

SENATE HEALTH, EDUCATION & SOCIAL SERVICES

11810 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

Amy Seitz

From: PTH [pth@gci.net]
Sent: Thursday, February 02, 2006 1:47 PM
To: Sen. Hollis French; Rep. Ethan Berkowitz
Cc: Sen. Bettye Davis, Sen. Tom Wagoner, Amy Seitz, Sen. Johnny Ellis
Subject: SB 244, HB 236

Dear Senator French and Representative Berkowitz,

I am requesting your help in the passing of SB 244 and HB 236

As a licensed acupuncturist in Anchorage, I feel it is in the benefit of the patients to have freedom of choice for their health care. I also feel strongly that the patient should be reimbursed for care, specifically acupuncture when provided by a licensed acupuncturist. Acupuncture is proven method of treatment for many conditions, there should be no discrimination to the patient in the treatment they choose to use and who provides the treatment service

Since 1972, Anchorage has been my home. I grew up on the east side and currently live in Turnagain. The passing of these bills is very important for me and my patients and I would greatly appreciate your support.

Sincerely,
Beverly Sorenson, L.Ac
2448 W. Marston Dr
Anchorage, AK 99517

Amy Seitz

From: Sorensen, Camille [csorensen@cpgh.org]
Sent: Thursday, February 02, 2006 10:17 AM
To: Sen. Tom Wagoner
Cc: Amy Seitz; alaskaarmed@gci.net
Subject: Letter of Support for SB 244 and HB236

Senator Tom Wagoner
145 Main Street Loop, Ste 226
Kenai, AK 99611

Dear Senator Wagoner,

I am writing in support of SB 244 and HB 236 that will mandate insurance payments for acupuncturists in Alaska.

I know that there are a variety of studies proving the effectiveness of acupuncture as a treatment for a range of physical and mental complaints. I can personally vouch for the use of acupuncture as a treatment to relieve several allergy symptoms. I had never previously used acupuncture, but after suffering from allergies for several days, I was willing to try anything for relief. I had an acupuncture treatment and was immediately, and completely relieved of all allergy symptoms.

I suffer from eczema and an autoimmune disease and would like to receive more acupuncture treatments in support of better health. However, they are not inexpensive. I qualify for Indian health services and find it costs much less to be prescribed antihistamines than pay for acupuncture out of my own pocket, even if the drugs are less effective than acupuncture. I also have insurance and hope that soon it will cover acupuncture and other alternative medical therapies.

I highly encourage you to support this important step in providing affordable health care to Alaskans

Sincerely,

Camille Sorensen
Marketing Specialist
Central Peninsula General Hospital

*Camille Sorensen
Marketing Specialist
(907) 714-4600
csorensen@cpgh.org*

"Our lives are not determined by what happens to us but by how we react to what happens, not by what life brings to us, but by the attitude we bring to life. A positive attitude causes a chain reaction of positive thoughts, events, and outcomes. It is a catalyst, a spark that creates extraordinary results."

Amalyn@cpgh.org

Amy Seitz

From: L A Spikes [liz@carlesonhomes.com]
Sent: Wednesday, February 01, 2006 4:43 PM
To: Amy Seitz
Subject: *****SPAM***** I support the change in Alaska Statute 11.36.090 (bill SB244)

February 01, 2006

Dear Amy Seitz,

I have been receiving acupuncture treatment and I support the change in Alaska Statute 11.36.090 (bill SB244) which will allow acupuncture insurance reimbursement and remove unfair discrimination against acupuncturists.

Thank you for your support of this bill.

Sincerely,

Lizabeth A Spikes

Lizabeth A Spikes

Licensed Real Estate Assistant - Coldwell Banker

Sales & Marketing - Carleson Homes and Development, Inc.

907-376-5765 Direct Line

907-232-9361 Cell

907-376-5799 Fax



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February 2, 2006

Senator Tom Wagoner
145 Main Street Loop, Ste. 226
Kenai, AK 99611

Dear Senator Wagoner,

I am writing in support of SB 244 and HB 236 to make insurance payments for acupuncture a reality.

In 2004, our Service Area Board contracted with the Public Health Resource Group, Inc. to conduct a randomized survey of our service area residents on priority health issues.

Overall, the percentage of adults classified as not well or having some health issues was higher than the State and the U.S. averages. In addition, 1 in 5 adults in the Kenai region reported three or more chronic conditions including back pain, which ranked especially high among 45-64 years and 65+ years. There is also a higher rate of depression than most of the State and nation.

Over the past several years, I have served on a Prescription Drug Taskforce working to reduce the use of narcotic prescriptions that resulted in addiction and death in our community. There have been numerous deaths attributed to OxyContin overdoses and there is ongoing abuse of prescription drugs in our region. It is important that our residents have affordable access to non-pharmaceutical treatments. This will lower patient risks that will result in better outcomes for our patients and offer more treatment options.

The population of the Kenai Region frequently uses alternative health services. The study in 2004 showed 1 in 2 individuals have used alternative care. The extent to which we can integrate alternative care with medical care for chronic conditions will help to maximize the patient health status and provide more affordable care to all.

I commend you for your efforts in this area and can promise you that you will see benefits to the health status of the population of our state if this bill becomes law.

Best regards,

Bonnie J. Nichols - President
Healthy Communities/Healthy People

February 1, 2006

Janet Tune, L.Ac.,
3911 Eastwind Drive
Anchorage, AK 99516

RE: SB244 – Eliminating unfair discrimination against Acupuncturists.

My name is Janet Tune. I have been an Alaskan Resident for over 40 years, previously working in the insurance industry and receiving a Bachelors Degree in Business from Alaska Pacific University.

It is my understanding that there is legislation that could be passed to add Acupuncturists under AS 21.36.090 – Unfair Discrimination for services provided under group health insurance. This is through SB244 which states, "An Act prohibiting unfair discrimination against an acupuncturist; amending the definition of 'provider' as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans; and providing for an effective date."

I hope you will take a few minutes to read about my life experience and circumstances on my decision to practice this type of medicine.

I was involved in a very serious vehicle accident in the fall of 2000. I was advised by doctors that I would most likely never walk normally again due to the extent of my injuries. I was basically given no hope and was advised my active lifestyle in Alaskan activities would come to an end. It was in early 2001 that I tried acupuncture as a 'last resort' because I had 'nothing to lose'. I did standard physical therapy, physical therapy with a naturopath as well as herbs and acupuncture with dramatic changes. The evening after my third acupuncture treatment I walked fairly normally - - something I had not been able to do for seven months. My walking truly brought me to tears. The treatment allowed me to be mobile for just a few days, but, it gave me something I had not had for quite some time...hope. I was eventually able to walk normally with some intermittent pain and have been able to return to an active Alaskan lifestyle.

A little over a year after my auto accident, I was diagnosed with breast cancer. This too was a shocking and devastating diagnosis. This is when I found out about the ability of acupuncture to work not only on a physical level, but on an emotional level as well.

Due to my healing experiences with acupuncture I left my 23-year career in Commercial Insurance and recently received a Masters Degree in Acupuncture. I feel that Acupuncture is a very powerful and effective medicine. Acupuncture has been around as a form of medicine for over 3000 years – this is many times longer than our system of western medicine. There is definitely a priority for each type of medicine and I hope this can be recognized in allowing insurance billing for Acupuncturists through Legislation. I feel this would be a positive step in integrating both types of medicine and allowing Alaskans to receive the best and well-rounded health care possible.

I hope you will allow Alaska residents to receive reimbursement and have acupuncture recognized as a remarkable addition to currently reimbursable healthcare.

Sincerely –

Janet Tune, L.Ac., M.Ac., Dipl. Ac.

Amy Seitz

From: mel reamer [m.e_l@hotmail.com]
Sent: Wednesday, February 08, 2006 2:38 PM
To: Amy Seitz; senator_tom_wagner@legis.state.ak.us; alaskaormed@gci.net
Subject: insurance for acupuncture

hello, my name is Melissa Reamer. I am a student at Kenai Central High School. I am writing because today was Job Shadow day at my school and I chose to go to Karleens Day Spa and Acupuncture. I am hoping to pursue a career in Alternative Medicine and after my experience today I think that acupuncture, along with other alternative healing techniques, is something that is very beneficial to the patient in relieving pain along with other health problems. After seeing how much better patients feel after being treated with alternative methods at Karleens, I feel that acupuncture is definitely something that should be covered by insurance.

Thank You

Melissa Reamer

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Amy Seitz

From: Kris Harris [maudy@gci.net]
Sent: Monday, February 06, 2006 7:30 AM
To: Amy Seitz
Subject: Re: Legislative Bill SB244 and HB236

Dear Ms. Seitz,

I'm writing to ask Senator Wagner to support this Bill. Our daughter has cerebral Palsy and benefits greatly from receiving acupuncture. Atrophy is one of the things we work the hardest to prevent in Cassie's body. The combination of acupuncture and massage therapy have benefited her greatly. It would enable us to continue to keep her strong and healthy if our insurance would help cover the cost. I am a firm believer in preventative medicine rather than reactive. This has been extremely preventative in Cassie's life. She was looking at having surgery on her right ankle because of the tightness of the tendon. After seeing her acupuncturist, her heel was able to rest completely on the ground! Wouldn't you agree it is much better (and cheaper) to take care of a situation like this without surgery? Thank you!

Kris Harris

Amy Seitz

From: Jim Balamaci [Jim@specialolympicsalaska.org]
Sent: Friday, February 03, 2006 4:20 PM
To: Sen. Tom Wagoner
Cc: Amy Seitz
Subject: Alaska Statute 11.36.090 (bill SB244)

Dear Senator Wagoner,

I have been receiving acupuncture treatment and receiving tremendous benefit. I have found acupuncture to be highly effective form of health care and I would like to see acupuncture become more accessible for all Alaskans. Therefore I strongly support the change of Alaska Statute 11.36.090 (bill SB244), which will allow acupuncture insurance reimbursement and remove unfair discrimination against acupuncture coverage.

Thank you for your support of this bill.

Sincerely,

Jim Balamaci

Amy Seitz

From: moiles@gci.net
Sent: Friday, February 03, 2006 3:35 PM
To: Amy Seitz; Sen. Tom Wagoner; alaskaarmed@gci.net; Sen. Con Bunde; Sen. Ralph Seekins;
Sen. Ben Stevens; Sen. Johnny Ellis

This message is a plea for your review of the existing discrimination against acupuncture. Being a person suffering from Multiple Sclerosis, I have found that Acupuncture allows the brain signals to flow through my body again which has eliminated the need for expensive medications. Please consider including this procedure in our health care benefits. Thank You.

mail2web - Check your email from the web at <http://mail2web.com/> .

Amy Seitz

From: Mary Minor [mminor@gci.net]

Sent: Friday, February 03, 2006 3:38 PM

To: Sen. Ben Stevens; Sen. Con Bunde; Senator Johnny Ellis; Sen. Ralph Seekins; Sen. Tom Wagoner

Subject: SB 244

As a primary care provider, I have often sent patients to licensed acupuncturists for treatment, particularly of pain conditions and addictions. I have found my patients benefit greatly from acupuncture. I hope you will make acupuncture available to more Alaskans by prohibiting health insurance policies from discrimination against acupuncture treatment. The benefit to the public from having non-narcotic options for pain management and helping them to kick habits such as smoking would be incalculable. Thanks for your consideration

Mary Minor, ND

Re: Legislative Bill SB244 and HB236.

Amends Alaska Statute 21.36.090. This amendment will allow acupuncture insurance reimbursement and remove the unfair discrimination.

I believe in acupuncture and have benefited from these services.
I support Bill SB244 and HB236

SB 244 sponsored by Senator Tom Wagner is scheduled to go to Labor and Commerce Committee on February 7th, and then to HESS in the Senate. The companion bill HB 236, is sponsored by Rep. Kertulla in the House and is scheduled for State Affairs and then to Labor and Commerce.

Contact info:

amy_seitz@legis.state.ak.us
senator_tom_wagoner@legis.state.ak.us
Fax number 907-465-4779

This is Senator Wagoner's assistant
Senator Wagoner

Mary Taylor
Sincerely,
Mary Taylor
PO Box 7224
Nikiski, AK 99635
907-776-5181

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Abstract

Objective.

To provide health care providers, patients, and the general public with a responsible assessment of the use and effectiveness of acupuncture for a variety of conditions.

Participants.

A non-Federal, nonadvocate, 12-member panel representing the fields of acupuncture, pain, psychology, psychiatry, physical medicine and rehabilitation, drug abuse, family practice, internal medicine, health policy, epidemiology, statistics, physiology, biophysics, and the public. In addition, 25 experts from these same fields presented data to the panel and a conference audience of 1,200.

Evidence.

The literature was searched through Medline, and an extensive bibliography of references was provided to the panel and the conference audience. Experts prepared abstracts with relevant citations from the literature. Scientific evidence was given precedence over clinical anecdotal experience.

Consensus Process.

The panel, answering predefined questions, developed their conclusions based on the scientific evidence presented in open forum and the scientific literature. The panel composed a draft statement, which was read in its entirety and circulated to the experts and the audience for comment. Thereafter, the panel resolved conflicting recommendations and released a revised statement at the end of the conference. The panel finalized the revisions within a few weeks after the conference. The draft statement was made available on the World Wide Web immediately following its release at the conference and was updated with the panel's final revisions.

Conclusions.

Acupuncture as a therapeutic intervention is widely practiced in the United States. While there have been many studies of its potential usefulness, many of these studies provide equivocal results because of design, sample size, and other factors. The issue is further complicated by inherent difficulties in the use of appropriate controls, such as placebos and sham acupuncture groups. However, promising results have emerged, for example, showing efficacy of acupuncture in adult postoperative and chemotherapy nausea and vomiting and in postoperative dental pain. There are other situations such as addiction, stroke rehabilitation, headache, menstrual cramps, tennis elbow, fibromyalgia, myofascial pain, osteoarthritis, low back pain, carpal tunnel syndrome, and asthma, in which acupuncture may be useful as an adjunct treatment or an acceptable alternative or be included in a comprehensive management program. Further research is likely to uncover additional areas where acupuncture interventions will be useful.

Introduction

Acupuncture is a component of the health care system of China that can be traced back for at least 2,500 years. The general theory of acupuncture is based on the premise that there are patterns of energy flow (Qi) through the body that are essential for health. Disruptions of this flow are believed to be responsible for disease. Acupuncture may correct imbalances of flow at identifiable points close to the skin. The practice of acupuncture to treat identifiable pathophysiological conditions in American medicine was rare until the visit of President Nixon to China in 1972. Since that time, there has been an explosion of interest in the United States and Europe in the application of the technique of acupuncture to Western medicine.

