the Association of Village Council Presidents in the Yukon-Kuskokwim delta Calista Region now serve a total of 970 families, nearly 20% of all families receiving TANF services in Alaska. Consistent with the TANF goal of family self-sufficiency, tribal TANF programs in Alaska strongly support moving tribal members from welfare to work. Since the first Alaska tribal TANF program began operation in 1999, the number of Alaska Native tribal TANF recipients has dropped by over 33 percent.

From the outset, the State of Alaska has supported the establishment and development of the tribal TANF programs. The NFAP program affirms the state's interest in promoting regional responsibility and local control for public assistance programs in Alaska. Families served by

tribal TANF programs have been successful in leaving welfare for employment and self-sufficiency. Moreover, interest in the development of Tribal TANF programs is increasing. Three additional tribal organizations have begun the process of formally planning their tribal TANF program.

The Alaska Department of Health and Social Services makes the following recommendations in regard to the Native Family Assistance Program:

Reauthorize the Native Family Assistance Program.

Across the nation, federal welfare reform has been successful in moving families from welfare to work. The three tribal programs currently operating in Alaska have successfully administered TANF programs that reflect the unique needs and conditions in local communities while effectively moving tribal members towards self-sufficiency through employment. Tribes have a better grasp of social and economic conditions that inform their work and allow them to tailor services based on the unique needs of local communities. This local presence and familiarity with village and community life puts the tribes in the best position to administer their programs and to successfully promote self-sufficiency for their clients.

Both state and tribal officials agree that federal funds alone are insufficient for the successful operation of a tribal TANF program that is comparable to the state run program. Supplementing tribal TANF programs with Native Family Assistance grants will maximize federal block grant funds available to tribes, and will promote effective welfare-to-work service delivery models for rural Alaska. The Alaska Legislature should pass the Governor's proposed legislation that will make the NFAP program permanent.

Expand availability of Native Family Assistance grants to all tribal groups authorized in federal law to operate tribal TANF programs.

Three additional Native non-profits not currently authorized to receive Native Family Assistance Grants are actively planning tribal TANF programs as authorized in federal law. At least one additional non-profit has expressed interest revealing a strong trend toward development of tribal TANF programs in Alaska. Expansion of the availability of Native Family Assistance grants will ensure that all tribal organizations federally authorized to deliver tribal TANF programs will have the opportunity to access the necessary state resources and provide effective and innovative public assistance programs to their members.

Alaska Native Family Assistance Program Pilot Projects

Introduction

The 21st Alaska Legislature passed Chapter 96, SLA 2000 authorizing the Alaska Department of Health and Social Services (DHSS) to award and administer Alaska Native Family Assistance Program (NFAP) grants to Native non-profit organizations operating tribal Temporary Assistance for Needy Families (TANF) programs. The law provides that these grants are available on a pilot basis to four Alaska Native tribal entities: Metlakatla Indian Community of the Annette Island Reserve, the Association of Village Council Presidents, the Tanana Chiefs Conference, and the Tlingit-Haida Central Council. The law also requires DHSS to report to the Governor and the Legislature on the status of these pilot programs, and to make recommendations regarding the continuation of the NFAP program and expansion of the program to make grants available to all Alaska Native non-profit organizations authorized to receive federal funds to operate tribal TANF programs in Alaska. Chapter 96, SLA 2000 will sunset on June 30, 2005.

This report will provide background on the authorization and funding of tribal TANF programs, present information on the status of tribal TANF programs operating in Alaska, and make recommendations as to the continuation and expansion of the NFAP grant program.

Background

The passage of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), commonly known as "welfare reform," changed the face of welfare in America. After years of growing caseloads, the new law ended the individual entitlement to welfare cash benefits and established a cap on federal funding in the form of a fixed block grant. In exchange for this new method of funding, states were allowed a great deal more flexibility in the administration of their programs. This devolution of authority to states was similarly extended to American Indian and Alaska Native organizations. For the first time in history, Native people were authorized by the federal government to run a major welfare program through their own tribal governments and organizations.

To be eligible to operate a tribal TANF program, a Native entity must complete a Tribal Family Assistance Plan and submit it for approval to the Secretary of the U.S. Department of Health and Human Services. The plan must outline the tribe's approach to providing welfare-related services, specify which entity or entities will be providing the services, define the population and service area, provide that duplicative services will not be provided by a state or other tribe, identify employment opportunities in the area and how the tribe will enhance those opportunities for TANF recipients, and apply certain fiscal accounting and auditing procedures.

As of FY 2002, 36 tribal TANF plans were approved to operate on behalf of 175 tribes serving over 8,400 families nationwide. A 2001 report published by the National Congress of American Indians estimates that a third of all American Indian and Alaska Native TANF recipients

received support through tribal TANF programs in 2001. Figure 1 shows the growth in tribal TANF programs since their inception in 1997.

