ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
5267 SHES SB 331 - SB 372

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(10) the manner in which the object is displayed for sale;

(11) whether the owner, or the person having control of the object, is a legitimate supplier of like or related items to the community, such as a distributor or dealer of tobacco products;

(12) direct or circumstantial evidence of the ratio of sales of the object to the total sales of the business enterprise;

(13) the existence and scope of legitimate uses for the object in the community;

(14) expert testimony concerning its use.

Sec. 11.74.050. PENALTIES. (a) Except as provided in (b) of this section, a person who violates this chapter is guilty of a class A misdemeanor. up to $5000 + 1 yr

(b) A person 18 years of age or over who violates AS 11.74.020 by delivering drug paraphernalia to a person under 19 (18) years of age who is at least three years younger than the person delivering the drug paraphernalia is guilty of a class C felony. up to $10,000 + 5 yrs

Sec. 11.74.060. FORFEITURES. (a) Drug paraphernalia may be forfeited to the state either upon conviction of the defendant of a violation of AS 11.74.010 - 11.74.020 or upon judgment of a court in a separate civil proceeding in rem that an item of drug paraphernalia was used in a violation of AS 11.74.010 - 11.74.020.

(b) It is not a defense in an in rem proceeding brought under this section that a criminal proceeding is pending or has resulted in a conviction or acquittal of a person of a violation of AS 11.74.010 - 11.74.020, or that a criminal proceeding has been dismissed, or that the item of drug paraphernalia has not been forfeited in any criminal proceeding, or that multiple actions are pending.

Sec. 11.74.070. SEIZURE OF DRUG PARAPHERNALIA. (a) Drug paraphernalia subject to forfeiture under this section may be seized by a

peace officer upon an order issued by a court having jurisdiction over the property upon a showing of probable cause that the paraphernalia is subject to forfeiture under AS 11.74.060(a).

(b) Seizure without a court order may be made if

(1) the seizure is incident to a valid arrest or search under a valid search warrant;

(2) the paraphernalia subject to seizure has been the subject of a prior judgment in favor of the state in a criminal proceeding or civil proceeding in rem based on a violation of AS 11.74.-010 - 11.74.020; or

(3) there is probable cause that the paraphernalia was or is being used in violation of AS 11.74.010 - 11.74.020 and the property is easily movable; paraphernalia seized under this paragraph may not be held for more than 48 hours or until an order continuing the seizure may be applied for and issued by a court, whichever is earlier.

Sec. 11.74.080. CUSTODY. Paraphernalia taken or detained under AS 11.74.060(a) is in the custody of the Department of Public Safety subject only to an order or decree of the court having jurisdiction over the forfeiture proceedings. If property is seized under this chapter, the Department of Public Safety may

(1) place the paraphernalia under seal;

(2) remove the paraphernalia to a place designated by the court;

(3) take custody of the paraphernalia and remove it to an appropriate location for disposition according to law.

(b) Within 10 days of a seizure under this section, the state shall inventory the paraphernalia seized and its contents and appraise the value of the items seized.

Sec. 11.74.090. DISPOSITION OF PARAPHERNALIA. Paraphernalia forfeited under this section shall be disposed of according to court order. The court may order the Department of Public Safety to

(1) destroy paraphernalia harmful to the public;

(2) take custody of the paraphernalia and use it in the enforcement of this chapter, AS 11.71, or AS 17.30, or transfer it to another agency of the state for a use designated by the court in furtherance of the administration of justice;

(3) take custody of the paraphernalia and remove it for disposition in accordance with law; or

(4) forward it to the United States Drug Enforcement Administration for disposition. (Use to demonstrate in Ed.)