Acupuncture describes a family of procedures involving stimulation of anatomical locations on the skin by a variety of techniques. There are a variety of approaches to diagnosis and treatment in American acupuncture that incorporate medical traditions from China, Japan, Korea, and other countries. The most studied mechanism of stimulation of acupuncture points employs penetration of the skin by thin, solid, metallic needles, which are manipulated manually or by electrical stimulation. The majority of comments in this report are based on data that came from such studies. Stimulation of these areas by moxibustion, pressure, heat, and lasers is used in acupuncture practice, but because of the paucity of studies, these techniques are more difficult to evaluate.

Acupuncture has been used by millions of American patients and performed by thousands of physicians, dentists, acupuncturists, and other practitioners for relief or prevention of pain and for a variety of health conditions. After reviewing the existing body of knowledge, the U.S. Food and Drug

Administration recently removed acupuncture needles from the category of "experimental medical devices" and now regulates them just as it does other devices, such as surgical scalpels and hypodermic syringes, under good manufacturing practices and single-use standards of sterility.

Over the years, the National Institutes of Health (NIH) has funded a variety of research projects on acupuncture, including studies on the mechanisms by which acupuncture may produce its effects, as well as clinical trials and other studies. There is also a considerable body of international literature on the risks and benefits of acupuncture, and the World Health Organization lists a variety of medical conditions that may benefit from the use of acupuncture or moxibustion. Such applications include prevention and treatment of nausea and vomiting; treatment of pain and addictions to alcohol, tobacco, and other drugs; treatment of pulmonary problems such as asthma and bronchitis; and rehabilitation from neurological damage such as that caused by stroke.

To address important issues regarding acupuncture, the NIH Office of Alternative Medicine and the NIH Office of Medical Applications of Research organized a 2-1/2-day conference to evaluate the scientific and medical data on the uses, risks, and benefits of acupuncture procedures for a variety of conditions. Cosponsors of the conference were the National Cancer Institute, the National Heart, Lung, and Blood Institute, the National Institute of Allergy and Infectious Diseases, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Institute of Dental Research, the National Institute on Drug Abuse, and the Office of Research on Women's Health of the NIH. The conference brought together national and international experts in the fields of acupuncture, pain, psychology, psychiatry, physical medicine and rehabilitation, drug abuse, family practice, internal medicine, health policy, epidemiology, statistics, physiology, and biophysics, as well as representatives from the public.

After 1-1/2 days of available presentations and audience discussion, an independent, non-Federal consensus panel weighed the scientific evidence and wrote a draft statement that was presented to the audience on the third day. The consensus statement addressed the following key questions:

- What is the efficacy of acupuncture, compared with placebo or sham acupuncture, in the conditions for which sufficient data are available to evaluate?
- What is the place of acupuncture in the treatment of various conditions for which sufficient data are available, in comparison or in combination with other interventions (including no intervention)?
- What is known about the biological effects of acupuncture that helps us understand how it works?
- What issues need to be addressed so that acupuncture can be appropriately incorporated into today's health care system?
- What are the directions for future research?

1. What is the Efficacy of Acupuncture, Compared With Placebo or Sham Acupuncture, in the Conditions for Which Sufficient Data Are Available To Evaluate?

Acupuncture is a complex intervention that may vary for different patients with similar chief complaints. The number and length of treatments and the specific points used may vary among individuals and during the course of treatment. Given this reality, it is perhaps encouraging that there exist a number of studies of sufficient quality to assess the efficacy of acupuncture for certain conditions.

According to contemporary research standards, there is a paucity of high-quality research assessing efficacy of acupuncture compared with placebo or sham acupuncture. The vast majority of papers studying acupuncture in the biomedical literature consist of case reports, case series, or intervention studies with designs inadequate to assess efficacy.

This discussion of efficacy refers to needle acupuncture (manual or electroacupuncture) because the published research is primarily on needle acupuncture and often does not encompass the full breadth of acupuncture techniques and practices. The controlled trials usually have involved only adults and did not involve long-term (i.e., years) acupuncture treatment.

Efficacy of a treatment assesses the differential effect of a treatment when compared with placebo or another treatment modality using a double-blind controlled trial and a rigidly defined protocol. Papers should describe enrollment procedures, eligibility criteria, description of the clinical characteristics of the subjects, methods for diagnosis, and a description of the protocol (i.e., randomization method, specific definition of treatment, and control conditions, including length of treatment and number of acupuncture sessions). Optimal trials should also use standardized outcomes and appropriate statistical analyses. This assessment of efficacy focuses on high-quality trials comparing acupuncture with sham acupuncture or placebo.

Response Rate.

As with other types of interventions, some individuals are poor responders to specific acupuncture protocols. Both animal and human laboratory and clinical experience suggest that the majority of subjects respond to acupuncture, with a minority not responding. Some of the clinical research outcomes, however, suggest that a larger percentage may not respond. The reason for this paradox is unclear and may reflect the current state of the research.

Efficacy for Specific Disorders.

There is clear evidence that needle acupuncture is efficacious for adult postoperative and chemotherapy nausea and vomiting and probably for the nausea of pregnancy.

Much of the research is on various pain problems. There is evidence of efficacy

for postoperative dental pain. There are reasonable studies (although sometimes only single studies) showing relief of pain with acupuncture on diverse pain conditions such as menstrual cramps, tennis elbow, and fibromyalgia. This suggests that acupuncture may have a more general effect on pain. However, there are also studies that do not find efficacy for acupuncture in pain.

There is evidence that acupuncture does not demonstrate efficacy for cessation of smoking and may not be efficacious for some other conditions.

Although many other conditions have received some attention in the literature and, in fact, the research suggests some exciting potential areas for the use of acupuncture, the quality or quantity of the research evidence is not sufficient to provide firm evidence of efficacy at this time.

Sham Acupuncture.

A commonly used control group is sham acupuncture, using techniques that are not intended to stimulate known acupuncture points. However, there is disagreement on correct needle placement. Also, particularly in the studies on pain, sham acupuncture often seems to have either intermediate effects between the placebo and 'real' acupuncture points or effects similar to those of the 'real' acupuncture points. Placement of a needle in any position elicits a biological response that complicates the interpretation of studies involving sham acupuncture. Thus, there is substantial controversy over the use of sham acupuncture in control groups. This may be less of a problem in studies not involving pain.

2. What is the Place of Acupuncture in the Treatment of Various Conditions for Which Sufficient Data Are Available, in Comparison or in Combination With Other Interventions (including No Intervention)?

Assessing the usefulness of a medical intervention in practice differs from assessing formal efficacy. In conventional practice, clinicians make decisions based on the characteristics of the patient, clinical experience, potential for harm, and information from colleagues and the medical literature. In addition, when more than one treatment is possible, the clinician may make the choice taking into account the patient's preferences. While it is often thought that there is substantial research evidence to support conventional medical practices, this is frequently not the case. This does not mean that these treatments are ineffective. The data in support of acupuncture are as strong as those for many accepted Western medical therapies.

One of the advantages of acupuncture is that the incidence of adverse effects is substantially lower than that of many drugs or other accepted medical procedures used for the same conditions. As an example, musculoskeletal conditions, such as fibromyalgia, myofascial pain, and tennis elbow, or

epicondylitis, are conditions for which acupuncture may be beneficial. These painful conditions are often treated with, among other things, anti-inflammatory medications (aspirin, ibuprofen, etc.) or with steroid injections. Both medical interventions have a potential for deleterious side effects but are still widely used and are considered acceptable treatments. The evidence supporting these therapies is no better than that for acupuncture.

In addition, ample clinical experience, supported by some research data, suggests that acupuncture may be a reasonable option for a number of clinical conditions. Examples are postoperative pain and myofascial and low back pain. Examples of disorders for which the research evidence is less convincing but for which there are some positive clinical trials include addiction, stroke rehabilitation, carpal tunnel syndrome, osteoarthritis, and headache. Acupuncture treatment for many conditions such as asthma or addiction should be part of a comprehensive management program.

Many other conditions have been treated by acupuncture; the World Health Organization, for example, has listed more than 40 for which the technique may be indicated.

3. What is Known About the Biological Effects of Acupuncture That Helps Us Understand How It Works?

Many studies in animals and humans have demonstrated that acupuncture can cause multiple biological responses. These responses can occur locally, i.e., at or close to the site of application, or at a distance—mediated mainly by sensory neurons to many structures within the central nervous system. This can lead to activation of pathways affecting various physiological systems in the brain as well as in the periphery. A focus of attention has been the role of endogenous opioids in acupuncture analgesia. Considerable evidence supports the claim that opioid peptides are released during acupuncture and that the analgesic effects of acupuncture are at least partially explained by their actions. That opioid antagonists such as naloxone reverse the analgesic effects of acupuncture further strengthens this hypothesis. Stimulation by acupuncture may also activate the hypothalamus and the pituitary gland, resulting in a broad spectrum of systemic effects. Alteration in the secretion of neurotransmitters and neurohormones and changes in the regulation of blood flow, both centrally and peripherally, have been documented. There is also evidence of alterations in immune functions produced by acupuncture. Which of these and other physiological changes mediate clinical effects is at present unclear.

Despite considerable efforts to understand the anatomy and physiology of the "acupuncture points," the definition and characterization of these points remain controversial. Even more elusive is the scientific basis of some of the key traditional Eastern medical concepts such as the circulation of Qi, the meridian system, and other related theories, which are difficult to reconcile with contemporary biomedical information but continue to play an important role in

the evaluation of patients and the formulation of treatment in acupuncture.

Some of the biological effects of acupuncture have also been observed when "sham" acupuncture points are stimulated, highlighting the importance of defining appropriate control groups in assessing biological changes purported to be due to acupuncture. Such findings raise questions regarding the specificity of these biological changes. In addition, similar biological alterations, including the release of endogenous opioids and changes in blood pressure, have been observed after painful stimuli, vigorous exercise, and/or relaxation training; it is at present unclear to what extent acupuncture shares similar biological mechanisms.

It should be noted also that for any therapeutic intervention, including acupuncture, the so-called "non-specific" effects account for a substantial proportion of its effectiveness and thus should not be casually discounted. Many factors may profoundly determine therapeutic outcome, including the quality of the relationship between the clinician and the patient, the degree of trust, the expectations of the patient, the compatibility of the backgrounds and belief systems of the clinician and the patient, as well as a myriad of factors that together define the therapeutic milieu.

Although much remains unknown regarding the mechanism(s) that might mediate the therapeutic effect of acupuncture, the panel is encouraged that a number of significant acupuncture-related biological changes can be identified and carefully delineated. Further research in this direction not only is important for elucidating the phenomena associated with acupuncture, but also has the potential for exploring new pathways in human physiology not previously examined in a systematic manner.

4. What Issues Need To Be Addressed So That Acupuncture Can Be Appropriately Incorporated Into Today's Health Care System?

The integration of acupuncture into today's health care system will be facilitated by a better understanding among providers of the language and practices of both the Eastern and Western health care communities.

Acupuncture focuses on a holistic, energy-based approach to the patient rather than a disease-oriented diagnostic and treatment model.

An important factor for the integration of acupuncture into the health care system is the training and credentialing of acupuncture practitioners by the appropriate State agencies. This is necessary to allow the public and other health practitioners to identify qualified acupuncture practitioners. The acupuncture educational community has made substantial progress in this area and is encouraged to continue along this path. Educational standards have been established for training of physician and non-physician acupuncturists. Many acupuncture educational programs are accredited by an agency that is

recognized by the U.S. Department of Education. A national credentialing agency exists for nonphysician practitioners and provides examinations for entry-level competency in the field. A nationally recognized examination for physician acupuncturists has been established.

A majority of States provide licensure or registration for acupuncture practitioners. Because some acupuncture practitioners have limited English proficiency, credentialing and licensing examinations should be provided in languages other than English where necessary. There is variation in the titles that are conferred through these processes, and the requirements to obtain licensure vary widely. The scope of practice allowed under these State requirements varies as well. While States have the individual prerogative to set standards for licensing professions, consistency in these areas will provide greater confidence in the qualifications of acupuncture practitioners. For example, not all States recognize the same credentialing examination, thus making reciprocity difficult.

The occurrence of adverse events in the practice of acupuncture has been documented to be extremely low. However, these events have occurred on rare occasions, some of which are life-threatening (e.g., pneumothorax). Therefore, appropriate safeguards for the protection of patients and consumers need to be in place. Patients should be fully informed of their treatment options, expected prognosis, relative risk, and safety practices to minimize these risks before their receipt of acupuncture. This information must be provided in a manner that is linguistically and culturally appropriate to the patient. Use of acupuncture needles should always follow FDA regulations, including use of sterile, single-use needles. It is noted that these practices are already being done by many acupuncture practitioners; however, these practices should be uniform. Recourse for patient grievance and professional censure are provided through credentialing and licensing procedures and are available through appropriate State jurisdictions.

It has been reported that more than 1 million Americans currently receive acupuncture each year. Continued access to qualified acupuncture professionals for appropriate conditions should be ensured. Because many individuals seek health care treatment from both acupuncturists and physicians, communication between these providers should be strengthened and improved. If a patient is under the care of an acupuncturist and a physician, both practitioners should be informed. Care should be taken to ensure that important medical problems are not overlooked. Patients and providers have a responsibility to facilitate this communication.

There is evidence that some patients have limited access to acupuncture services because of inability to pay. Insurance companies can decrease or remove financial barriers to access depending on their willingness to provide coverage for appropriate acupuncture services. An increasing number of insurance companies are either considering this possibility or now provide coverage for acupuncture services. Where there are State health insurance plans, and for populations served by Medicare or Medicaid, expansion of coverage to include appropriate acupuncture services would also help remove

financial barriers to access.

As acupuncture is incorporated into today's health care system, and further research clarifies the role of acupuncture for various health conditions, it is expected that dissemination of this information to health care practitioners, insurance providers, policymakers, and the general public will lead to more informed decisions in regard to the appropriate use of acupuncture.

5. What Are the Directions for Future Research?

The incorporation of any new clinical intervention into accepted practice faces more scrutiny now than ever before. The demands of evidence-based medicine, outcomes research, managed care systems of health care delivery, and a plethora of therapeutic choices make the acceptance of new treatments an arduous process. The difficulties are accentuated when the treatment is based on theories unfamiliar to Western medicine and its practitioners. It is important, therefore, that the evaluation of acupuncture for the treatment of specific conditions be carried out carefully, using designs that can withstand rigorous scrutiny. In order to further the evaluation of the role of acupuncture in the management of various conditions, the following general areas for future research are suggested.

What are the demographics and patterns of use of acupuncture in the United States and other countries?

There is currently limited information on basic questions such as who uses acupuncture, for what indications is acupuncture most commonly sought, what variations in experience and techniques used exist among acupuncture practitioners, and are there differences in these patterns by geography or ethnic group. Descriptive epidemiologic studies can provide insight into these and other questions. This information can in turn be used to guide future research and to identify areas of greatest public health concern.

Can the efficacy of acupuncture for various conditions for which it is used or for which it shows promise be demonstrated?