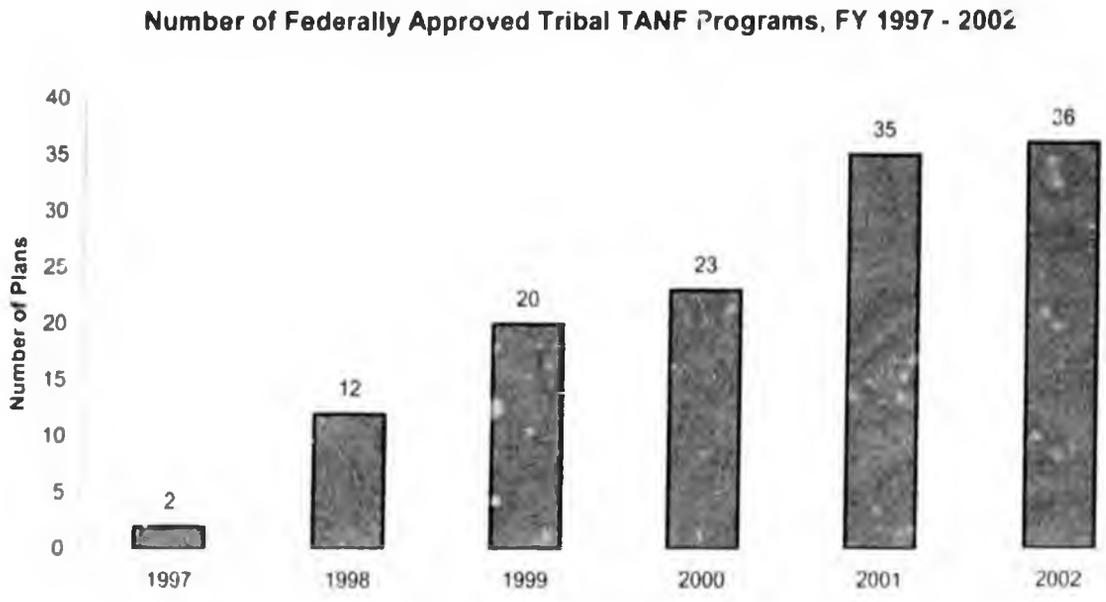


Figure 1

PRWORA also specifies which Native entities are eligible to operate Tribal TANF programs in Alaska. These are limited to the Metlakatla Indian Community of the Annette Island Reserve and the twelve Alaska Native regional non-profit corporations: Arctic Slope Native Association, Kawerak, Inc., Maniilaq Association, Association of Village Council Presidents, Inc., Tanana Chiefs Conference, Cook Inlet Tribal Council, Bristol Bay Native Association, Aleutian and Pribilof Islands Association, Chugachmiut, Tlingit and Haida Central Council, Kodiak Area Native Association, and Copper River Native Association. The law also contains a special rule for Alaska requiring certain aspects of tribal programs to be comparable to the state's TANF program. The federal Department of Health and Human Services in consultation with the tribes and the State of Alaska established these "comparability criteria" to include certain program eligibility criteria, benefit levels, minor parent requirements, work participation and child support enforcement. Chapter 96, SLA 2000, which established the Native Family Assistance Program, mirrors federal law by authorizing the state to coordinate with these Native organizations in the development of their Native family assistance programs.

Alaska currently has three tribal TANF programs serving nearly 20% of all TANF families in Alaska. From the outset, the State of Alaska has supported the establishment and development of the tribal TANF programs. Just as the devolution of authority from the federal government to the state has allowed for the success of welfare reform in Alaska, so has the authority granted to Native organizations provided a better framework for meeting the unique circumstances facing Alaska Native families on welfare. Programs run locally by Native organizations are more culturally relevant, better attuned to local economic circumstances, and better coordinated with other social services provided by Native organizations. Tribal TANF programs provide for an

added measure of Native self-governance and self-determination and ultimately, are better equipped to achieve the purposes of PRWORA.

Funding Tribal TANF: Federal Block Grant & Alaska Native Family Assistance Program

The federal funding provisions regarding tribal TANF programs are contained in Section 412 of PRWORA. The law establishes that the federal Department of Health and Human Services fund tribes who have submitted an approved tribal family assistance plan with a portion of the state's TANF block grant. The share of the state's block grant that is transferred to a tribal TANF program is based on the amount of federal funds spent by the state in 1994 for Native families residing in the service area identified by the tribe in their tribal family assistance plan.

While PRWORA is silent on the issue of state funding for tribal TANF programs, both the state Department of Health and Social Services and the TANF-authorized tribes concur that in order for tribal organizations to successfully operate state-comparable programs, they require both federal and state financial support. This agreement, along with interest of three Alaska tribal entities in providing TANF programs, provided the impetus for passage of Chapter 96, SLA 2000 and the development of the Native Family Assistance Program (NFAP) in Alaska.

The principle that guides the level of state funding provided to tribal TANF programs through NFAP grants is that the amount should be fair and equitable when compared to the level of state funding for the Alaska Temporary Assistance Program. To achieve this end, the state considers the total amount of federal and state money that would otherwise be used to provide Temporary Assistance to Native families living in the designated service area in a given base year. Five funding categories are included: cash benefits, childcare assistance, work services (case management, supportive services, transportation, client training, etc.), eligibility determination services and administration. From this total, the federal block grant and the state's share of child support collected on behalf of the tribal TANF families are deducted. The difference is issued as a Native family assistance grant. The state grant has been considered a block grant so that the Native program operates under the same fixed funding parameters as the state's TANF program.

NFAP grants are negotiated yearly with tribal TANF providers and funds are transferred on a quarterly basis. NFAP grants are expended solely on cash benefit payments, except for administrative costs not to exceed 15 percent of the total grant amount.

There are currently three Tribal TANF programs receiving Native Family Assistance Grants: the Tanana Chiefs Conference (TCC), the Tlingit and Haida Central Council (T&H), and the Association of Village Council Presidents (AVCP).

Table 1 shows the amounts granted between FY 1999 and FY 2004.

Native Family Assistance Grants, FY 1999 - 2004

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	Total
Tanana Chiefs	$2,405,200	$2,405,200	$2,405,200	$2,405,200	$2,405,200	$2,405,200	$14,431,200
Tlingit & Haida			$2,575,500	$2,575,500	$2,575,500	$2,575,500	$10,302,000
Assoc of Village Council Presidents			$3,740,400	$3,740,400	$3,740,400	$3,740,400	$21,733,200
TOTAL	$2,405,200	$2,405,200	$8,721,100	$8,721,100	$8,721,100	$8,721,100	$39,694,800

Table 1

Native Family Assistance Program Grant Oversight

Tribal providers who receive NFAP grants enter into a contractual agreement with the State of Alaska to provide timely and accurate cash assistance, eligibility services, case management and other welfare-to-work services, supportive services, child care assistance and administrative support to all eligible families living within their service area. The contract requires tribal providers to report monthly to DPA describing the amount of grant funds expended for TANF program benefits. Contract provisions also include an agreement between tribal providers and the state to share information, work cooperatively and coordinate services to eligible families.

The NFAP contract requires that tribes establish an eligibility and data management computer system that will capture and provide information needed for an interface between the Division of Public Assistance Eligibility Information System (EIS), the Child Support Services Division (CSSD) and the tribal program. The tribal program must agree to cooperate with CSSD to establish paternity and to establish, modify, or enforce a child support order for a dependent child.