Sec. 11.74.100. DEFINITIONS. In this chapter

(1) "controlled substance" has the meaning given in AS 11.71.900;

(2) "drug paraphernalia" and "paraphernalia" mean equipment, products, and materials of any kind that are used or intended for use, intended or designed (all) for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of AS 11.71 or AS 17.30; "drug paraphernalia" or "paraphernalia" includes, but not limited to

(A) kits used, designed for use, or intended for use in planting, propagating, cultivating, growing or harvesting of any species of plant that is a controlled substance or from which a controlled substance can be derived;

(B) kits used, designed for use, or intended for use in manufacturing, compounding, converting, producing, processing,

or preparing controlled substances;

(C) isomerization devices used, designed for use, or intended for use in increasing the potency of a species of plant that is a controlled substance;

(D) testing equipment used, designed for use, or intended for use in identifying, or in analyzing the strength, effectiveness, or purity of controlled substances;

(E) scales and balances used, designed for use, or intended for use in weighing or measuring controlled substances;

(F) diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose, and lactose, used, designed for use, or intended for use in cutting controlled substances;

(G) separation gins and sifters used, designed for use, or intended for use in removing twigs and seeds from, or in otherwise cleaning or refining, marijuana;

(H) blenders, bowls, containers, spoons, and mixing devices used, designed for use, or intended for use in compounding controlled substances;

(I) capsules, balloons, envelopes, and other containers used, designed for use, or intended for use in packaging small quantities of controlled substances;

(J) containers and other objects used, designed for use, or intended for use in storing or concealing controlled substances;

(K) hypodermic syringes, needles, and other objects used, designed for use, or intended for use in parenterally injecting controlled substances into the human body;

(L) objects used, designed for use, or intended for

use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the human body, such as

(i) metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls;

(ii) water pipes;

(iii) carburetion tubes and devices;

(iv) smoking and carburetion masks;

(v) roach clips, meaning objects used to hold burning material, such as a marijuana cigarette, that has become too small or too short to be held in the hand;

(vi) miniature cocaine spoons and cocaine vials;

(vii) chamber pipes;

(viii) carburetor pipes;

(ix) electric pipes;

(x) air-driven pipes;

(xi) chillums;

(xii) bongs;

(xiii) ice pipes or chillers.

Effective date.

→ Should Marij be outlawed.

Sup. Ct. overturns

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB 331
PUBLISH DATE:

FISCAL NOTE

REQUEST

Revision Date:
Title: An Act relating to drug paraphernalia

Agency Affected: Public Safety
BRU: Alaska State Troopers

Sponsor: Sen. Fischer
Requestor:

Components: Criminal Investigations Bureau

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY88	FY89	FY90	FY91	FY92	FY93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUNDS						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

No increased enforcement level is anticipated to result from passage of this legislation.

Prepared by: Francis C. Allan
Division: Alaska State Troopers

Phone: 269-5691
Date. 1/26/88

Approved by Commissioner: Arthur E. English (Orders for)
Agency: Public Safety

Date: 1/26/88

Distribution: (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

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[illegible] costs aver[illegible]

[illegible] Model—$[illegible]

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continued from page 20

developers and businessmen with interests in the tourist trade have pushed local politicians to clear the potential tourist zone on the west coast of "hippie weirdos" who smoke and grow pot. (Prior to last summer's raids, and the recent sting, Hilo mayor Dante Carpenter had been noted for his low key policy toward enforcement of marijuana laws.)

Pot: Big Business for Hawaii

Acknowledged for years as a principal underground business in the economically depressed islands, the marijuana trade has long operated in an atmosphere of tolerant symbiosis between pot businessmen and local law enforcement. With an economy dependent on the tourist trade, and with a high unemployment rate, Hawaiians turned to marijuana as a major business over the last two decades: NORML's 1986 marijuana crop report estimates the value of the Hawaii crop at 1 billion, 722 million dollars. Some sources claim that as many as 30,000 Hawaiians are engaged in marijuana growing. Law enforcement officials offer lower though less precise figures, but admit that a substantial number of citizens are involved in growing and/or selling pot.