Relatively few high-quality, randomized, controlled trials have been published on the effects of acupuncture. Such studies should be designed in a rigorous manner to allow evaluation of the effectiveness of acupuncture. Such studies should include experienced acupuncture practitioners to design and deliver appropriate interventions. Emphasis should be placed on studies that examine acupuncture as used in clinical practice and that respect the theoretical basis for acupuncture therapy.

Although randomized controlled trials provide a strong basis for inferring causality, other study designs such as those used in clinical epidemiology or outcomes research can also provide important insights regarding the usefulness

of acupuncture for various conditions. There have been few such studies in the acupuncture literature.

Do different theoretical bases for acupuncture result in different treatment outcomes?

Competing theoretical orientations (e.g., Chinese, Japanese, French) currently exist that might predict divergent therapeutic approaches (i.e., the use of different acupuncture points). Research projects should be designed to assess the relative merit of these divergent approaches and to compare these systems with treatment programs using fixed acupuncture points.

In order to fully assess the efficacy of acupuncture, studies should be designed to examine not only fixed acupuncture points, but also the Eastern medical systems that provide the foundation for acupuncture therapy, including the choice of points. In addition to assessing the effect of acupuncture in context, this would also provide the opportunity to determine whether Eastern medical theories predict more effective acupuncture points.

What areas of public policy research can provide guidance for the integration of acupuncture into today's health care system?

The incorporation of acupuncture as a treatment raises numerous questions of public policy. These include issues of access, cost-effectiveness, reimbursement by State, Federal, and private payors, and training, licensure, and accreditation. These public policy issues must be founded on quality, epidemiologic and demographic data and effectiveness research.

Can further insight into the biological basis for acupuncture be gained?

Mechanisms that provide a Western scientific explanation for some of the effects of acupuncture are beginning to emerge. This is encouraging and may provide novel insights into neural, endocrine, and other physiological processes. Research should be supported to provide a better understanding of the mechanisms involved, and such research may lead to improvements in treatment.

Does an organized energetic system that has clinical applications exist in the human body?

Although biochemical and physiologic studies have provided insight into some of the biologic effects of acupuncture, acupuncture practice is based on a very different model of energy balance. This theory might or might not provide new insights to medical research, but it deserves further attention because of its potential for elucidating the basis for acupuncture.

How do the approaches and answers to these questions differ among populations that have used acupuncture as a part of their healing tradition for centuries, compared with populations that have only recently begun to incorporate acupuncture into health care?

Conclusions

Acupuncture as a therapeutic intervention is widely practiced in the United States. There have been many studies of its potential usefulness. However, many of these studies provide equivocal results because of design, sample size, and other factors. The issue is further complicated by inherent difficulties in the use of appropriate controls, such as placebo and sham acupuncture groups.

However, promising results have emerged. For example, efficacy of acupuncture in adult post-operative and chemotherapy nausea and vomiting and in postoperative dental pain. There are other situations such as addiction, stroke rehabilitation, headache, menstrual cramps, tennis elbow, fibromyalgia, myofascial pain, osteoarthritis, low back pain, carpal tunnel syndrome, and asthma for which acupuncture may be useful as an adjunct treatment or an acceptable alternative or be included in a comprehensive management program. Further research is likely to uncover additional areas where acupuncture interventions will be useful.

Findings from basic research have begun to elucidate the mechanisms of action of acupuncture, including the release of opioids and other peptides in the central nervous system and the periphery and changes in neuroendocrine function. Although much needs to be accomplished, the emergence of plausible mechanisms for the therapeutic effects of acupuncture is encouraging.

The introduction of acupuncture into the choice of treatment modalities readily available to the public is in its early stages. Issues of training, licensure, and reimbursement remain to be clarified. There is sufficient evidence, however, of its potential value to conventional medicine to encourage further studies.

There is sufficient evidence of acupuncture's value to expand its use into conventional medicine and to encourage further studies of its physiology and clinical value.

Consensus Development Panel

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ACUPUNCTURE WORKS

AN NIH PANEL ENDORSES THE ANCIENT CHINESE NEEDLE TREATMENT--AT LEAST FOR SOME CONDITIONS

BY DICK THOMPSON

James Keyser for TIME



For an ancient Chinese custom that turns patients into human pincushions, acupuncture is surprisingly popular these days. America's growing interest in alternative medicine and the quasi endorsement of the Food and Drug Administration (which last year took acupuncture's extra-fine needles off its list of "experimental" medical devices) have helped create a sharp spike in demand for the prickly procedure.

About a million Americans spend \$500 million a year on acupuncture for

complaints ranging from gallstones to migraines to low-back pain; today even dogs and horses are trotting off to see their acupuncturists.

But does it work? Most Western-trained physicians remain skeptical. Explanations that acupuncture restores the balance of yin and yang by tinkering at critical points along life-force meridians sound to scientists suspiciously like quackery. Advocates counter that their claims are supported by hundreds of research studies--as well as a successful track record that extends back 2,500 years.

To sort through the controversy and assess the quality of that research, the National Institutes of Health last week assembled a panel of experts in a scientific court known officially as a consensus conference. After three days of analyzing studies and interrogating practitioners, the panel was unexpectedly upbeat. "It's time to take acupuncture seriously," said its chairman, David Ramsay, president of the University of Maryland. "There are a number of situations where it really does work."

The panel found acupuncture effective in treating painful disorders of the muscle and skeletal systems, such as fibromyalgia and tennis elbow--even more effective, in some cases, than conventional therapies. It was judged to be a "reasonable option" for the relief of postoperative pain and low-back pain. And it won qualified endorsement as a supplement to standard remedies for drug addiction, carpal-tunnel syndrome, osteoarthritis and asthma.

Acupuncture's one great advantage over Western medicine is that it does no harm; unlike drugs and surgery, acupuncture has virtually no side effects. For acupuncturists who have been saying this for years, it was recognition long overdue. "[The panel's report] is a great step toward breaking down the barriers," said Larenz Ng, a pioneer of acupuncture research and now a professor of neurology at George Washington School of Medicine.

One big barrier remains: acupuncture springs from a system of faith that scientists find almost incomprehensible. The treatment rests on the Taoist belief that two life forces, yin and yang, combine to produce a vital life energy, called ch'i (or qi), that flows through the body along pathways known as meridians, which were charted thousands of years ago. People get sick when these life forces are knocked out of balance, and the job of the acupuncturists is to nudge ch'i back into equilibrium. They do this by pushing needles through the skin, sometimes several inches into the body, at specific points along the meridians, and then twisting or twirling them or pulsing them with a low electric current.

What puzzles scientists is that these points and meridians don't correspond to any biological system in the body. How, then, can sticking a needle into the ear, for example, affect a distant organ like the gallbladder? One possible explanation, for which the panel found "considerable evidence," is that acupuncture works at least in part by releasing opioids, natural morphine-like substances, into the central nervous system.

However it happens, scientists know that acupuncture produces measurable changes in the brain. Some of the most compelling evidence presented last week was a series of brain scans taken by Dr. Abass Alavi, chief of nuclear medicine at the University of Pennsylvania Hospital in Philadelphia. Alavi's images showed dramatic changes in regions of the central nervous system that coordinate the perception of pain. "Acupuncture definitely changed the landscape of pain we see in the brain," Alavi told the panel.

Not everyone was persuaded. Dr. Wallace Sampson, a member of the National Council Against Health Fraud, complained that the panel had not invited the naysayers. And although the studies presented were mostly conducted in Western countries using accepted scientific methods, several critics pointed out that the best-designed experiments showed the poorest

results.

The future of acupuncture in the U.S., however, will probably not rest on the quality of these experiments. If it's cheaper and less painful than going to the hospital, and if it gets results, Americans will use it. A Boston University researcher told the panel that the saving from just faster stroke rehabilitation and effective carpal-tunnel-syndrome treatment could cut the nation's annual medical bill by \$11 billion. Such a saving is sure to catch the eye of HMOs and private health insurers. As Daniel Cherkin, a senior scientific investigator for a large HMO in Seattle, puts it, "Why something works is not of interest to those individuals and organizations providing care." What matters these days is that it works for less.

CLEARLY EFFECTIVE

- Postoperative pain from dental surgery
- Nausea and vomiting from chemotherapy and anesthesia

MAY BE EFFECTIVE

- Migraines
- Tennis elbow
- Arthritis
- Menstrual cramps
- Low-back pain

UNCERTAIN

- Stroke rehabilitation
- Asthma
- Carpal-tunnel syndrome
- Immune-system enhancement

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Conditions Treated

By addressing the underlying imbalances that eventually cause pain, illness or other symptoms, acupuncture improves ones health from the inside out. After treatment, feel better in ways never expected – in addition to noticing improvement in the original condition.

While acupuncture is used to treat many conditions, enhance overall health, and improve immune functioning, it has also been endorsed by the World Health Organization as for treating the following:

Infections

- Colds and Flu
- Bronchitis
- Hepatitis

Internal

- Hypoglycemia
- Asthma
- High Blood Pressure
- Ulcers
- Colitis
- Indigestion
- Hemorrhoids
- Diarrhea
- Constipation
- Diabetes

Eyes-Ears-Nose-Throat

- Deafness
- Ringing in the Ears
- Earaches
- Poor Eyesight
- Dizziness
- Sinus Infection
- Sore Throat
- Hay Fever

Musculo-skeletal & Neurologic

- Arthritis
- Neuralgia
- Sciatica
- Back Pain
- Bursitis
- Tendonitis
- Stiff Neck
- Bell's Palsy
- Trigeminal Neuralgia
- Headache
- Stroke
- Cerebral Palsy
- Polio
- Sprains

Genito-Urinary & Reproductive

- Impotence
- Infertility
- Pre-menstrual Syndrome (PMS)
- Pelvic Inflammatory Disease (PID)
- Vaginitis
- Irregular Period/Cramps
- Morning Sickness

Mental-Emotional

Anxiety
Depression
Stress
Insomnia

Dermatological

Eczema
Acne
Herpes

Acupuncture for pain conditions

Arthritis
Low Back Pain
Sciatica
Bursitis
Tendonitis
Neck/Shoulder Pain
Carpal Tunnel
Headaches
Muscle Strain

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ACUPUNCTURE ASSISTANCE FOR WITHDRAWAL FROM TOBACCO SMOKING

by Subhuti Dharmananda, Ph.D., Director, Institute for Traditional Medicine, Portland, Oregon

The effectiveness of acupuncture for drug withdrawal, including smoking cessation, has been proclaimed by acupuncturists in the U.S. since the early 1980's. Much of the work in this area was stimulated by the reports of Michael Smith, who developed an acupuncture protocol for "drug detox" in the late 1970's. His work focused especially on the use of ear acupuncture, following the work of surgeon-acupuncturist Paul Nogier in France. Smith has also pursued the question of the nature of addiction and the setting required to help patients overcome addiction. Though Smith's work was mainly involved with difficult inner-city drug problems like heroin addiction, the principles and methods have been applied to nicotine addiction in daily smokers. Explanations for the role of acupuncture in drug withdrawal, such as inducing enkephalins and endorphins to reduce the anxiety and stress as the blood levels of the drug decline, were proposed. The results of testing for these substances have been somewhat contradictory.

Several state and city governments have indicated their support by providing funds for acupuncture centers focusing on drug withdrawal for illegal drugs or illegal use of drugs (such as driving under the influence of alcohol). Such support continues in several cities (there are more than 300 acupuncture-based substance abuse programs in the U.S., many of them funded by governmental agencies) and an organization to promote this methodology, the National Acupuncture Detoxification Association (NADA), was formed in 1988. It has a current membership of nearly half of all American acupuncturists.

There is now great social reinforcement for stopping smoking. The medical profession, to the extent it is represented by the largest member organization, the American Medical Association, has taken up a campaign to encourage all smokers to quit, regardless of their current health status (formerly, this effort was made only when smoking was a known contributor to the disease the patient suffered from). Public health messages about the harm associated with smoking have dramatically increased in numbers. As a result, personal support for continued restraint is easily obtained. Nonetheless, the long-term quit rate for tobacco smoking appears to be holding fairly constant, with slightly more than half of all people who take up the habit giving it up at some time in their life.

The currently accepted stop-smoking methods usually involve counseling plus application of nicotine in doses that reduce craving for the drug while being diminished gradually. Nicotine patches and nicotine gum are examples of delivery systems that separate the nicotine from the act of smoking. The effectiveness of these methods can be determined with some accuracy because it is possible to provide placebo alternatives and observe the difference in smoking cessation rates.

In order to interpret the studies of acupuncture effects on smoking cessation, it is important to examine some basic considerations in any kind of smoking cessation approach:

1. Patients who volunteer to stop smoking, because they desire to quit, are more likely to succeed than patients who are assigned, cajoled, or otherwise induced to enter a program with little personal desire to quit.
2. Short-term smoking cessation, that is, stopping smoking at the end of a stop-smoking program, is easier to attain than long-term smoking cessation. Regardless of the method used to stop smoking, once the stop-smoking treatment method is withdrawn (with successful cessation), a variety of factors can affect the individual so as to induce re-initiation of smoking. Generally, if a person has stopped smoking for a full six months, the chances of starting smoking again are very low. Therefore, six month cessation rates, one year cessation rates, and two year cessation rates are similar regardless of the method employed.
3. Short term smoking cessation success may depend on the extent to which the intervention provides regular reinforcement of the stop-smoking effort. A person left to his or her own is more likely to resume smoking than a person who daily encounters someone who reinforces the stop smoking attempt.

4. Those who take up smoking in their teens and maintain the habit for many years have a more difficult time quitting smoking than those who take up smoking later in life. The "early-onset" smoking addiction may correlate with genetic and behavioral patterns that lead to addiction, while "late onset" smoking is more often a habit of choice. About 80% of U.S. smokers begin their habit by age 18.

For these reasons, acupuncture research that involves daily treatment of volunteer patients—especially those who took up smoking late and who desire to stop smoking—should attain a high level of short-term effect, and the long-term effect should be reasonably good, but not necessarily better than other methods that take volunteer patients of similar characteristics.

Research about acupuncture effects on smoking cessation have mostly been conducted without a control group. This means that all of the non-specific effects of a stop-smoking program, such as the decision to stop smoking, the regular visits to a stop-smoking assistant (a health professional, for example), and the cessation of smoking at least for a day or two during the program as occurs for those who do not quit the program, all contribute to a positive outcome that could also be attained by a placebo treatment. Therefore, it is difficult to know the full contribution, if any, of acupuncture to the success rate.

REVIEWS OF ACUPUNCTURE RESEARCH ON SMOKING CESSATION

Two major reviews of this subject have been presented recently. One, a two part report in the *Journal of Traditional Chinese Medicine* (1, 2), is by Cui Meng, at the Institute of Information on Traditional Chinese Medicine, in Beijing. The other appeared in a special issue of the *Journal of Alternative and Complementary Medicine*, which presented the papers from the NIH Technology Assessment Workshops on acupuncture (3). The article of interest in the latter journal was authored by Patricia Culliton (who works at the Hennepin Faculty Associates in Minneapolis, which may be the biggest Chinese medicine treatment center in the U.S.), and Tom Kiresuk, who works at the Center for Addiction and Alternative Medicine Research.