The NFAP contract allows DPA to monitor and evaluate the tribal TANF program to assure that grant money is being used to serve eligible families. Such oversight items may include:

- Accurate eligibility and benefit determinations;
- Penalties, sanctions, and disqualification;
- Benefits issuance;
- Maximum payment levels;
- Minor Parent living arrangement and school attendance requirements;
- Child support cooperation;
- Coordination with other public assistance programs such as Medicaid, Food Stamps, Adult Public Assistance, Chronic and Acute Medical Assistance, and General Relief Assistance;
- Adequate case file documentation;
- Adequate and timely notice of adverse actions;
- Tracking 60-month time limit and appropriate exemptions; and
- Fair Hearing and Appeal process.

Should the tribal TANF provider fail to comply with the terms of the NFAP grant, DPA has the authority to suspend the grant until the provider takes corrective action or successfully appeals the suspension. To date, no tribal provider has been found to be out of compliance with the terms of their NFAP grant.

Development of Tribal TANF Programs in Alaska

The decision to assume responsibility for a tribal TANF program is a significant and complex decision for tribal organizations. Operating TANF presents important opportunities, but can also pose risks that may result in harm to the most vulnerable tribal members. To mitigate these risks and to build consensus among members, tribal TANF providers in Alaska undertook a rigorous decision-making and planning process.

The first step in planning for tribal TANF involved consensus building among tribal members. Tribal providers conducted regional, local and village meetings and teleconferences to discuss state and federal welfare reform legislation and its implications for Tribal TANF programs. Region-wide surveys of tribal preferences in program design were conducted and draft concept papers based on consensus elements of the survey were developed and circulated for discussion.

The thirteen Alaska tribes federally authorized to operate TANF programs worked cooperatively with the State of Alaska to reach agreement on the outline for a draft Tribal Family Assistance Plan (TFAP). A group known as the "Single Point of Contact" state and tribal representatives, or SPOC group, met regularly with a Native rights attorney hired by the tribes to come to consensus on such issues as the definition of a tribal service area, who would be served by a tribal TANF program, and the of comparability of state and tribal TANF programs. The SPOC group developed a model TFAP that became the template for Tribal TANF plans in Alaska.

Each tribal provider developed a draft TFAP that was reviewed by villages and communities in the service area. Final drafts of the plans were reviewed and approved by the Board of Directors of each Tribal entity and submitted to the Federal Department of Health and Human Services. Federal staff reviewed each tribe's plan and provided feedback as part of the approval process.

The experiences of Alaska's tribal TANF providers indicate that developing a sound TFAP requires more than meeting statutory requirements and following DHHS rules. The tribes have to define their own objectives and rules, negotiate terms with the state, and assemble resources for planning and start-up. Tribes decide to operate their own TANF program primarily because they believe they provide a better service to their members and achieve better employment outcomes by coordinating with Native employment programs. The TFAP is an opportunity to articulate the mission and goals of the tribal TANF program and to design the program

accordingly, including defining expectations for participation, acceptable work activities and sanction policies.

All three tribal TANF providers worked with the state in developing their TFAPs, and also received federal guidance. State staff provided information and guidance about staffing levels, policy and procedures and information systems needed to operate their programs. The state provided training and technical assistance including the collocation of state staff at tribal program facilities to assist in ongoing training and support.

While the state provided valuable technical assistance to help tribes develop their TANF plans, PRWORA does not provide any start-up funds to support planning or information system development prior to the approval of a tribal plan by DHHS and the subsequent grant award. In-kind support such as useful information, data and insights where garnered from staff working in related federally funded programs such as Native Employment Works (NEW) and the Workforce Investment Act (WIA). This lack of federal start-up technical assistance and planning funds is a concern of states and has been noted as a deficiency in federal law that must be addressed.

Although the tribal providers in Alaska encountered challenges, they developed transition strategies and implemented tribal TANF operations that enabled start-up and continued service delivery. Important elements of these strategies included gradual transitions to tribal program operation, continuation of state involvement in program operations for an interim period, maintenance of good working relationships with the state TANF agency and adjustment of policies and procedures as needed.

Structure and Philosophy of Tribal TANF Programs in Alaska

Federal law provides tribes the flexibility to design and implement their TANF programs in a manner that addresses the unique needs and circumstances of their members. They can define such elements as the program service area, service population (e.g., all Native families in the service area or only enrolled members of the tribe), time limits, benefits and services, the definition of "family," eligibility criteria, and work activities. Tribes have the ability to establish, through negotiation with the federal Department of Health and Human Services, their own program work participation rate targets and required work hours. Tribes must provide the rationale for proposed work requirements, including how they are consistent with the purposes of TANF and with the economic conditions and resources available to the tribe.

The tribal TANF programs also recognize the role of traditional tribal activities in the lives of their members and have incorporated them into their program structure. They accept traditional activities such as subsistence fishing, hunting, and gathering as well as traditional crafts as legitimate work participation. Because many TANF participants have little experience with work in a cash economy, these traditional activities can be critical to the growth of a sense of responsibility and to the development of employment skills.

The location and accessibility of tribal TANF programs help overcome employment barriers in rural Alaska. Often state TANF offices and resources are not available to village residents living far off the road system. Tribal TANF programs have developed program offices in towns and

villages throughout rural Alaska bringing critical TANF services to families in their own communities. Tribal TANF programs have also been successful in coordinating the various human service programs they offer such as employment, workforce development, training and social services. This holistic approach results in efficient services that promote the health and self-sufficiency of the entire family.

Tribes administering TANF programs have the option to administer their programs utilizing Public Law 102-477, which authorizes the integration of various employment, training, and related services provided by tribal governments under a Bureau of Indian Affairs approved 477 plan. Currently, 11 of the 36 Tribal TANF programs are administered under this program including the three programs in Alaska. The tribes that utilize this option do so to integrate and consolidate their TANF programs with other related and complementary support programs. This allows tribes to simplify their budgeting, operating, and reporting systems, while maximizing their resources and service delivery capabilities. Financial reporting relating to the TANF program has been integrated to the maximum extent possible, while still meeting the minimum statutory requirement for ensuring proper expenditure of TANF funds. Performance reporting must of necessity be maintained separately in order to meet minimum statutory and regulatory reporting requirements.

Tribal TANF providers may also develop their own strategies for achieving the program goal of family self-sufficiency. The tribal TANF programs, like the state's Alaska Temporary Assistance Program (ATAP), have adopted a philosophy that emphasizes work as a means of independence from public assistance. Along with a cash benefit, each program offers services that promote rapid employment, self-sufficiency, and family stability. Tribes have adopted strategies designed to prepare TANF participants for employment including adult education, job skill training, and work experience, and to eliminate barriers to employment by addressing such problems as lack of quality and affordable childcare, domestic violence, health and mental health difficulties, and untreated alcohol or substance abuse.

Status of Tribal TANF Programs in Alaska

Currently, tribal TANF programs in Alaska are serving a total of 970 families. Approximately forty percent of families have one child and 30 percent have two children.

Consistent with the goal of self-sufficiency, tribal TANF programs strongly support moving tribal members from welfare to work with an average of 40 percent of adults engaged in work or work participation activities. Since the first Alaska tribal TANF program began operation in 1999, the number of Alaska Native tribal TANF recipients has dropped by over 33 percent.

While tribal TANF results are below the state caseload reduction of 52 percent, this is a positive result when considering the challenge of securing employment in rural areas served by the state's tribal TANF programs. Figure 2 compares caseload reduction in the Alaska Temporary Assistance program with that of the three tribal TANF programs.

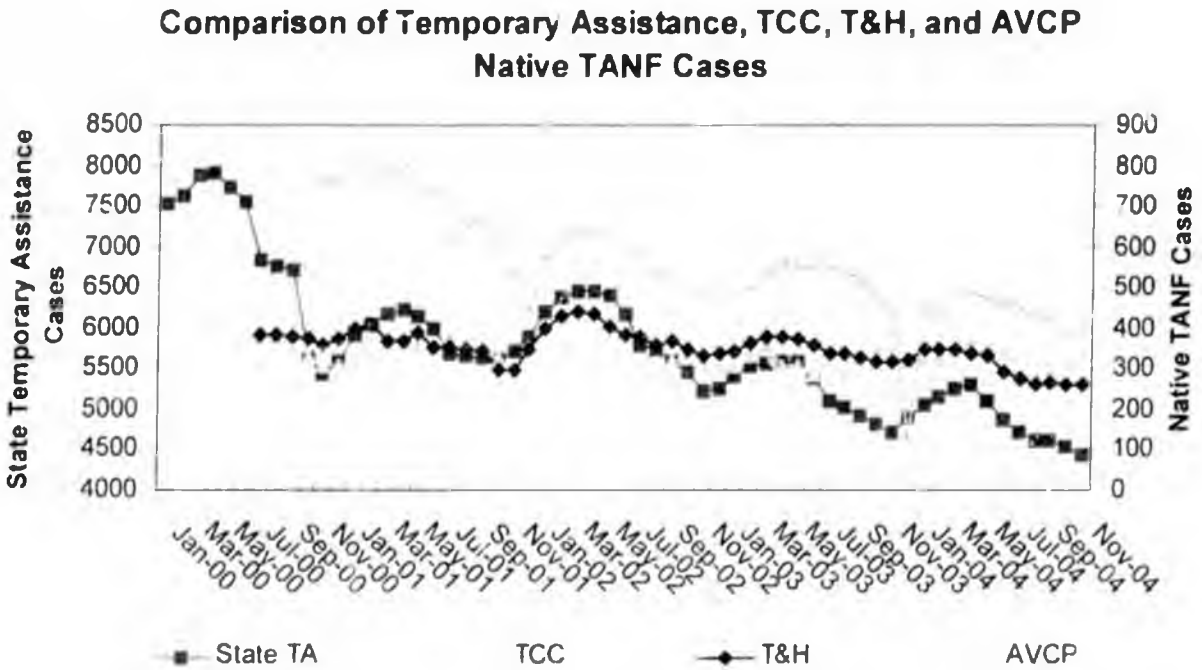


Figure 2

Tanana Chiefs "Athabascan Self-Sufficiency Assistance Partnership Program" (ASAP)

The service area for the ASAP program includes Fairbanks and 42 villages in Doyon Region of interior Alaska. This program serves all families in which the head of the household is Alaska Native or American Indian. The program began operation in October 1998, and in FY 2004 served an average of 315 families per month.

The ASAP program 2003 funding includes $5,312.1 in federal funding and $2,405.2 in state funding through the NFAP grant program. During FY 2003 the ASAP program provided services to approximately 1,618 clients including 289 families receiving childcare assistance for 468 children. The program authorized approximately $1.8 million in cash benefits to eligible recipients and over $253,000 in direct client or supportive services.

The goal of the ASAP program is to strengthen individuals, their families and their communities by increasing their capacities to support each other through meaningful work and employment, and to develop local resources and jobs to decrease dependency on cash assistance programs. The program is based on four guiding principals: every family has basic needs, which must be met; every family has something to offer their community; it takes a lot of work to meet the needs of a family and a community; and in every community, everyone should support themselves and each other by the work that they do.

Services provided by the ASAP program include case management, on-the-job training, short term job training, counseling and skill building, help with child care expenses, referrals for paid employment, referrals for community work services, structured job search to teach specific job search skills, transitional services including child care assistance and post-employment services, GED or high school instruction, vocational training, and higher education. Additional services

offered to families include financial literacy training, mentorship from members of the local community and linkages to therapeutic treatment options.

An innovative feature of the ASAP progr[illegible] is a one-stop service center in each of the village council offices. This model of service coordination promotes a holistic focus on family needs and allows TCC to deliver a variety of services efficiently and effectively. Prior to the transition to the one-stop service centers, there was a zero percent overall work participation rate for village-based TANF recipients. Now, the ASAP program has met its work participation requirements, put families into work, offered opportunities for training and matched parents with specialized resources.

The ASAP program has also promoted financial self-sufficiency with the Earned Income Tax Credit (EITC) Program. The program helped 774 recipients apply for the EITC on their tax returns, with approximately $570,000 realized in tax refunds. During the next fiscal year ASAP will offer EITC preparation seminars through a contract with Alaska Business Development Center and in conjunction with the University of Alaska. This program will assist working TANF recipients as well as those who have left ASAP to participate in the EITC program to augment their household income.

Community collaborations enhance services provided to recipients. In 2003 the ASAP program partnered with the State of Alaska Department of Labor and Workforce Development to present the Fairbanks Job Fair. Eighty-six employers and over 2,400 individuals participated making this the largest job fair ever in Alaska. Through a partnership with the TCC Tribal College, staff at the ASAP program began the training to become Certified Career Development Facilitators (CDF). CDF's are qualified to work in Career Resource Centers, Welfare to Work programs, as well as a variety of workforce development settings.