In Cui's article, about using acupuncture for attaining abstinence from drug use, under abstaining from smoking, this is said:

The long-term effective rate was about 30%. Lebeau, et al., analyzed and studied a total of 84 papers involving over 10,000 volunteers for giving up smoking with acupuncture and psychotherapy, and found that the average withdrawal rate was about 60% at the end of treatment and it was about 30% at 12 months after treatment. Schwartz analyzed nearly 30 papers of studies on acupuncture abstaining from smoking, and found that the mean withdrawal rate ranged between 8% and 40% at 12 months after the end of treatment, and it was around 25% as followed up for six months in 13 papers involving 4,000 smokers.

To put this in perspective, what is being said is that after a few days of treatment (all that is needed for initial withdrawal, see below), about 60% of patients (average of all studies) had stopped smoking, and that rate dropped to about 25–30% within six months and stayed at that level (follow-up for two years gave the same result, as indicated elsewhere in his report). Of course, some individual reports analyzed to attain these averages indicated much higher short-term withdrawal rates, sometimes claiming over 90%. Because Chinese journals mainly publish only successful studies, the figures of 60% short-term and 30% long-term positive results are undoubtedly somewhat high, as the studies with low success rates usually don't get published and, therefore, don't get included in the calculated average outcome. Also included in his summary, Cui mentioned that Yves Requena in Paris reported on the use of ear plus nose acupuncture for smoking withdrawal. His study involved a total of 1138 smokers: 56% gave up smoking, and most of the others reduced the amount that they smoked (29% reduced smoking by less than half their previous amount). This outcome (for short-term smoking cessation) is consistent with the figure of 60% given above.

In the second part of his report, Cui describes factors that influence the outcome of treatment, based on the reported results. In sum, he concluded that the desire to stop smoking did not impact the short-term effects, but did affect long-term success; confidence in the possible effectiveness of the stop-smoking attempt did not influence outcome, and "psychic" support from the doctor exhibits "remarkable effect" on the cure. By psychic

support, he refers to talks by the doctor and tips on maintaining a non-smoking environment. He has a section of this article titled "Regarding the possibility of a placebo effect in acupuncture as a method in giving up smoking." Here, he says:

Results of 11 controlled studies on therapeutic acupuncture and placebo acupuncture treatments were that in only two studies the effects of the therapeutic acupuncture were significantly superior to those in placebo acupuncture ($P < 0.05$), while the therapeutic effects of placebo were somewhat better in another 3 of the 11 studies, suggesting that acupuncture may be a placebo therapy in stopping smoking."

Since sham acupuncture was used as a control, the failure of standard acupuncture to do better than the sham acupuncture may not rule out the value of acupuncture; it may simply indicate that the site of applying the needles is not especially important. This conclusion would be consistent with the high degree of variability among stop-smoking acupuncture treatments that are claimed to be effective (though an equally consistent conclusion would be that none of the treatments are effective).

In the review article by Culliton and Kirusek, which describes acupuncture therapy for treating persons with substance abuse problems, under the heading "nicotine" they state:

Generally, the literature regarding the use of acupuncture for smoking appears to be similar to the rest of the substance abuse acupuncture literature. Several articles can be characterized by their emotional tone and evident, prior beliefs. Believers find minimal supporting evidence as very encouraging, whereas debunkers dismiss the value of any preliminary findings. The studies are not comparable and have not been replicated... Overall, one might conjecture that many forms of psychosocial and other treatments will reduce smoking behavior temporarily. The treatments can be expected to become indistinguishable in longer term relapse rate comparisons. Nonspecific and placebo treatment effects may form the basis of the efficacy of all treatments. Generally, the research in this area is inconclusive....

In their section on "additional studies," this is said:

The meta-analysis by Ter, Reit, Kleijnen, and Knipschild (1990) reviewed 22 controlled clinical studies of the efficacy of acupuncture, including 15 cigarette smoking, 5 heroin, and 2 alcohol treatment studies. The authors concluded that the quality of research was generally poor and that the results did not support the efficacy of substance abuse acupuncture treatment.

These reviews suggest that acupuncture therapy for withdrawal from smoking may have marginal or no substantial effects beyond the non-specific influence of program participation (encouragement by the acupuncturist, structured setting, repeated office visits, etc.). This raises the question of whether or not it is worthwhile to delve in detail into any specific treatment protocols. In fact, Culliton and Kirusek point out that:

The acupuncture protocols vary as to location and number of needle site placement. The methods include staples, needles, lasers, and stitches, with and without electrical stimulation. The frequency and duration of treatments is not comparable [between studies]. Studies that use a total of two or three treatments on a once-per-week schedule may be testing subclinical dosages....

Similarly, Cui gives examples of several different treatment methods and point sets, and these serve just as a few examples of the dozens of methods used in the reports, with no mention of any specific treatment having been studied repeatedly.

In a review of pharmacotherapy for smoking (4), it was reported that in placebo controlled trials, nicotine gum and patches increased quit rates (all measured at six months) over placebo by a factor of 1.6 to 2.8. Nicotine nasal spray and nicotine inhaler had similar benefits, with improvements ranging from 1.0 (no improvement) to 3.5. A non-nicotine withdrawal drug, bupropion hydrochloride (an antidepressant), had two tests indicating an improvement by a factor of 1.5-1.7. According to these carefully designed studies, six month quit rates among the placebo groups ranged from 4-19%, with the wide range of variation attributed to

differences in trial designs. The highest quit rates reported with the tested therapies were in the range of 25–35%, consistent with the rates claimed in the Chinese studies summarized above (25–30%). Unfortunately, the American and Chinese studies cannot be compared directly, because the setting of the studies is so different. Still, it is tempting to suggest that acupuncture therapy may be as successful as the treatments currently accepted in the U.S., both attaining about a 30% long-term quit rate.

On the other hand, it has now been suggested that by combining two of the standard methods, the nicotine patch with either nicotine gum or nicotine nasal spray, it is possible to improve on the smoking cessation rates. In the *British Medical Journal*, a study conducted in Finland yielded results that suggested using the two methods together could double the smoking cessation rate compared to using only one of the methods. If that finding is confirmed by further studies, it would mean that a very effective method, superior to acupuncture therapy, is now available.

POSSIBLE CONTRIBUTIONS OF ACUPUNCTURE TO SMOKING CESSATION SUCCESS

The poor status of the acupuncture literature does not rule out the possibility that acupuncture, when performed properly, aids some people in drug withdrawal. Acupuncture is known to stimulate the production of enkephalins and endorphins, which have a potential effect if acupuncture stimulation is given at least daily or, more suitably, if stimulation can be repeated several times throughout each day of withdrawal (this is why once a week acupuncture may be "under-dosing"). However, Pomeranz studied the levels of these substances in the brain and found that they were not changed during acupuncture (3), since the brain is the site of the drug addiction problem, this negative finding may counter the claimed benefit of acupuncture on the basis of this important mechanism of action.

One of the possible contributions to smoking cessation is a possible change in the taste experience of cigarettes. This affect would be suited to persons who are unwilling to simply stop smoking and have their symptoms treated, and who, instead, want help in overcoming the desire for smoking.

In an evaluation conducted in China (5), it was reported that there is a change in taste thresholds caused by ear acupuncture with points selected for cigarette smoking withdrawal; the change occurs in both smokers and non-smokers. In a group of 28 smokers treated by acupuncture, 26 found that the taste of the smoke became less desirable or even objectionable.

The **English-Chinese Encyclopedia of Practical Traditional Chinese Medicine** (6) describes a treatment for stopping smoking using the ear points treated with strong stimulation, followed by retention of needles for 15–20 minutes; subcutaneous needles retained for longer periods could also be used. Body acupuncture is another method suggested; the points are to be needled by the reducing method, retaining the needles for 20–30 minutes (manipulating them 2–3 times). Further, electric stimulation can be undertaken for 15–20 minutes. From all these efforts, it is said that the smoker will know that the treatment is effective if after 2–3 days there is a change in the taste of the smoke, making it less desirable. It is also recommended, in this text, that the person increase nutritional food intake, take herbal pills to calm the heart and mind, and also take some vitamins.

Dr. Tan Yee-ying, reported on his experience treating tobacco smoking addiction at the Fourth International Congress of Chinese Medicine (7). Relying primarily on ear acupuncture, he would apply the needle twice per week for 5 weeks (10 treatments). During the first 2–3 weeks, nearly all smokers are able to quit (90%). A few smokers who did not respond to the auricular acupuncture alone would also get treated with appropriate body points to achieve success. Only 10% of the individuals he treated were unable to stop smoking by the end of the treatment. The long-term effectiveness of treatment was claimed to be high, of 270 who quit, only 25 (9%) resumed smoking. The change of taste of the smoke was noted by 210 persons, complaining that the taste had turned bad. Additionally, 30 persons felt nauseated by smoking as a result of treatment, and another 30 felt hot.

In all these studies, the patients did not simply quit smoking, but withdrew gradually. This withdrawal was largely as a result, at least according to the author's claims, of a change in taste, or other discomfort that occurred with smoking. Further research efforts to show that the taste of cigarette smoke could change

markedly by acupuncture therapy would be worthwhile, despite the fact that, at least thus far, no reports of acupuncture changing the taste of food and beverages have been reported. For example, acupuncture for treatment of obesity due to overeating is not said to function by making the food taste less desirable.

OTHER CONTRIBUTIONS OF ACUPUNCTURE

Because clinical studies of acupuncture for quitting smoking use success in smoking cessation as the measured end-point, other possible benefits of acupuncture treatment are not taken into consideration. Even in those situations where acupuncture fails to provide an increase in smoking cessation success rates compared to a placebo treatment, acupuncture may contribute to a better experience for the smoker attempting to quit. Acupuncture therapy is claimed, by recipients, to alleviate several symptoms, including nervousness, agitation, and other signs of mental distress. This calming effect may make the smoking cessation experience less stressful. In fact, some of the ear acupuncture protocols used for stopping smoking are also applied to non-smokers for simple treatment of stress reactions. Advertisements for one of the standard stop smoking products emphasize the ability of the product to "soothe" and to "calm" as the means of providing the desired effect on smoking cessation.

For those who succeed in stopping smoking, the positive experience of acupuncture on the discomforts during withdrawal may lead the recipient to encourage other smokers to try the stop-smoking procedure, using acupuncture as a means of making the process more acceptable. For those who fail to stop smoking, by minimizing the adverse symptoms of nicotine withdrawal may increase the likelihood that the individual will make a second attempt later, which might provide the opportunity for success.

SUMMARY

Perhaps the best evaluation of this field was referring again to Cui's review, he concluded:

The results of the present studies show that the therapeutic effect of acupuncture for stopping smoking and drinking are not lower than for other withdrawal therapies....It is an alternative when other methods fail. However, as with other therapies, there may be recurrence. The therapeutic effect decreases with time, and short-term therapeutic effects are also unstable....The therapeutic effects can be enhanced by the combined use of acupuncture and psychotherapy, giving a higher withdrawal rate....

As evidence of the instability of results, Cui cites a study by Lamontagne, in which smokers were divided into two groups, one with a high expectation of success in quitting and one with a low expectation of success. The study revealed no difference in outcomes between those two groups, but the resumption of smoking over time was evident. At the end of the acupuncture treatment period, 28% had quit smoking; after one month, 24% of the original group was still not smoking; after three months the figure was down to 20%; and by 6 months it was down to 10%. Researchers in the U.S. have indicated that persons who simply stop smoking on their own (cold turkey), do not have much long-term success, about 5% are still not smoking after one year, and this figure seems to correspond to the changes that are observed in the Lamontagne study. While the sum of all acupuncture stop-smoking studies suggests a long-term quit rate on the order of 25-30% (which is considerably higher than in this study), the general trend seems to be similar to this reported result: when there is as much as a 60% quit rate at the end of treatment, there is only a 25-30% maintained quit rate at six months.

Certainly, smokers who wish to quit smoking have a wide range of effective techniques available to them, including nicotine administration (patch, gum, nasal spray, and inhaler), psychotherapy, and acupuncture, and anyone who is encountering difficulty may be able to combine these therapies to attain their goal.

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Acupuncture for smoking cessation

What is acupuncture?

Acupuncture is a traditional form of alternative treatment for a wide range of illnesses, which started in the Far East thousands of years ago. Its aim is to improve the overall wellbeing of the patient, rather than the isolated treatment of specific symptoms. According to traditional Chinese philosophy, our health is dependent on the body's motivating energy - known as Qi - moving in a smooth and balanced way through a series of meridians (channels) beneath the skin. Qi consists of equal and opposite qualities - Yin and Yang - and when these become unbalanced, illness may result.¹

How does it work?

Acupuncturists claim that by inserting fine needles into the channels of energy, they can stimulate the body's own healing response and help restore its natural balance. The flow of Qi can be disturbed by a number of factors. These include emotional states (such as anxiety, stress, anger, fear or grief), poor nutrition, weather conditions, hereditary factors, infections, poisons and trauma. The principal aim of acupuncture in treating the whole person is to recover the equilibrium between the physical, emotional and spiritual aspects of the individual.¹ Recovering your equilibrium may help you with the effects of nicotine withdrawal.

How successful is acupuncture in stopping people smoking?

Acupuncture has been promoted for many years as being a successful aid in helping smokers to quit. However, a wide range of scientific studies have not produced any clear evidence that acupuncture is effective when compared with other anti-smoking treatments.^{2, 3} Altering where the needles are placed (for example in the ear lobes) does not appear to make any difference either.^{2, 3} Similar "acupuncture-like" treatments such as acupressure, laser therapy or electrostimulation also do not appear to be effective in helping you to give up either.^{2, 3}

Is it safe?

Acupuncture appears to be safe when performed by an experienced practitioner. Should you wish to try acupuncture, always make sure that the acupuncturist is registered with the British Acupuncture Council.

Are there any side-effects?

There may be some discomfort around the areas where the acupuncture needles are inserted, but this normally passes quickly. There are no other regularly reported side-effects from acupuncture. However, if acupuncture is administered incorrectly or without care, there is the possibility of infection from dirty needles or puncture wounds from pushing the needles in too far.⁴

What are the benefits of this option?

- No drugs are involved in acupuncture
- It is a relatively safe option, although it must be performed by an experienced practitioner
- Acupuncture is popular with smokers who prefer a "natural" or "alternative" method of trying to quit.

What are the disadvantages of this option?