Faith-based partnerships are also a feature of ASAP. Love In the Name of Christ (Love, INC) provides "Hope Seminars" focusing on a range of skills including cooking on a tight budget, time and credit management, marriage and family communication, and purchasing and caring for a car. Successful completion of the two-day seminar enables an individual to be eligible for the Love, INC vehicle donation program. Through a partnership with TCC Old Minto Recovery and St. Mathews Church, the ASAP program offers "Strengthening the Families." This eight-week course is designed to strengthen family communication, encourage prevention of substance abuse for the youth, and assist high-risk famlies with essential skills for rebuilding a healthy family life.

The ASAP program has been successful in reducing the program caseload and putting people to work. During FY 2003, 265 clients were placed in unsubsidized employment. Between FY 2002 and FY 2003, the TCC caseload dropped by 5 percent. Since the time TCC began their

TANF program, their caseload has dropped approximately 16 percent. Figure 3 shows the changes in caseload since the program began.

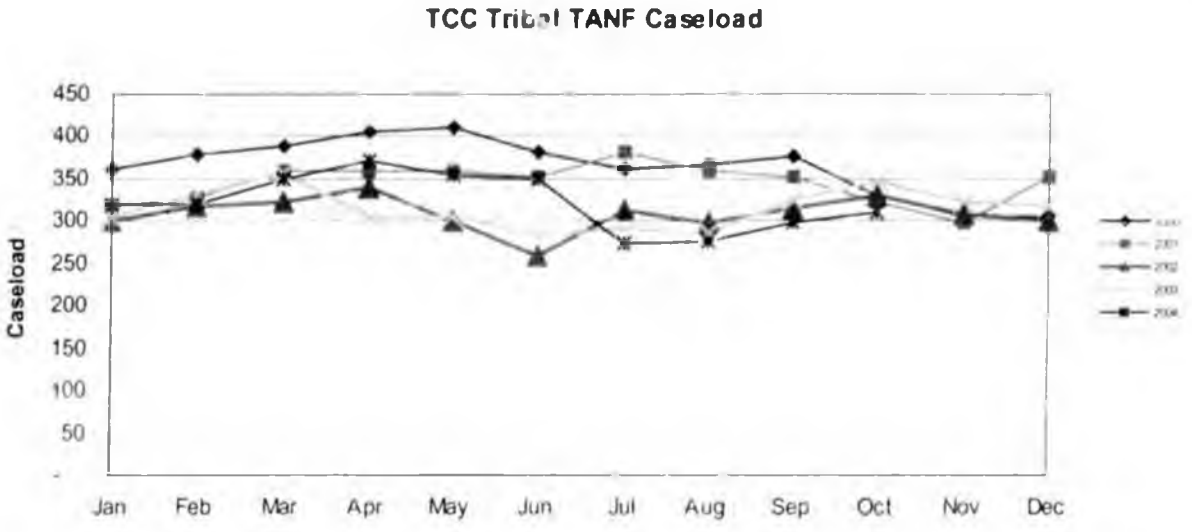


Figure 3

Central Council of Tlingit and Haida TANF Program

The T&H program serves Southeast Alaska, with eligibility restricted to households where at least one member is Alaska Native and enrolled or eligible for membership in a federally recognized tribe in the service area. These tribes include Angoon, Klukwan, Haines, Craig, Douglas, Hoonah, Hydaburg, Kake, Kasaan, Ketchikan, Klawock, Pelican, Petersburg, Saxman, Skagway, Tenakee, Wrangell, Sitka, Yakutat, and Juneau. The program began operation in July 2000. In FY 2003, the T&H program served an average of 315 families per month.

The 2003 T&H TANF program funding includes $ 2,367,150 million in federal funding and $2,575,500 in state funding through the Native Family Assistance Grant program. During FY 2003 the T&H TANF program provided services to approximately 350 clients including 208 families receiving childcare assistance for 624 children. The program authorized approximately $2,642,315 million in cash benefits to eligible recipients and over $801,000 in direct client or supportive services.

The overriding goal of the T&H tribal TANF program is to assist families to become self-sufficient. The program emphasizes work as a means to self-sufficiency with the expectation that both parents of children needing assistance must work to the extent of their ability. Program participants are encouraged to complete at least a high school education (or its equivalent), so that they can enjoy greater opportunities to obtain work that will produce sufficient income to support their families and contribute to their community. The program aims to discourage unwed pregnancies and works with all sectors of the community to discourage out-of-wedlock pregnancies, especially among teens, and encourages family stability by requiring teen parents to remain in their parents' or another responsible adult's home.

Services provided by the T&H TANF program include case management, adult basic education, employment assessment, adult vocational training and higher education, work experience and on-the-job training, job search skills and post-employment services. A variety of supportive services are offered to families who are actively participating in seeking employment, in school or in training including childcare, transportation, work clothing, tools for work, food and shelter assistance and linkages to therapeutic treatment options.

Service coordination is a key feature of the T&H TANF program. In 1994, T&H was the first Native American agency to utilize PL 102-477 to integrate a variety of services under their Employment and Training Division. Internally, the T&H TANF program coordinates with its Division of Employment and Training to utilize the services of Tribal Vocational Rehabilitation, childcare, Adult Vocational Training, Tribal Employment Rights and the Youth Opportunity Program.

Additional internal coordination includes Central Council Tribal Family and Youth Services, Headstart, and Tribal enrollment services for medical and mental health services. State agency partners in the delivery of services to TANF recipients include the Division of Public Assistance, the Department of Labor and Workforce Development, Child Support Services, the Division of Vocational Rehabilitation and the Office of Children's Service. Community partnerships with the Southeast Regional Resource Center, Catholic Community Services, St. Vincent DePaul, and women's shelters such as Aiding Women and Rape Emergencies (AWARE) help to address the needs of families with barriers to work.