- There is no good evidence that acupuncture works
- It can be slightly painful for some people
- It may be expensive
- It is not available on prescription

Contacts/further information

Action on Smoking and Health UK (ASH)
Tel 0800 169 0169

Quitline
Tel 0800 00 22 00

British Acupuncture Council
Helpline 020 8735 0400

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Zyban (Bupropion)

More information from a Chemical/Pharmacological Perspective

Brand Name	Zyban
Generic Name	Bupropion Hydrochloride - Sustained Release Tablets
Company	Glaxo-Wellcome
Indication(s)	An aid to smoking cessation treatment.
Contraindications	Patients treated with Wellbutrin or any other medications that contain bupropion, in patients with a current or prior diagnosis of bulimia or anorexia nervosa, in patients taking mono-amine oxidase inhibitors (MAOIs) and in patients who have shown a hypersensitivity to bupropion. Patients who have taken MAO inhibitors must wait at least 14 days between the discontinuation of MAO inhibitor therapy and the commencement of Zyban therapy.
Mechanism of Action	Inhibitor of the neuronal uptake of norepinephrine, serotonin and dopamine.
Dosage Form(s)	150 mg tablets
Administration	The recommended and maximum dose of Zyban is 300 mg/day given as 150 mg, twice daily. Dosing should begin at 150 mg/day for the first three days followed by an increase to the usual dose of 300 mg/day. Treatment should be initiated while the patient is still smoking and a target date for smoking cessation should be within the first two weeks of Zyban treatment. Zyban therapy should continue for 7 to 12 weeks, depending on the effect of the therapy. If the patient has not reduced smoking by the seventh week of Zyban therapy, it is unlikely that he/she will quit during that attempt and Zyban therapy should be discontinued.

Common Side Effects

Adverse events were compiled from two clinical studies, a dose-response trial and a comparator trial. Adverse events noted in the dose-response trial occurring at a frequency of greater than 2% and greater in the Zyban group than in the Placebo group are listed in the following table:

Adverse Event	Incidence Rate (%)	
	Zyban 100 - 300 mg/day (n=461)	Placebo (n=150)
Dry mouth	11	5
Insomnia	31	21

Dizziness	8	7
Arthralgia	4	3
Pruritis	3	<1
Rash	3	<1

Adverse events noted in the comparator trial occurring at a frequency of greater than 2 % and greater in the Zyban group than in the Placebo group are listed in the following table:

Adverse Event	Adverse Event Incidence in Comparative Trials (%)			
	Zyban 300 mg/day (n=243)	Nicotine Transdermal System (NTS) 21 mg/day (n=243)	Zyban and NTS (n=244)	Placebo (n=159)
Abdominal Pain	3	4	1	1
Nausea	9	7	11	4
Dry mouth	10	4	9	4
Constipation	8	4	9	3
Diarrhea	4	4	3	1
Anorexia	3	1	5	1
Myalgia	4	3	5	3
Arthralgia	5	3	3	2
Insomnia	40	28	45	18
Dream abnormality	5	18	13	3
Anxiety	8	6	9	6
Disturbed concentration	9	3	9	4
Dizziness	10	2	8	6
Nervousness	4	1	2	2
Phinitis	12	11	9	8
Increased cough	3	5	1	1
Pharyngitis	3	2	3	0
Application site reaction	11	17	15	7
Rash	4	3	3	2
Pruritis	3	1	5	1
Taste perversion	3	1	3	2

The second series of clinical trials examined the adverse events associated with Zofran treatment for the prevention of post-operative nausea and vomiting. These were placebo controlled trials:

Drug Interactions

In vitro studies indicate that bupropion is metabolized by the cytochrome P-450 2B6 enzyme. Therefore, there is potential for a drug interaction between Zyban and drugs that effect CYP2B6 such as orphenadrine and cyclophosphamide. Certain drugs such as carbamazepine, phenobarbital, and phenytoin may induce the metabolism of bupropion while others such as cimetidine may inhibit its metabolism. No formal studies have been conducted in humans to assess the effects of drug interactions.

Bupropion is the same active ingredient found in the anti-depressant Wellbutrin. Therefore, patient's being treated for depression with Wellbutrin should not take Zyban as it would increase the plasma levels of bupropion.

Two clinical trials were carried out to determine the effectiveness of Zyban as an aid in smoking cessation. The first trial was a dose-response trial during which the endpoint was abstinence from week 4 of the study.

Abstinence From Week 4 through Specified Week	Quit Rates by Treatment Groups (%)			
	Placebo (n=151)	Zyban 100 mg/day (n=153)	Zyban 200 mg/day (n=153)	Zyban 300 mg/day (n=156)
Week 7	17	22	27	36
Week 12	14	20	20	25
Week 26	11	16	18	19

The second trial was a comparator trial that also measured abstinence from week 4 of the study.

Abstinence From Week 4 through Specified Week	Quit Rates by Treatment Groups (%)			
	Placebo (n=160)	NTS (n=244)	Zyban 300 mg/day (n=153)	Zyban 300 mg/day and NTS (n=245)
Week 7	23	36	49	58
Week 10	20	32	46	51

These pages are for information purposes only and do not constitute a recommendation or endorsement of the product. Consult your physician concerning the availability and usage of these drugs for your particular situation.

Here's the Coverage that Different Insurance Plans Offer for Selected Providers

(AS OF PRINT DATE OF BROCHURE - SUBJECT TO CHANGE BY THE CARRIER)

Carrier	Coverage for Acupuncture?	For Massage Practitioners?	For Naturopathic Physicians?	For Chiropractors?	Referral Needed?
BLUE CROSS OF WASHINGTON & ALASKA <i>HEALTH PLUS PLAN</i>	YES*	YES*	YES*	RIDER EXEMPTS CHIRO FROM \$500 LIMIT YES*	ONLY INDIVIDUAL MANAGED CARE & POS PLANS: \$500 LIMIT FOR ALL PROVIDERS YES, UNLESS COVERED BY CHIRO RIDER
FIRST CHOICE HEALTH PLAN	FOR PAIN MANAGEMENT & CHEM DEPENDENCY ONLY	FOR REHABILITATION THERAPY ONLY	WITH \$500 ANNUAL LIMIT	WITH \$250 ANNUAL LIMIT	YES, UNLESS COVERED BY CHIRO RIDER
GROUP HEALTH COOPERATIVE <i>OPTIONS HEALTH CARE</i> VIRGINIA MASON - GROUP HEALTH ALLIANCE	YES* YES* YL	YES* YES* YES*	YES* YES* YES*	YES* YES* YES*	YES YES, EXCEPT CHIRO FOR FIRST 10 VISITS YES, EXCEPT CHIRO FOR FIRST 10 VISITS
KAISER FOUNDATION PLAN OF NW	YES*	YES*	YES*	YES*	YES, EXCEPT CHIRO WITH RIDER LIMITS
KITSAP PHYSICIANS SERVICE	YES*	YES*	YES*	YES*	UNDER MANAGED CARE PLANS ONLY
MEDICAL SERVICE CORPORATION	YES*	YES*	YES*	YES*	UNDER MSC CARE & PRIME CARE ONLY
NY LIFE HEALTH PLANS	YES*	YES*	YES*	YES*	UNDER MANAGED CARE PLANS ONLY
PACIFICARE OF WASHINGTON <i>PACIFICARE OF OREGON</i>	YES* YES*	YES* YES*	YES* YES*	LIMIT OF 10 ANNUAL VISITS LIMIT OF 10 ANNUAL VISITS	UNDER MANAGED CARE PLANS ONLY YES
PROVIDENCE HEALTH CARE	YES*	YES*	YES*	YES*	YES, EXCEPT SOUND ALTERNATIVES PLAN
QUAL-MED HEALTH PLAN	NO	FOR PHYSICAL THERAPY ONLY	YES*	WITH RIDER ONLY	YES
REGENCE/BCBS OF OREGON <i>HEALTH MAINTENANCE OF OREGON</i>	NO NO	NO NO	NO NETWORK PROVIDER ONLY	WITH RIDER ONLY NETWORK PROVIDER ONLY	NOT APPLICABLE YES
REGENCE WASHINGTON HEALTH <i>KING COUNTY MEDICAL/WALLA WALLA VALLEY MEDICAL/HMO WASHINGTON</i> <i>PIERCE COUNTY MEDICAL</i>	12 VISITS FOR PAIN MGMT. & CHEMICAL DEP. ONLY NO	FOR REHABILITATION & NEURO DEVELOPMENT ONLY NO	YES*, MAY BE DESIGNATED AS PRIMARY CARE PHYSICIAN MANAGED CARE PLANS ONLY	WITH RIDER ONLY; REDUCED BENEFIT WITH SELF-REFERRAL MANAGED CARE PLANS ONLY	YES, EXCEPT FOR NATUROPATH AS PRIMARY CARE PHYSICIAN & FOR CHIRO YES, EXCEPT WITH CHIRO RIDER
SELECTCARE HEALTH PLANS	ON A CASE-BY-CASE BASIS	YES*	ON A CASE-BY-CASE BASIS	ON A CASE-BY-CASE BASIS	YES, EXCEPT CHIRO WITH RIDER & 20 VISIT LIMIT
SISTERS OF PROVIDENCE (ORI)	YES*	YES*	YES*	YES*	YES, 60 VISIT CAP FOR ALL PROVIDERS
SKagit COUNTY MEDICAL BUREAU	MANAGED CARE PLANS ONLY	MANAGED CARE PLANS WITH REHAB COVERAGE ONLY	MANAGED CARE PLANS ONLY	MANAGED CARE PLANS ONLY OR WITH RIDER	YES, EXCEPT WITH CHIRO RIDER
VIRGINIA MASON HEALTH PLAN	YES*	YES*	YES*	YES*	YES, EXCEPT CHIRO WITH 10 VISIT LIMIT
WHATCOM MEDICAL BUREAU	FOR COVERED CONDITIONS IN MANAGED CARE ONLY	MANAGED CARE PLANS ONLY	MANAGED CARE PLANS ONLY	MANAGED CARE PLANS ONLY OR WITH RIDER	YES, 50 VISIT CAP FOR ALL PROVIDERS UNDER NON-MANAGED CARE PLANS

* ALTHOUGH THE INSURERS MAY HAVE INDICATED THEY COVER THE SERVICES OF THESE CATEGORIES, SOME CONTRACTS AND PLANS MAY INCLUDE ADDITIONAL RESTRICTIONS AND LIMITATIONS ON ACCESS. REVIEW YOUR POLICY FOR THE PARTICULAR REQUIREMENTS AND LIMITS OF YOUR COVERAGE





Insurance Information

You will need to check with your insurance provider to see if my services are covered. **Below you will find a form to print off and fill out as you ask your questions.** Please bring the form to my office or FAX it to me at 463-3021.

AUTO ACCIDENTS (PERSONAL INJURY CASES)

are usually covered. You will need to check for sure, and see if you need a written referral from a doctor. I will bill the insurance company for you.

ASEA HEALTH TRUST (STATE GENERAL GOVERNMENT UNIT)

now covers massage outside of a chiropractor's office, which is a change as of July 1, 2005. You need a Doctor's or Chiropractor's referral. The Maximum benefit per year is \$1000 combined total with massage and chiropractic. The insurance company will be billed for you.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND

covers acupuncture for pain only. (Covered at 90%, no limit on the number of visits.) This includes AEL&P union workers.

BLUE CROSS

Some Blue Cross plans in Juneau are now covering Acupuncture, if it is a group plan where the employer purchased a "Dimensions Plan". This is like a cafeteria plan, where the employer has the option of selecting acupuncture. *Employers who have selected acupuncture include:*

AEL&P - non-union employees (I don't know the details of this plan yet)

Alaska Bar Association (12 visits/year, \$20 co-pay and then 100% of the maximum allowed)

Alaska Public Employees Association (I don't know the details of this plan yet)

Alaskan Brewery (12 visits/year, covered at 80%)

Catholic Community Services has Blue Cross of California. They cover acupuncture for pain

management only. (12 visits/year, maximum \$25/visit, with a \$15 co-pay, so they only cover \$10/visit)

Gastineau Human Services (12 visits/year, covered at 80%. This may change February 1, so

check with your Personnel Officer)

Holland America - has Blue Cross of Washington. (12 visits/year, covered at 80%, \$300 individual deductible)

Perserverance Theater (I don't know the details of this plan yet)

Tlingit-Haida Regional Authority (12 visits/year, covered at 80%)

Wildflower Court (co-pay \$15, I don't know other details yet)

There may be others, as this plan is gaining popularity quickly. (*Check with Blue Cross for your*

particular plan – it can be different, even with the same employer.) Encourage your employer to select this plan/option in the future.

Employers who have the "Dimensions Plan" but have not selected acupuncture include:

City and Borough of Juneau (except for school district employees)
University of Alaska
Carrix

In the past, Blue Cross of Alaska has required acupuncture to be performed by a doctor or physical therapist, and has very recently decided to cover acupuncturists as well. Your employer may not yet be aware of this recent change and it has not yet been changed in your booklets. Check with Blue Cross for verification.

There is some confusion about the need for doctor's referrals. Blue Cross states that "Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition". **This does not mean that you need a doctor's referral or supervision.** It just means you have to be treated for a legitimate medical condition, and they will not cover the excluded items listed in your booklet, such as "stress", and for cosmetic reasons. When I verify your eligibility for benefits, I have to tell them what I am treating you for, and they tell me if they will cover it.

The **Federal Blue Cross plan** allows the employee to purchase additional coverage that covers acupuncture, for visits to acupuncturists who sign on for the plan, but there are no acupuncturists in Alaska signed up.

Individual Blue Cross plans are not covered.

CITY AND BOROUGH OF JUNEAU SCHOOL DISTRICT (this is now Aetna, and if they cover the same as Blue Cross did, it is 12 visits/year, covered at 70%) (*teachers are covered by NEA, see below*)

FEDERAL EXPRESS (Fed Ex)

insurance covers acupuncture. (20% co-pay, \$150 deductible, no restrictions other than conditions not allowed by your plan.)

GOLDEN RULE

Golden Rule covers my services.

NEA ALASKA (Juneau Teachers)

are covered at 85%, with a \$50 deductible. You do not need a referral from a doctor.

WORKER'S COMPENSATION

covers my services, and you will need to bring a doctor's *written* referral to my office on the first visit. I will need to confirm coverage with the company *prior* to your appointment, so be sure to tell me this is a Worker's Comp case. You will want to check to make sure your case was opened. I am required to bill Worker's Compensation for you.

FEDERAL PLANS

The only Federal Plans that I am aware of at this time that cover acupuncture are Mail Handlers (see <http://www.mhbp.com>) and Letter Carriers. I believe all Federal employees have the option to elect these plans. They cover acupuncture at 70%, for a maximum of

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 244
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title No Discrimination Against Acupuncturists RDU Corp. Bus & Prof Licensing (117)
 Component Corp. Bus & Prof Licensing
 Sponsor Wagner, Ellis
 Requester Health, Education & Social Services Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation prohibits unfair discrimination against an acupuncturist by health benefit plans. It does not impact the operations of the division.

Prepared by: Katherine Mason, Administrative Manager Phone (907) 465-2572
 Division: Corporations and Licensing Date/Time 2/27/06 11:59 AM
 Approved by: William C. Noll, Commissioner Date 2/27/2006
 Agency: Commerce, Community, and Economic Development

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 244
 () Publish Date: _____

Revision Date/Time (Note if correction): 2/27/06 11:58 a.m. Dept. Affected: Administration
 Title An Act prohibiting unfair discrimination against an acupuncturist; amending definition of 'provider'... RDU Centralized Administrative Services
 Component Group Health Insurance
 Sponsor Senator Wagoner
 Requester Senate Labor and Commerce Committee Component No. 2152

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Acupuncture is covered under the AlaskaCare plans when acupuncture is used in lieu of anesthesia at surgery. Adding this provider type to the list of covered providers under AS 21.26.090(d) would expand coverage only for evaluation and management (E&M) services for this provider type.

Costs to the AlaskaCare health plans with the addition of Acupuncturists as recognized providers is expected to be offset by the current coverage of evaluation and management services by other recognized providers.

Prepared by: Melanie Millhorn, Director Phone 465-4408
 Division Group Health Insurance Date/Time 2/27/06 11:58 AM
 Approved by: Mike Tibbles, Deputy Commissioner Date 2/27/2006
 Agency Department of Administration

SB

2550

Alaska State Legislature

SENATOR
GENE THERRIAULT
Chair

SESSION ADDRESS
State Capitol
Juneau, Alaska 99801-1182
(907) 465-4797
Fax: (907) 465-3884

Legislative Budget and Audit Committee SPONSOR STATEMENT SB 250

"An Act relating to the termination date of the Council of Domestic Violence and Sexual Assault; and eliminating references to the network on domestic violence and sexual assault.

This legislation stems from recommendations contained in the Legislative Audit Report entitled "Council on Domestic Violence and Sexual Assault Sunset Audit", dated September 23, 2005.

Legislative Audit concluded that the Council on Domestic Violence and Sexual Assault (Council) continues to serve a public need and is operating in the public interest. Accordingly, SB 250 extends the sunset date of the Council to June 30, 2014 for an eight-year extension.

Legislative Audit also recommended that the Legislature amend the Council statutes related to the appointment of Council members. Current law requires the Network on Domestic Violence and Sexual Assault (Network), a non-profit corporation, to submit a list of recommended candidates to the Governor for appointment when a vacancy occurs. Further, statutes require that the Governor fill any unexpired term of a Council member after consultation with the Network.

The Network annually receives a grant from the Council for a legal advocacy project and the appearance of conflict exists when a Council member reviews, evaluates, approves and monitors a grant to the same nonprofit organization that may have been responsible for recommending that individual be appointed to the Council. SB 250 deletes both statutory references that produce this appearance of conflict.

This audit was conducted under revisions made last session to the sunset process. The standard sunset period for occupational boards and non-occupational boards was changed from "not to exceed four years" to "not to exceed eight years". Additionally, to better measure operational performance, two new criteria were added to statute that must be considered in the course of a sunset review by the auditors:

- The extent to which the board, commission, or agency has effectively attained its objectives and the efficiency with which it has operated.
- The extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

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Alaska State Legislature

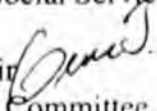
SENATOR
GENE THERRIAULT
Chair

SESSION ADDRESS
State Capitol
Juneau, Alaska 99801-1182
(907) 465-4797
Fax: (907) 465-3884

Legislative Budget and Audit Committee

DATE: February 2, 2006

TO: Senator Fred Dyson, Chair
Senate Health, Education & Social Services Committee

FROM: Senator Gene Therriault, Chair 
Legislative Budget and Audit Committee

RE: SB 250 – Request For Hearing

This is to request the Senate Health, Education & Social Services Committee hear SB 250 – relating to the termination date of the Council of Domestic Violence and Sexual Assault; and eliminating references to the network on domestic violence and sexual assault.

Attached are the following items:

- copy of the bill
- sponsor statement
- one page “fact” sheet
- sunset audit report on the Council of Domestic Violence and Sexual Assault

Please contact Tom Maher (x3613) of my staff with questions or for additional information.

Thank you for your consideration.

attachments

cc: Pat Davidson, Legislative Auditor

INTERIM ADDRESS

119 N. Cushman Suite 101, Fairbanks, Alaska 99701 • (907) 488-0857 • Fax: (907) 488-4271



Alaska State Legislature

Senate Majority Web: www.akrepublicans.org

Sponsor: Rules By Request of LEG BUDGET & AUDIT
Current Version: SB 250
Contact: W. Tom Maher, 465-3613

Fact Sheet for: Senate Bill 250

Short Title: DOMESTIC VIOLENCE/SEXUAL ASSAULT COUNCIL

Summary:

- Extends the termination date of the Council on Domestic Violence and Sexual Assault to June 30, 2014.
- Eliminates statutory references to the network on domestic violence and sexual assault.

Benefits:

- Continues the planning and coordination of full-range services to victims, families and the perpetrators of domestic violence and sexual assault.
- Helps combat domestic violence and sexual assault, an on-going priority at both the state and national level.

Background:

- SB 250 implements a recommendation of Legislative Audit to extend the Council on Domestic Violence and Sexual Assault. It also removes references to the Network on Domestic Violence and Sexual Assault to avoid potential conflicts of interest in the appointment process. The Network receives a grant from the Council and the appearance of conflict exists when a Council member may evaluate and approve a grant to the same non-profit organization that may have been responsible for recommending that individual be appointed to the Council.

States began adopting sunset laws in the 1970s as part of a national movement to increase the accountability of government and to reduce bureaucracy. The routine redetermination of the need for some aspect of government increases the likelihood that government growth is productive and deliberate.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB250-DPS-CDVSA-2-16-06
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Public Safety
 Title "An Act extending the termination date of the RDU Council on Domestic Violence & Sexual Assault
Council on Domestic Violence and Sexual Assault ..." Component CDVSA
 Sponsor Legislative Budget and Audit Committee
 Requester Senate Health, Education, Social Services Committee Component No. 521

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Passage of this legislation will not have a fiscal impact on the Department of Public Safety.

Prepared by: Special Assistant Cliff Stone Phone 907-465-2649
 Division: Commissioner's Office Date/Time 2/16/06 6:27 PM
 Approved by: Commissioner William Tandeske Date 2/16/2006
 Agency: Department of Public Safety

AMENDMENT # 1

Offered in the Senate HESS Committee
To: SB 250

By: Senator EITON

Page 1, line 2:

Following "Assault";
Insert "amending the council membership and the qualifications for membership of the council's public members;"
Delete the first occurrence of "and"

TITLE CHANGE

Page 1, line 7:

Following "three"
Delete "persons"
Insert "public members [PERSONS]"

Page 1, line 7:

Following "governor":
Insert "who shall include"
(a) one member who resides in a community not connected to the highway or marine highway system,
(b) one member who is a survivor of domestic violence or sexual assault or who has counseled or advocated for survivors of domestic violence or sexual assault; and
(c) one member who is an expert in domestic violence and sexual assault program service delivery"

Page 2, line 3:

Delete the second occurrence of "and"
Insert "and"

(6) the executive director of the Alaska Network on Domestic Violence and Sexual Assault, who shall serve as an ex officio, nonvoting member" NON VOTING

Page 2, line 12:

Insert a new section to read:

*Sec. 3. AS 18.66.020(c) is amended to read:

(c) A person who receives compensation from or is an employee of a domestic violence, sexual assault, or crisis intervention or prevention program may not be appointed as a voting member to the council.

Renumber the following bill section(s) accordingly.

Insert a new section to read:

Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. The provisions of AS 18.66.020(a)(1)(A)-(C), added by sec. 1 of this Act, apply to vacancies among the public members of the Council on Domestic Violence and Sexual Assault that occur on or after the effective date of sec. 1 of this Act.

AMENDMENT

11 2

Offered in the Senate HESS Committee
To: SB 250

By: Senator Elton

Page 2, line 12:

Insert new bill sections to read:

Sec. 4. AS 18.66.020 is amended by adding a new subsection to read:

(d) A public member appointed by the governor may not be an officer or active employee of the state.

Renumber the following bill section accordingly.

Page 2, line 15:

Insert a new bill section to read:

Sec. 7. Section 4 of this Act takes effect August 1, 2007.



State of Alaska
Department of
Public Safety

Frank H. Murkowski, Governor
William Tandeske, Commissioner

February 21, 2006

The Honorable Senator Gene Thiemault
State Capitol
Room 119
Juneau, AK 99801-1182

Dear Senator Thiemault:

Thank you for the opportunity to comment on proposed amendments to SB250 extending the sunset date for the Council on Domestic Violence and Sexual Assault (CDVSA). The Department of Public Safety (DPS) supports the extension of CDVSA to June 30, 2014 as proposed.

As to proposed amendments, I offer the following comments:

DPS does **not oppose** removal of the requirement that the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) be consulted by the Governor prior to public member appointments

DPS does **not oppose** the designation of one public member position being from a rural area; however, the exclusion of small communities served by the marine highway system but not a traditional road seems overly restrictive. DPS has advocated for a representative from rural areas on the council as seen in the most recent appointment of a resident of Dillingham.

DPS **opposes** the designation of the two remaining public member positions to a survivor, counselor, or advocate and an expert in domestic violence and sexual assault program service delivery.

The staff of CDVSA and the programs funded through CDVSA bring those qualities to the day-to-day operations and discussions. Public involvement in government is essential. Public members with a wide variety of life experience are valuable to any board or commission. The proposed changes overly restrict the appointment of qualified and interested citizens. Further, the checks and balances of the current process would be eroded by the mandatory inclusion of public members that are from the precise disciplines funded through the CDVSA.

DPS **opposes** the addition of the executive director of the ANDVSA as an ex-officio, non-voting member of the council. I believe it is critical for the CDVSA to maintain objectivity and keep the programs they are responsible for evaluating and funding at a professional "arms length." The executive director of ANDVSA is employed by the programs funded through CDVSA. Although CDVSA and ANDVSA must work closely together at an operational level, the inclusion of the ANDVSA executive director at the council level is inappropriate.

DPS **opposes** the proposed prohibition of state employees serving as public members. There are excellent candidates for the council who also happen to be employed by the state. An alternative to the

The Honorable Senator Gene Theriault
February 21, 2006
Page 2

current proposal may be to prohibit appointment of a PX or EX official other than the four designated in statute. That would allow qualified state employees who have interests in domestic violence and sexual assault issues to volunteer their services. CDVSA has had a number of highly motivated and productive public members who were state employees. It would be unfortunate to lose a candidate because of their unrelated employment.

As I have evaluated the proposed amendments to SB 250, I have tried to consider a number of questions, including: What needs to be fixed? How will these changes make the Council better? I am concerned that a number of the proposed changes will not improve CDVSA and only raise more challenges.

The views I am expressing are those of DPS and not the CDVSA, of which I am a member. I appreciate the opportunity to provide comments. As always, I am available to discuss this with you or your staff should you wish.

Sincerely,



William Tandeske

cc: Jana Stewart, CDVSA Chair
Barbara Mason, Executive Director, CDVSA

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

February 22, 2006

Senator Gene Therriault, Chair
Senate Legislative Budget and Audit Committee
State Capitol, Room 119
Juneau, AK 99801-1182

Dear Senator Therriault:

Thank you for giving me the opportunity to comment on proposed changes to SB 250. As you know this bill extends the sunset date for the Council on Domestic Violence and Sexual Assault (CDVSA) to June 30, 2014. The Department of Health and Social Services (DHSS) supports this proposed extension.

However, DHSS does have some concerns regarding proposed changes or amendments.

- (1) DHSS recognizes the importance of maintaining a positive working relationship with all of the members of the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) as well as the many other stakeholders that make up the domestic violence and sexual assault "services" system in Alaska. Because this system includes not only services for victims but other organizations such as the police, hospitals, programs for batterers, mental health and substance abuse providers, etc. we do not support a single group (ANDVSA) being identified in statute as having "exclusive" consultative authority re: appointments to the CDVSA.
- (2) DHSS supports the designation of one public member position being from a rural area. We think it's vitally important the Council is provided with a "rural perspective" when making programmatic and fiscal decisions. DHSS, however, does not support the overly restrictive language in the proposed amendment.
- (3) DHSS does not support the designation of a survivor, counselor or advocate for the two remaining public member positions. As indicated under number one (1), our system is much broader and therefore we should not "restrict" membership to these specific "categories" of individuals. In all likelihood there are people in the business community, as well as in the broader health and social services community, who have an interest in preventing and dealing with domestic violence and sexual assault.
- (4) DHSS does not support the addition of the Executive Director of the ANDVSA as an ex-officio, non - voting member of the CDVSA. This appears to create a potential "conflict of interest". Since the council makes recommendations for funding member agencies of ANDVSA, it would be inappropriate for the Executive Director of ANDVSA to be involved in these or decisions.

● Page 2

February 22, 2006

(5) DHSS does not believe there should be a prohibition against state employees serving on the council. As suggested under number three (3), there are individuals both in the private and public sector (i.e. state employees) who would be excellent candidates for the council. I don't believe we should restrict our pool of qualified and committed potential council members.

In conclusion, I hope this provides the Department of Health and Social Services perspective on SB 250. We support the extension of the sunset date to June 30, 2014, but have several concerns and reservations about the proposed changes or amendments to the bill. These have been articulated above.

If you wish clarification or want to discuss this further please let me know.

Sincerely,



Bill Hogan
Deputy Commissioner
Board Member CDVSA

BH: dj

cc: Senator Fred Dyson, Chair, Senate Health, Education and Social Services Committee
Janna Stewart, CDVSA Chair
Barbara Mason, Executive Director, CDVSA

Jason Hooley

From: Susan Parkes [Susan_Parkes@law.state.ak.us]
Sent: Tuesday, February 21, 2006 3:24 PM
To: Jason Hooley
Cc: Tom Maher
Subject: SB 250

Jason - I am the Department of Law representative on the Council on Domestic Violence and Sexual Assault. This morning I received a letter sent to me on Friday requesting written comments regarding SB 250 and proposed amendments. I hope that this email will suffice; I apologize for its informality. I was traveling to Juneau today and have a 4:00 p.m. budget hearing.

I have seen a copy of Commissioner Tandeske's February 21, 2006 letter to Senator Therriault regarding SB 250. I support and echo his position regarding the bill and amendments. I would like to just make a few additional comments. First, the Network is a valuable resource to the Council. The Network has always been welcome at our meetings and have been given time on our meeting agendas to make a report to the Council.

We often solicit their input on other specific agenda items when we believe it would be valuable to our decision making. I believe they have a "voice" on the Council, without being made an "ex-officio member which creates the conflict discussed in Commissioner Tandeske's letter.

Finally, I also oppose the amendment which would exclude state employees as public members. Not only does it discourage good candidates who happen to work for the State, but it also creates a problem for any public member who may during the course of their appointment to the Council become employed with the State. It would require the individual to choose between continuing on the Council or a State job.

I hope that these comments are useful. Please let me know if you need anything further. I will be attending the hearing tomorrow on behalf of the Department of Law.