The T&H TANF program has been successful in reducing the program caseload and putting people to work. During FY 2003, 270 clients were placed in unsubsidized employment. Between FY 2002 and FY 2003, the T&H caseload dropped by 5 percent. Since the time T&H began their TANF program, their caseload has dropped approximately 7 percent. Figure 2 below shows the changes in caseload since the program began

T&H Tribal TANF Caseload

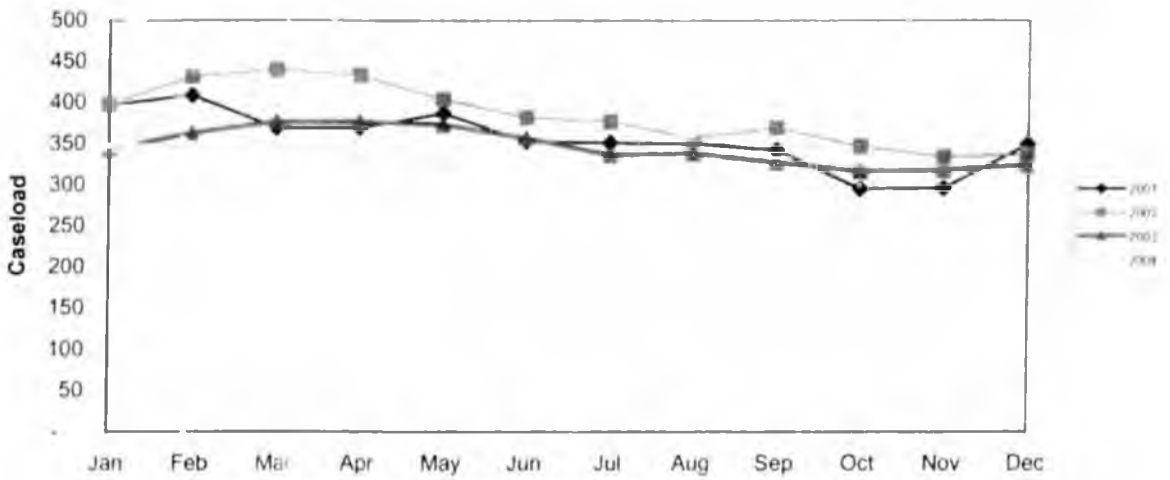


Figure 2

Association of Village Council Presidents TANF Program

The AVCP program serves Bethel and the 56 federally recognized tribes surrounding the Yukon-Kuskokwim Delta. In order to provide state public assistance in a uniform and cost effective manner, this program is designated as a "regional public assistance program," as it serves all Alaska Native families as well as non-Native families in the service area. This program began operation in October 2000. In FY 2003, the AVCP program served an average of 510 families per month.

The 2003 AVCP TANF program funding included $5,420.8 in federal funding and $3,740,400 in state funding through the Native Family Assistance Grant program. During FY 2003 the ASAP program provided services to approximately 550 clients including 18 families receiving childcare assistance for 36 children. The program authorized approximately $3.4 million in cash benefits to eligible recipients.

The overriding goal of AVCP TANF is to assist families to become self-sufficient through employment. The program provides comprehensive services that meet the basic needs of families throughout the region while improving communities and strengthening individuals. Work and supportive services are offered internally or through referrals to community agencies.

The AVCP TANF program coordinates internally with other AVCP services and programs, in particular the Education, Employment, Training and Childcare Division (EET&CC). Services include adult vocational training, employment services, and Head Start. EET&CC services promote economic and social development of tribal members in order to reduce joblessness and to more fully develop the academic, occupational and literacy skills that make individuals more competitive in the workforce. State agency partners in the delivery of services to TANF recipients include the Division of Public Assistance, the Department of Labor and Workforce Development and Child Support Services in the Department of Revenue.

The AVCP TANF program has been successful in reducing the program caseload and putting people to work. Between FY 2002 and FY 2003, the T&H caseload dropped by 10 percent. Since the time AVCP began their TANF program, their caseload has dropped approximately 40 percent. Figure 5 below shows the changes in caseload since the program began.

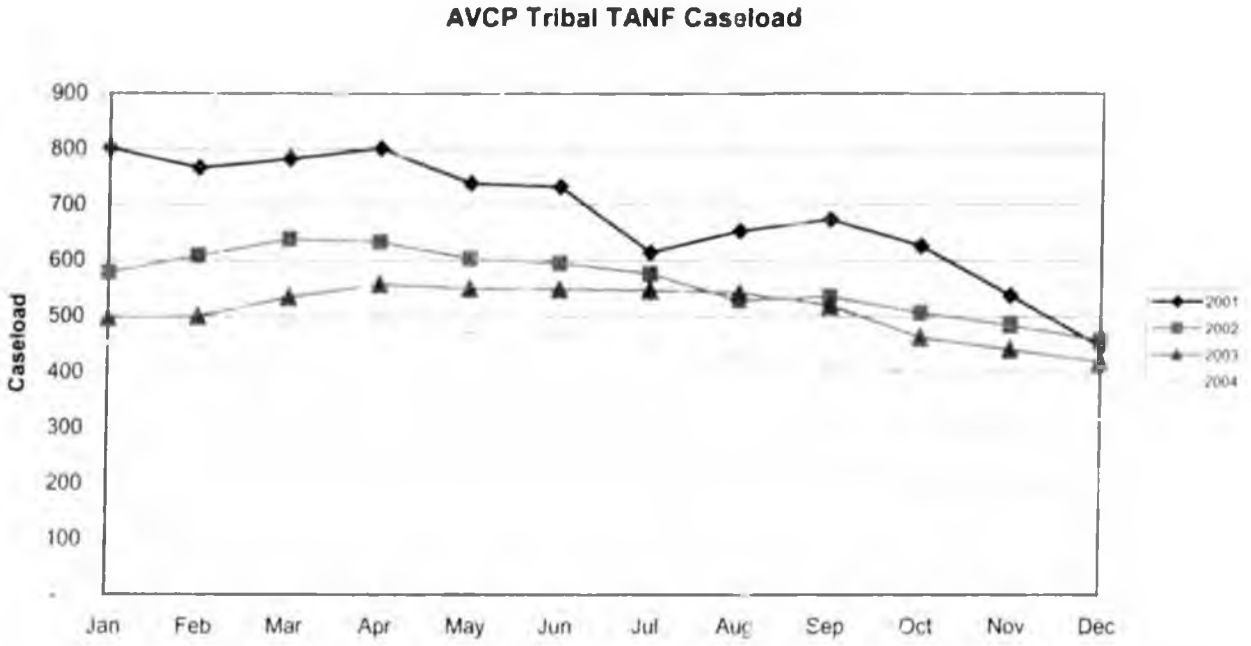


Figure 5

Obstacles and Lessons Learned

A common difficulty for tribes in Alaska was the development, operation and maintenance of computer information systems to support TANF operations. A TANF information system must support enrollment of program participants and help tribes track and report services provided and participant activities. Information systems are also crucial to the exchange of data with TANF partners such as the Alaska Child Support Services Division.