Susan

AMENDMENT

OFFERED IN THE SENATE

BY SENATOR ELTON

TO: SB 250

1 Page 1, line 2:

2 Delete the first occurrence of "and"

3 Insert "relating to public members of the Council on Domestic Violence and

4 Sexual Assault appointed by the governor"

5

6 Page 1, line 3, following "assault":

7 Insert "; and providing for an effective date"

8

9 Page 1, line 7:

10 Delete "persons"

11 Insert "public members who are not employed by the state or a state entity and

12 who are [PERSONS]"

13

14 Page 2, following line 14:

15 Insert new bill sections to read:

16 "** Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to
17 read:

18 APPLICABILITY. The provisions of AS 18.66.020(a)(1), as amended by sec. 1 of
19 this Act, apply to vacancies among the public members of the Council on Domestic Violence
20 and Sexual Assault that occur on or after the effective date of sec. 1 of this Act.

21 * Sec. 5. Section 1 of this Act takes effect August 1, 2007."

**SENATE COMMITTEE REPORT
First Committee of Referral**

DATE: 1/26/06

FURTHER: Finance

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

DATE TURNED
IN TO OFFICE: 3.3.06

Health, Education and Social Services Committee considered

SENATE BILL NO. 250

SB 250 DOMESTIC VIOLENCE/SEXUAL ASSAULT COUNCIL

"An Act extending the termination date of the Council on Domestic Violence and Sexual Assault; and eliminating statutory references to the network on domestic violence and sexual assault."

and recommends:

- be replaced with _____ CS _____ (_____)
- adopt previous _____ CS _____ (_____)
- attached amendment(s)
- adopt Letter of Intent by _____ Committee
- further referral to _____ Committee

CS Senate Bill:
<input type="checkbox"/> Same Title
<input type="checkbox"/> New Title
SCS House Bill:
<input type="checkbox"/> Same Title
<input type="checkbox"/> Technical Title Change
<input type="checkbox"/> New Title w/ SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DPS	2/16			X	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
<i>[Signature]</i>				✓
<i>[Signature]</i>			✓	
<i>[Signature]</i>			✓	
<i>[Signature]</i>				✓
CHAIR: <i>[Signature]</i>	✓			

Audit Report



DEPARTMENT OF PUBLIC SAFETY
COUNCIL ON DOMESTIC VIOLENCE
AND SEXUAL ASSAULT
SUNSET AUDIT

September 23, 2005

Audit Control Number:

12-20039-06

Division of Legislative Audit
P.O. Box 113300, Juneau, Alaska 99811-3300



LEGISLATIVE BUDGET AND AUDIT COMMITTEE

DIVISION OF LEGISLATIVE AUDIT

The Legislative Budget and Audit Committee is a permanent interim committee of the Alaska Legislature. The committee is made up of five senators and five representatives, with one alternate from the Senate and two from the House. The chairmanship of the committee alternates between the two chambers every legislature.

The committee is responsible for providing the legislature with audits of state government agencies. The programs and activities of state government now cost more than \$6 billion a year. As legislators and administrators try increasingly to allocate state revenues effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by the Division of Legislative Audit helps provide that information.

As a guide to all their work, the Division of Legislative Audit complies with generally accepted auditing standards established by the American Institute of Certified Public Accountants and with government auditing standards established by the U.S. General Accounting Office.

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November 23, 2005

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 and Title 44 of the Alaska Statutes (sunset legislation), the attached report is submitted for your review.

DEPARTMENT OF PUBLIC SAFETY
COUNCIL ON DOMESTIC VIOLENCE
AND SEXUAL ASSAULT

November 23, 2005
Audit Control Number
12-20039-06

This audit was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(1). Alaska Statute 44.66.050(c) lists criteria to be used to assess the demonstrated public need for a given board, commission, agency, or program subject to the sunset review process. Currently under AS 44.66.010(a)(5), the Council on Domestic Violence and Sexual Assault is scheduled to terminate on June 30, 2006. The Council would have one year from that date to conclude operations.

In our opinion, the termination date for the Council on Domestic Violence and Sexual Assault should be extended. The Council serves a public need and is operating in the public's interest. We recommend that the legislature extend the Council's termination date to June 30, 2014.

The audit was conducted in accordance with generally accepted government audit standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology.

A handwritten signature in black ink that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Titles 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Council on Domestic Violence and Sexual Assault (Council) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner. Currently, under AS 44.66.010(a)(5) the Council will terminate on June 30, 2006, having one year from that date to conclude its operations.

Objectives

There are two central, interrelated objectives of our report. They are:

1. To determine if the termination date of the Council should be extended.
2. To determine if the Council is operating in the public's interest. The assessment of the operations, and performance of the Council, was based upon AS 44.66.050(c). This statute sets out criteria to be used in determining a demonstrated public need for the Council.

Scope and Methodology

Our audit reviewed the operation and activities of the Council on Domestic Violence and Sexual Assault for the period of July 1, 2001 through June 30, 2005.

During the course of our examination, we attended the June 2005 funding meeting in Anchorage and interviewed various council members, staff, grantees, and individuals from state agencies. We also reviewed and evaluated the following:

- Applicable statutes and regulations
- Budget documents, session laws, and other legislative information related to the Council's operations
- Minutes of the Council meetings
- Grantee on-site monitoring performance and fiscal reviews prepared by the Council staff
- Statistical reports submitted by grantees
- Financial reports from the State Accounting System
- Other documents related to the Council's operations and mission, as necessary

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ORGANIZATION AND FUNCTION

The Council on Domestic Violence and Sexual Assault (Council) was established in the Department of Public Safety in 1981 by Alaska Statute 18.66. This statute gives the Council the authority "*...to provide for planning and coordination of services to victims of domestic violence or sexual assault or to their families and to perpetrators of domestic violence and sexual assault and to provide for crisis intervention and prevention programs.*"

The primary functions of the commission include:

- developing, implementing, maintaining, and monitoring crisis intervention and prevention programs in coordination with authorities in the field of domestic violence and sexual assault;
- coordinating services with the Departments of Law, Education and Early Development, Public Safety, Health and Social Services, Corrections, and other state agencies and community groups;
- consulting with public employers, state and community agencies to provide continuing education programs for employees, and to formulate standards and procedures for health care employees;
- providing technical assistance to programs, state and community agencies; and
- dispensing, overseeing, monitoring, and coordinating existing services and developing expanded services/programs to meet the needs of victims of domestic violence, sexual assault, and other violent crimes.

The Council consists of seven members—four of whom are the commissioners or their designees—from the Departments of Public Safety (DPS), Health and Social Services (DHSS), Education and Early Development (DEED), and Law (DOL). The balance of the Council is comprised of persons from the public, appointed by the governor.

By statute, before making an appointment, the governor receives recommendations from and consults with the Alaska Network on Domestic Violence and Sexual Assault (Network) which is a nonprofit, private organization.¹

The Council is staffed by an executive director, an administrative manager, three associate coordinators, a statistical technician, an administrative assistant, and an administrative clerk.

¹ The Alaska Network on Domestic Violence and Sexual Assault is comprised of 20 programs, many of which are council-funded programs.

Council Members

As of November 23, 2005

Janna Stewart, Public Member, Chair
Susan Parkes, DOL, Vice Chair
Ann House, Public Member
Barbara Thompson, DEED
Karleen Jackson, DHSS
Kimberly Williams, Public Member
William Tandeske, DPS

The Council is authorized to receive and disperse both state and federal funds. Traditionally, a large part of the Council's responsibilities involve administering grants made to local community organizations for domestic violence, sexual assault, and crisis intervention and prevention programs. Grant administration includes providing technical assistance and monitoring the activities of the various grantees and contractors.

The community programs funded by the Council provide a variety of services to the public. Most importantly, their efforts are directed toward providing victims a safe environment, either through housing at a community shelter or the use of a network of designated "safe homes." Additionally, the programs are involved in educating and counseling the victim about domestic violence and sexual assault issues and providing a batterer's intervention services.

The Council's coordination role and responsibilities with other state and local agencies is extensive. For FY 06, the Council approved 19 community-based victim services programs, four community-based batterer's intervention programs, and two prison-based batterers' programs. (See Appendix A)

Funding Sources

The Council receives state general funds from two separate funding sources: the state general revenue and withheld Permanent Fund Dividends from convicted felons and misdemeanants who are incarcerated.

The Council also receives state and federal funds through the use of interagency receipts from the Department of Corrections (DOC) and DHSS. DHSS funds are: Sexual Assault Prevention (SAP), Rape Prevention and Education (RPE), Temporary Assistance for Needy Families (TANF), and Behavioral Health Alcohol Grant. Both SAP and RPE funds are part of the large Centers for Disease Control and Prevention grant administered by DHSS.

Additionally, many of the grants issued by the Council are supported by direct federal funds. Federal funds are received by the Council from sources such as:

- Family Violence Prevention Services Act
U.S. Department of Health and Human Services

The Family Violence Prevention Services Act provides federal funding to all states. This funding is used for domestic violence programs throughout Alaska. The programs receiving grants provide assistance funds to victims of domestic violence and their children. These programs operate shelter facilities which are staffed around the clock and provide a full spectrum of services, including basic food and immediate shelter, crisis intervention, counseling, and medical/legal/personal advocacy.

- **Crime Victims Assistance**
U.S. Department of Justice

This grant authorizes financial compensation for victims of crime and financial support for state and local agencies that provide services to crime victims. This fund is a U.S. Treasury account, generated entirely by the fines and penalties levied against criminals convicted of federal crimes. The majority of this funding is awarded directly to programs providing services to victims of domestic violence, sexual assault, and other violent crimes.

- **Violence Against Women Act (VAWA)**
U.S. Department of Justice

The grant services combine a series of federal sanctions and initiatives—as well as national, state, and local resources—to improve the response to crimes against women. These funds are delineated to five specific areas: prosecution, law enforcement, victim services, judicial, and discretionary. In April 1995, Governor Knowles designated the Council as lead agency for coordination and management of VAWA funds for the State of Alaska.

To accomplish this mission, the statewide Violence Against Women Planning and Implementation Committee (committee) was created.² The committee developed the annual plan for VAWA funding upon the Council's approval. The Council was then responsible for funding distribution, and subrecipient monitoring, of these projects.

In FY 04 the Council decided to disband the committee, citing inefficiency and duplication of duties performed by Council members and staff. The Council approves the spending plans of the Departments of Law and Public Safety, the Alaska Court System, and the Alaska Network on Domestic Violence and Sexual Assault for the prosecution, law enforcement, judicial, and victim services components, respectively. For the discretionary component, the Council distributes the fund through its Request for Proposal (RFP) grant process.

- **Grants to Encourage Arrest Policies**
U.S. Department of Justice

The Grants to Encourage Arrest Policies Program is a component of VAWA. This grant was focused on the development and implementation of laws, policies, and protocols that encourage or mandate the arrest of domestic violence offenders.

The Council currently receives supplemental funds to assist community-driven initiatives in providing regional state-tribal forums on domestic violence. The forums are attended by state troopers, local prosecutors, tribal/state judiciary, village public safety officers,

² The committee was comprised of 21 representatives of the VAWA components.

tribal members/citizens, victim advocates, probation/parole and other social service/care providers, to enhance their skills and develop a greater understanding of topics critical to the safety of women and their children, offender accountability, and coordinated response to domestic violence. The training is also designed to promote communication, cooperation, and a mutual respect among the tribal/state/federal response systems.

- **Rural Domestic Violence and Child Victimization**
U.S. Department of Justice

The Rural Domestic Violence and Child Victimization Enforcement Grant implements certain provisions of the Violence Against Women Act. While this grant closed out in FY 03, the program provided a unique opportunity for law enforcement and prosecution agencies, the courts and nongovernmental victim services, community organizations, businesses in rural communities, and Indian tribes to collaborate in creating protocols and strategies tailored specifically to meet the needs of rural populations.

- **Supervised Visitation, Safe Havens for Children**
U.S. Department of Justice

The Safe Havens programs provides an opportunity for communities to support the supervised visitation and safe exchange of children, by and between parents, in situations involving domestic violence, child abuse, sexual assault, or stalking.

The State of Alaska through the Council—and in a collaborative effort with the Cook Inlet Tribal Council, Inc., Alaska State Court System, and Abused Women's Aid in Crisis—implemented the only supervised visitation center in the State.

- **Denali Commission**

To continue the capital improvement project started in FY 02 with private grants from the Wells Fargo Bank and the Rasmuson Foundation, the Council pursued grant funding with the Denali Commission. In FY 04, the Denali Commission received congressional direction to allocate \$5 million toward the upgrade and construction of shelters for victims of domestic violence. The Council has provided the Denali Commission with preaward, advisory input, and technical assistance to make optimal funding allocation decisions. As of March 2005, \$3.95 million has been committed for repair/renovation, new construction projects, or conceptual planning/design of shelter buildings.

REPORT CONCLUSIONS

Under AS 18.66, the Council on Domestic Violence and Sexual Assault (Council) is authorized to provide for the State's planning and coordination of full-range services to victims, their families, and perpetrators of domestic violence and sexual assault. Combating domestic violence and sexual assault is identified as an ongoing priority at both the state and national level.

Aside from the operational concerns addressed in this report, the Council is serving a public need and is operating in the public's interest. Currently, AS 44.66.010(a)(5) requires the Council to be terminated on June 30, 2006. We recommend the legislature extend the Council's termination date to June 30, 2014.

The Council is still facing personnel issues resulting from continual staff turnover. The Council has worked on developing personnel policies, procedures, and desk manuals to assist the staff; but due to limited staff, the Council was forced to focus primarily on grant maintenance and monitoring responsibility. Two of the Council's statutory mandates were not addressed. (See Recommendation 2)

The Council intends to work on a strategic plan to assess the effectiveness of services currently being provided by grantees and other state and local entities. The plan's overall goal is to identify and address existing gaps in service. One of the missions of the Council is to provide leadership in meeting the needs of domestic violence and sexual assault victims. A long-term strategic plan is certainly needed to assist the staff in establishing priorities. The work plan will help Council staff to effectively plan and coordinate services with state and community agencies, as well as provide services previously not offered to reduce the causes and incidence of domestic violence and to alleviate their effects.

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FINDINGS AND RECOMMENDATIONS

The Council on Domestic Violence and Sexual Assault's (Council) prior sunset audit³ reported several administrative weaknesses. Recommendation No. 1 is not resolved and reinstated below as Recommendation No. 2. Prior audit Recommendations No. 2 and 3 were resolved. Recommendations No. 4 and 5 were partially resolved and are readdressed and combined into Recommendation No. 1 below.

Recommendation No. 1

The Council should address its statutory responsibilities to consult with the Department of Education and Early Development and the Department of Health and Social Services.

Prior Finding

Statutory changes implemented in July 1, 1996, significantly increased the scope of the Council's responsibilities. In response, the Council's budgeted staff increased from four to eight positions. During our last sunset audit, the Council was unable to or ineffective in addressing some of their statutory responsibilities due to administrative weaknesses and lack of prioritization.