Unlike states, tribes did not receive funding to develop their own TANF information systems. In response, the state provided seed money to tribes to purchase a computer software product designed specifically for tribal TANF programs. The tribes are using this product with varying level of success and continue to struggle with the need to provide accurate data to state and federal agencies.

Because of the limitations of their own computer systems capacity, there is growing interest among tribal TANF providers in contracting with the state for use of the Eligibility Information System (EIS) used to administer programs in the Division of Public Assistance. Cook Inlet Tribal Council, scheduled to begin providing tribal TANF in July 2005, has made the decision to use EIS for at least two years while developing their own system. Two of the three groups currently providing tribal TANF have also expressed interest in converting to EIS. Using the EIS system may yield significant savings and efficiencies, particularly with respect to data transfers between agencies. The state will continue to support usage of EIS for tribal TANF programs in Alaska.

Trends in Tribal TANF

Interest in the development of Tribal TANF programs is on the increase. As of the current date, three additional groups have formally initiated planning for tribal TANF programs.

Cook Inlet Tribal Council. Cook Inlet Tribal Council, Inc. (CITC) provides social, educational and employment services to Alaska Natives and Native Americans living in the Cook Inlet region. Established in 1983 by Cook Inlet Region, Inc. (CIRI) as a nonprofit social service agency, CITC administers over forty culturally appropriate programs designed to assist individuals and families to achieve self-sufficiency. Annually these programs serve an average of 13,000 Alaska Natives and Native Americans.

Over the last 20 years, Cook Inlet Tribal Council has grown from a staff of fifteen employees and total revenue of $91,863 to a large and complex Native corporation, with over 245 employees and an annual operating budget in excess of $31 million in the Year 2003. CITC's continuum of services runs through five departments: Substance Abuse Services, Youth Development Services, Educational Services Systems, Employment and Training Services, and Family Services.

CITC is preparing to add TANF to their comprehensive array of family services. With a planned start date of July 2005, the CITC Tribal TANF program will serve approximately 700 families in the Anchorage area.

Bristol Bay Native Association. The Bristol Bay Native Association (BBNA) is an alliance of 30 Tribal Councils from villages in the Bristol Bay area of southwest Alaska. A non-profit service agency, BBNA provides educational, social and workforce development services to families and individuals as well as economic development opportunities for the region. BBNA is in the early planning phase of their TANF program with a scheduled start date of October 2005. The proposed program will serve approximately 125 families in the Bristol Bay region.

Maniilaq. Additionally, the Maniilaq Association has recently begun formal planning for a TANF program to serve Northwest Alaska. Maniilaq is the non-profit Native Consortium located in the hub village of Kotzebue, providing tribal, health and social services to native and non-native residents of the Northwest Arctic Borough and Pt. Hope. The proposed program will serve approximately 145 families.

Recommendations

Reauthorize the Native Family Assistance Program.

Across the nation, federal welfare reform has been successful in moving families from welfare to work. One of the main reasons for this success has been the fact that the federal welfare reform law afforded the states the flexibility to design and run their own unique TANF programs. In the same light, the federal law allows Alaska Native tribes to run their own programs designed by their members, locally controlled, and culturally relevant. Tribes have a better grasp of social and economic conditions that inform their work and allow them to tailor services based on the

unique needs of local communities. This local presence and familiarity with village and community life puts the tribes in the best position to administer their programs and to successfully promote self-sufficiency for their clients.

The Native Family Assistance Grant program affirms the state's interest in promoting regional responsibility and local control for public assistance programs in Alaska. The three tribal programs currently operating have successfully administered TANF programs that reflect the unique needs and conditions in local communities and have been proven effective in moving tribal members towards self-sufficiency through employment. The single regional public assistance program operating in the Yukon-Kuskokwim area of Alaska that serves both Native and non-Native families in the region has been shown to be administratively efficient and cost effective. Reauthorization of the Native Family Assistance program will ensure that tribal groups currently delivering TANF services will continue to provide comparable and culturally relevant services in their own villages and communities, and may also improve the delivery of the Temporary Assistance program in rural areas.

Both state and tribal officials agree that federal funds alone are insufficient for the successful operation of a tribal TANF program that is comparable to the state run program. Supplementing tribal TANF programs with Native Family Assistance grants will maximize federal block grant funds available to tribes, and will promote effective welfare-to-work service delivery models for rural Alaska. The Alaska Legislature should pass the Governor's proposed legislation that will make the NFAP program permanent.

Expand availability of Native Family Assistance grants to all tribal groups authorized in federal law to operate tribal TANF programs.

Two additional Native non-profits not currently authorized to receive Native Family Assistance Grants are actively planning tribal TANF programs as they are authorized to do in federal law. At least one additional non-profit has expressed interest revealing a strong trend toward development of tribal TANF programs in Alaska. Expansion of the availability of Native Family Assistance grants will ensure that all tribal organizations federally authorized to deliver tribal TANF programs will have the opportunity to access the necessary state resources and provide effective and innovative public assistance programs to their members.