The prior sunset audit reported that grantees had varying degrees of success in gaining access to their local schools and used a variety of methods to address domestic violence and sexual assault education needs. In addition, although the Council collaborated with the Alaska Family Violence Prevention Project, Department of Health and Social Services (DHSS), on a domestic violence and child abuse workshops, the Council has not worked with DHSS to develop standards and procedures as required in AS 18.66.300.

Alaska Statute AS 18.66.050(3) and (12) states the Council shall:

(3) consult with authorities in the field, develop, implement, maintain, and monitor domestic violence, sexual assault, and crisis intervention and prevention programs, including education programs...and school curricula on the cause, prevention, and treatment of domestic violence and sexual assault. [emphasis added]

(12) consult with the Department of Health and Social Services in the formulation of standards and procedures for delivery of services to victims of domestic violence by health care facilities and practitioners of healing arts and personnel in those facilities as required in AS 18.66.300.

³ Audit Control Number 12-20014-02, Department of Public Safety, Sunset Audit on Council on Domestic Violence Assault dated October 31, 2001.

Legislative Audit's Current Position

The Council has faced personnel issues resulting from position turnover since FY 01, particularly in the executive director and associate coordinator positions. During the past four years, three individuals were hired for the executive director's position. The executive director and associate coordinators are key positions for the Council to fulfill its 14 mandates.

With limited staffing and several mandates, the Council chose to focus primarily on their grant funding and oversight role. This is to ensure continued funding of grant programs. Grant accountability and reporting is time consuming, but essential for the programmatic and administrative oversight of grants for victim services and batterers intervention programs.

However, there is still a need for a more coordinated effort with the Department of Education and Early Development (DEED) towards education in school districts throughout the State. AS 14.30.360(b) states "*the state board shall establish guidelines for a health and personal safety education program. Personal guidelines shall be developed in consultation with the Council on Domestic Violence and Sexual Assault...*" There are currently no health and personal safety education guidelines available on domestic violence and sexual assault for school personnel to use. The Council should consult with DEED, school district representatives, and grantees who have worked toward curriculum development, in creating a comprehensive standardized curriculum to be used within the schools statewide.

There is also a need for the Council to become involved with DHSS to ensure that standards and procedures are available for the delivery of services by health care facilities and its personnel. Council-funded grantees are often approached by health care providers on issues of domestic violence and sexual assault.

However, as the statewide representative, the Council should coordinate this effort at the departmental-level rather than at the grantee-level. The Council should consult with DHSS regarding development of comprehensive standards and procedures to be used by all agencies for the victims of domestic violence and sexual assault, including council-funded grantees and health care providers within the State.

AS 18.66.050(3) and AS 18.66.050(12) discuss the Council working with state departments to develop standards, procedures, and education programs. However, due to limited staffing and the Council's focus on grant maintenance and monitoring, the Council has been unable to fully address these statutory mandates. Given the significance of these mandates, we recommend that the Council take immediate action and implement procedures to address both statutes.

Recommendation No. 2

The legislature should amend the Council on Domestic Violence and Sexual Assault's statutes related to appointment of council members.

Prior Finding

The Network on Domestic Violence and Sexual Assault (Network) submits recommendations, to the Governor, of public members qualified to serve on the Council. The Network also receives grant funds from the Council. The Council consists of four state officials and three public members appointed by the governor. Alaska Statute 18.66.020(a)(1) and AS 18.66.020(b), in part, states:

(a)(1) The council consists of three persons appointed by the governor after consultation with the Network on Domestic Violence and Sexual Assault, a non profit corporation; The Network on Domestic Violence and Sexual Assault shall submit a list to the governor of persons recommended for appointment.

(b) ... A vacancy on the council shall be filled for the unexpired term by appointment by the governor after consultation with the Network on Domestic Violence.

The Network also annually receives a grant from the Council for a legal advocacy project. The grant is the victim services⁴ allocation of the Violence Against Women Act (VAWA) federal funding received by the Council.

The appearance of a conflict of interests exists when a council member reviews, evaluates, approves, and monitors a grant to the same nonprofit corporation which was responsible for recommending that individual to the council membership.

It is entirely appropriate for the governor to consult with any interested parties when making appointments to the Council. However, it is a statutory mandate for the governor to consult with the Network, over the appointment of public members, when the Network itself is a subgrantee of the Council that raises an appearance of a conflict of interest.

Legislative Audit's Current Position

Since the last audit, AS 18.66.020 has not been revised and the Network continues to get funding from the Council. However, of the last five public members appointed to the Council, only two were recommended by the Network.

⁴ The VAWA federal funds are distributed in the following manner: 5% for judicial; 25% for law enforcement; 25% prosecution; 30% for victim services; and 15% to discretionary funds.

To avoid any appearance of a conflict of interest between public member appointments and receiving funding, we continue to recommend the legislature amend AS 18.66.020 to: (1) eliminate the mandate for the Network to recommend individuals to the governor for appointment to the Council, and (2) eliminate the requirement for the governor to consult with the Network on the appointment or reappointment of the council's public members.

ANALYSIS OF PUBLIC NEED

The following analyses of board activities relate to the public need factors defined in AS 44.66.050(c). These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

Determine the extent to which the board, commission, or program has operated in the public interest.

The Council has awarded and administered grant funds to local community organizations and programs that provide services to victims of domestic violence and sexual assault, batterer intervention services to perpetrators of domestic violence, and crisis intervention and prevention programs. The presentation element of the funding meeting is generally accepted and approved by all of the grantees. Public participation was encouraged and legislative intent was considered in the funding process. The Council strives to treat urban and rural participants fairly throughout the grant award process. The Council exercises oversight and performs on-site audits of most grant recipients.

The Council coordinates the efforts of many state and community agencies, working toward a comprehensive statewide system, to combat domestic violence and sexual assault. Overall, we conclude that the Council is performing its coordination duties.

The Council provides technical assistance in various forms to state agencies, law enforcement agencies, grantees, and community groups on a regular basis.

The Council worked on getting private and federal funding for capital improvement projects for the facilities of victim services providers. In addition, the State of Alaska, through the Council—in a collaborative effort with the Cook Inlet Tribal Council, Alaska State Court System, and Abused Women's Aid in Crisis—implemented the only supervised visitation center in the State with federal funding.

The Council has provided funds to assist in the development of training materials and participation in training events related to domestic violence and sexual assault. The Council has also provided statewide training with the regional State-Tribal forum on domestic violence. Training has been used by law enforcement officers, prosecutors, judicial officers, tribal citizens, probation/parole officers, social service providers, grantees, and community groups.

The Council provides domestic violence and sexual assault education on a local level through its grantees. The Council maintains a lending library with educational and reference materials available that are both adequate and appropriate to address the cause, prevention, and treatment of domestic violence and sexual assault.

Determine the extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.

The Council's board members have been appointed in accordance with Alaska statutes. All appointed members have shown an interest in matters dealing with the domestic violence and sexual assault. In addition, the Council is in a position to facilitate the resolution of coordination issues at the local level with representatives who oversee these areas at the state level.

The Council installed a new web-based database system in early FY 05. Although fairly new, the database system will be able to provide accurate, unduplicated statistical programmatic information for decision making. Overall, this system is expected to meet a critical need for coordinated standardized measurement and recording of statistical data between agencies.

AS 18.66.050(10) requires the Council to submit an annual report to the governor, and notify the legislature about the availability of the report. Although the statute is silent if such report is to be based on the calendar year or fiscal year, customarily the Council has submitted reports on fiscal year basis. The Council submitted the report to the governor on time for FY 02; but a few months late for FY 03 and FY 04 due to staff vacancy.

For the FY 06 grant award, the Council did not fund new programs choosing to maintain core services with existing council-funded programs. With a shrinking budget, the Council faced tough grant-funding decisions. The Council's grant award process is objective. The Council members reviewed the overall needs, economies of scale, duplication of services within geographic areas, and sustainability of existing programs. During the FY 05 funding meeting, grantees presented their financial struggle in keeping staff due to increasing operational costs, such as heating, lighting, and health insurance.

Other than occasional operational costs, the victim services programs have not received substantial core services funding increases.⁵ In addition, the batterers intervention programs have not seen any increase in their grant awards. In fact, the community-based batterers intervention programs had their budget reduced from \$320,000 to \$200,000 in FY 04. The schedule of grants awarded between FY 03 through FY 06 is located on Appendix A.

The financial schedule shown in Exhibit 1 (on the following page) depicts the Council's actual operating expenditures and funding sources between FY 02 through FY 05. The Council's funding sources are federal, state general funds, permanent fund dividends⁶, and interagency receipts from DHSS and the DOC. Overall, the Council's operating budget has decreased between FY 02 and FY 05 and amounts paid by the general fund continue to fall.

⁵ Using carry over authorization from prior year federal grants, the Council funded an extra \$513,159 to cover health insurance cost increases in FY 03 for victim services programs. For the FY 06 grant awards, the legislature also appropriated an additional \$200,000 for the victim services programs to cover operational costs.

⁶ These are Permanent Fund Dividend amounts withheld from convicted felons and misdemeanants who are incarcerated. The PFD is the main source of funding for the Council's batterers intervention program.

Exhibit 1
Schedule of Operating Expenditure and Funding Sources

	<u>FY02</u>	<u>FY03</u>	<u>FY04</u>	<u>FY05</u>
Expenditures:				
Personal Services	432,156	486,533	441,162	380,137
Travel	54,548	47,743	87,933	116,594
Contractual	544,252	536,279	539,782	529,788
Supplies	7,233	15,273	6,001	14,418
Equipment	4,474	1,997	9,382	-
Grants to Programs ⁷	7,950,647	8,555,081	8,262,676	7,742,461
Total Operating Expenditures	\$ 8,993,310	\$ 9,642,906	\$9,346,936	\$8,783,398
Funding Sources				
Federal Receipts	2,363,358	2,966,083	4,452,958	3,627,593
Interagency Receipts from DHSS ⁸	1,351,840	1,592,114	494,237	1,007,221
Interagency Receipts from DOC ⁹	155,382	174,565	174,700	157,990
Other Miscellaneous Receipts	291	507	701	438
General Fund Appropriations	5,122,439	4,909,637	4,224,340	3,990,156
Total Funding Sources	\$ 8,993,310	\$ 9,642,906	\$9,346,936	\$ 8,783,398

Additionally, in order to maintain funding for the grantee programs, the Council decided to fill their FY 05 budget shortfall through vacancies in Council staff. Although this is a reasonable decision, the Council has not fulfilled its statutory mandates due to limited staff resources, see Recommendation No. 1.

Determine the extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

The Council is generally asked by other agencies to review statutory changes contained in proposed legislation. Typically, Council members/staff review and comment on proposed legislation rather than developing and seeking support for its own measures. The Council discusses pertinent bills deciding which legislation the Council should support, remain neutral on, or oppose. The executive director develops, analyzes, and testifies on bills at the direction of the Council.

⁷ Grant amounts exclude capital improvement expenditures funded through capital appropriations.

⁸ Department of Health and Social Services' RSA mostly funds the victim services programs.

⁹ \$98,238 of the Department of Corrections' RSA funds the prison-based batterers intervention programs, with the remainder amount funding the administrative costs for both community-based and prison-based batterers intervention programs.

Legislation that was supported by the Council include the following:

- HB 332 (Chapter 91 SLA 2002) – amended the Council’s statute where the Council hires the executive director and the executive director now hires the staff. This legislation also placed the executive director and staff into exempt service.
- HB 328 (Chapter 15 SLA 2004) – related to certain victim’s rights and the Violent Crimes Compensation Board.
- HB 385 (Chapter 111 SLA 2004) – related to awarding child custody
- HB 398 (Chapter 19 SLA 2004) – established the domestic violence fatality review teams in areas of the State.

Determine the extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

The Council encourages interested parties to comment on its decisions or regulations by publicly announcing its meetings. The Council holds at least four meetings per year, normally in Anchorage or Juneau. Meetings held in Juneau are typically teleconferenced statewide.

Determine the extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

The Council encourages public participation by posting the Council’s meeting schedule on their website. Time is provided on the agenda of every public meeting for public comment. Grantee agencies are allocated time to speak directly to the Council at the main “funding” meeting. Also at each of its meetings, the Council schedules time for presentations from the Network and other community groups involved in the field of domestic violence and sexual assault.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims’ rights or the office of the ombudsman have been processed and resolved.

We found no problems in this area. Complaint procedures are in place, followed when complaints are made, and files are maintained. No complaint activity was noted from FY 02 through FY 05.

Determine the extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

Since the Council does not regulate any occupations or professions, this is not applicable.

Determine the extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

No complaints against the Council were identified.

Determine the extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

The previous sunset audit reported administrative issues with the line of authorities and undefined job responsibilities with the staff. Although the administrative weaknesses have been resolved, the Council is still facing personnel issues related to constant staff turnover. It takes considerable time to train new personnel and finish projects due to staff turnover.

The Council chose to concentrate on fulfilling its mandates through grant funding although with fewer resources, and focused less on its other mandates such as: (1) consultation with Department of Education and Early Development (DEED) to develop and implement standardized school curricula, and (2) Department of Health and Social Services (DHSS) to formulate standards and procedures for health care personnel.

There is still need for a more coordinated effort towards education in school districts across the State. The Council should consult with DEED's school district representatives and grantees, who have worked toward creating a comprehensive standardized curriculum to guide schools across the State.

There is also a need for statewide coordination efforts between the Council and DHSS, ensuring standards and procedures are available to health care facilities and practitioners of the healing arts and personnel in those facilities that provide services for victims of domestic violence in the communities across the State.

Determine the extent to which the board, commission, or agency has effectively attained its objectives and purposes and the efficiency with which the board, commission, or agency has operated.

The Council's purpose is to provide planning and coordination of services for victims of domestic violence or sexual assault or to their families, to perpetrators of domestic violence and sexual assault, and to provide for crisis intervention and prevention programs.

The Council, as the state agency responsible for administering the majority of crime victim assistance funding resources in Alaska, has been very effective with their coordination of services and outreach efforts through their grant award process. As an effective means to use and spread limited funds, the Council has ensured that Council-funded programs provide

coordinated efforts within the local communities such as law enforcement agencies, tribal groups, social service providers, hospitals, schools, courts systems, among others.

To continue with its mission, the Council plans to work on strategic planning to assess the effectiveness of services currently being provided by grantees and other state and local entities. The overall goal of the plan is to identify and address existing gaps in service.

Determine the extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

One of the Council's major objectives is the coordination of agencies, both state and local, that share the similar objective of combating the effects of domestic violence and sexual assault. No other agency is in a position to have an impact on this issue in this manner. Its existence is to help ensure that various agencies work together to effectively respond to Alaska's high rate of domestic violence and sexual assault. As a result, its activities do not duplicate the activities of the governmental agencies or the private sector.