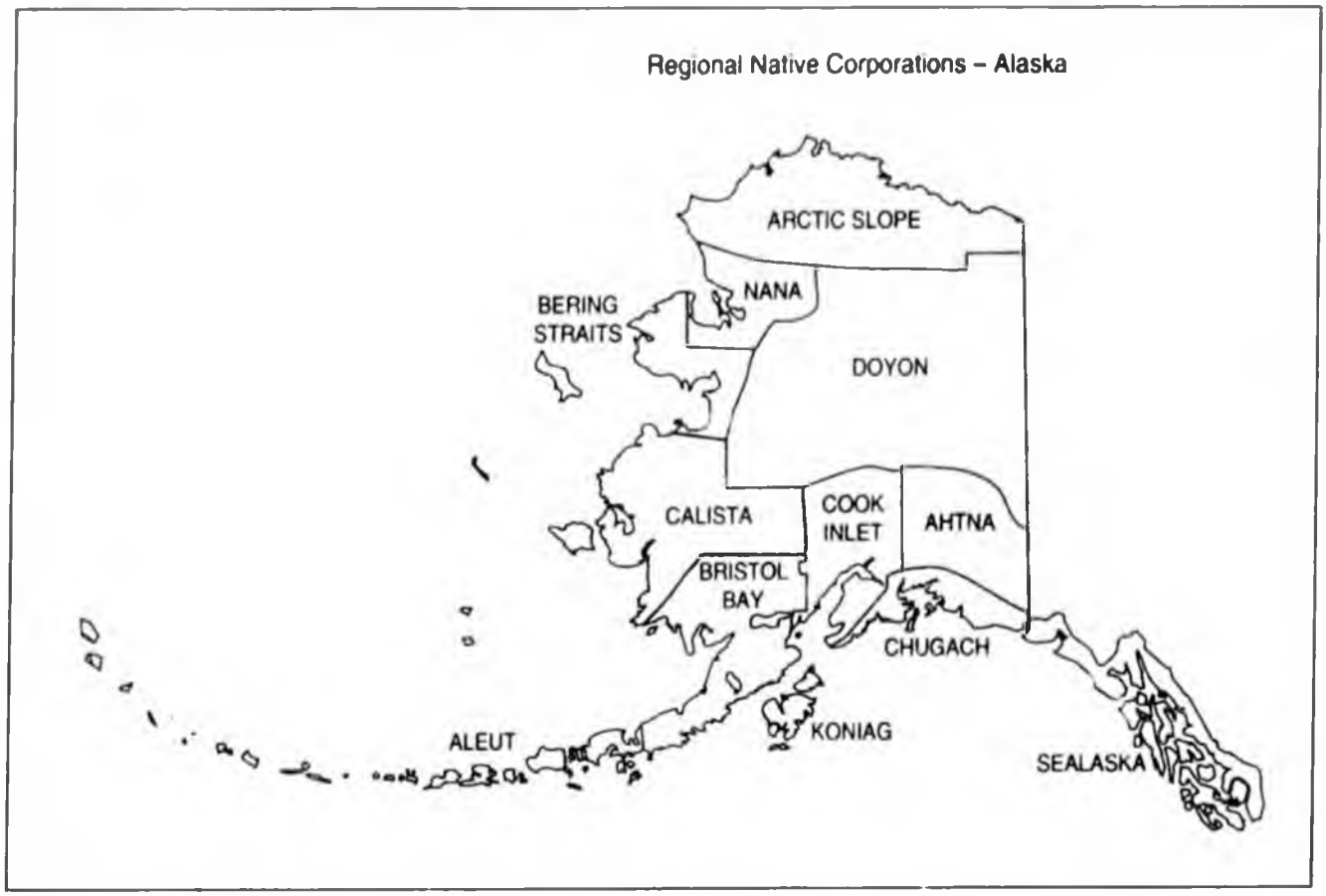
Appendix A

Table and Map: Regional Native Corporations and their Non-Profit Organizations

Regional Native Corporations and their Non-Profit Organizations

Alaska Native Regional Corporations	Regional Non-Profit Organization
Arctic Slope Regional Corporation	Arctic Slope Native Association
Bering Straits Native Corporation	Kawerak, Inc.
Nana	Maniilaq Association
Calista Corporation	Association of Village Council Presidents, Inc
Doyon, Limited	Tanana Chiefs Conference
Cook Inlet Region, Inc.	Cook Inlet Tribal Council
Bristol Bay Native Corporation	Bristol Bay Native Association
Aleut Corporation	Aleutian and Pribilof Islands Association
Chugach Alaska Corporation	Chugachmiut
Sealaska Corporation	Tlingit and Haida Central Council
Koniag, Inc.	Kodiak Area Native Association
Ahtna, Inc.	Copper River Native Association
Metlakatla Indian Community of the Annette Island Reserve *	

* The only Indian Reservation in Alaska



Appendix B

Selected Sections from PL 104-193, the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA)

Section 412. Direct Funding and Administration by Indian Tribes
Section 419. Definitions

SEC. 412. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

'(a) GRANTS FOR INDIAN TRIBES-

'(1) TRIBAL FAMILY ASSISTANCE GRANT-

'(A) IN GENERAL- For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each Indian tribe that has an approved tribal family assistance plan a tribal family assistance grant for the fiscal year in an amount equal to the amount determined under subparagraph (B), and shall reduce the grant payable under section 403(a)(1) to any State in which lies the service area or areas of the Indian tribe by that portion of the amount so determined that is attributable to expenditures by the State.

'(B) AMOUNT DETERMINED-

'(i) IN GENERAL- The amount determined under this subparagraph is an amount equal to the total amount of the Federal payments to a State or States under section 403 (as in effect during such fiscal year) for fiscal year 1994 attributable to expenditures (other than child care expenditures) by the State or States under parts A and F (as so in effect) for fiscal year 1994 for Indian families residing in the service area or areas identified by the Indian tribe pursuant to subsection (b)(1)(C) of this section.

'(ii) USE OF STATE SUBMITTED DATA-

'(I) IN GENERAL- The Secretary shall use State submitted data to make each determination under clause (i).

'(II) DISAGREEMENT WITH DETERMINATION- If an Indian tribe or tribal organization disagrees with State submitted data described under subclause (I), the Indian tribe or tribal organization may submit to the Secretary such additional information as may be relevant to making the determination under clause (i) and the Secretary may consider such information before making such determination.

'(2) GRANTS FOR INDIAN TRIBES THAT RECEIVED JOBS FUNDS-

'(A) IN GENERAL- The Secretary shall pay to each eligible Indian tribe for each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002 a grant in an amount equal to the amount received by the Indian tribe in fiscal year 1994 under section 482(i) (as in effect during fiscal year 1994).

'(B) ELIGIBLE INDIAN TRIBE- For purposes of subparagraph (A), the term 'eligible Indian tribe' means an Indian tribe or Alaska Native organization that conducted a job opportunities and basic skills training program in fiscal year 1995 under section 482(i) (as in effect during fiscal year 1995).

'(C) USE OF GRANT- Each Indian tribe to which a grant is made under this paragraph shall use the grant for the purpose of operating a program to make work activities available to members of the Indian tribe.

'(D) APPROPRIATION- Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $7,638,474 for