Citizens Protest

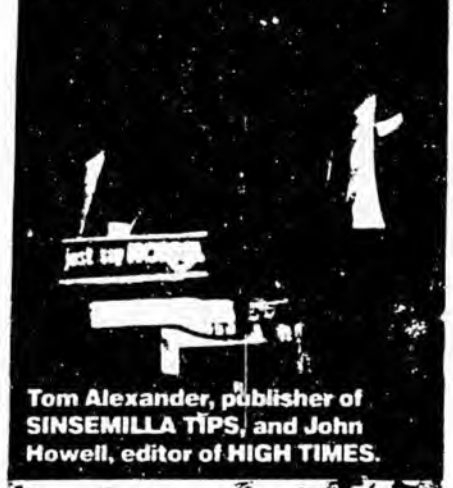
In a grass-roots reaction to these developments, a citizens' group has been formed to lobby for reform in the marijuana laws. At a press conference held in Hilo in midMay, the Marijuana Issue Political Action Committee announced its purpose as that of an educational and political lobby. "The many potgrowers and smokers on this island will no longer passively tolerate government intervention or harassment," said MIPAC spokesman Ron Olson. "We are going to educate and agitate for reform along the lines of the Orego. Marijuana Initiative." At press time, a rally was planned for the Hilo Tennis Stadium in July, featuring local political figures, panel discussions, a chile and rice "pig-out" eating contest, and rock music. MIPAC claims that local politicians, aware of the economic necessities that encourage Hawaiians to become involved in the marijuana business, are susceptible to more enlightened attitudes toward law enforcement than those evident recently. For more information, contact MIPAC, 688 Kinoole St., Suite 104B, Hilo, Hawaii (808) 935-0804.

Once again, the "War on Drugs" seems to have brought to a crisis point the many legal, economic, and political issues which swirl around the current marijuana policies.

Caveat

And remember, any sane grow store will NEVER discuss marijuana cultivation with its customers. They're under too much heat, trying to operate legitimately in public. Any grow store that does inquire about pot growing has to be viewed with extreme prejudice. If this sting has worked once, they're bound to try it again. ●

John Sajo (right) of OMI receives an award from NORML National Director Jon Gettman.



Tom Alexander, publisher of SINSEMILLA TIPS, and John Howell, editor of HIGH TIMES.

HIGH TIMES Advertising Manager Sandy Rosen in front of her booth at the convention.

The final treat for conference attendees was a banquet at a North African restaurant, capped by an exotic belly dance.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

ON

SENATE BILL NO. 331

"An Act relating to drug paraphernalia; and providing for an effective date."

CS SB 331 provides for legal penalties for an individual who is found guilty of manufacturing, delivering or advertising for the sale of drug paraphernalia.

The Department of Health and Social Services is supportive of the intent of this legislation. The Department, through the State Office of Alcoholism and Drug Abuse, discourages the use of drugs of all kinds and promotes this position through its support of community education and treatment of individuals who use drugs. This bill complements these efforts by restricting the availability to the public of drug paraphernalia associated with drug use.

Problems related to alcohol and drug abuse have frequently been discussed during recent meetings of the Governor's Interim Commission on Children and Youth and the Senate Special Committee on Suicide Prevention. Specific strategies recommended to impact these problems included increasing the availability of youth outpatient counseling and additional school curriculum programs.

While supportive of CS for SB 331, the DHSS defers examination of the enforcement provisions of this bill to the Departments of Public Safety and Law.

Myra M. Munson

Myra M. Munson
Commissioner

2-17-88

George Murdock

For Matthew C. Felix
Coordinator

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version : Senate Bill 331
Publish Date :

REQUEST:

Revision Date:

Agency Affected : Health & Social Services
Title : "An Act relating to drug paraphernalia; BRU : Alcoholism & Drug Abuse
and providing for an effective date."
Sponsor : Fischer
Requestor : N/A

Components : N/A

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by : Matthew Felix by George Mundell
Phone : 586-6201
Division : Alcoholism and Drug Abuse
Date : 2/17/88

Approved by Commissioner : Myra M. Munson
Date : 2-12-88
Agency :

Distribution (by preparer) :
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)
Senate Secretary

Message from Linda Adams:

By 1980, 8 Fed District Courts had upheld Model drug paraphenalia laws.
Maryland, Delaware and New Jersey have had law Challenged and upheld.

Harry Myers, Drug Enforcement Agency in D.C. is original drafter of model law. Gave following info to Ms. Adams.

In 1986, a comprehensive study of all states having passed model law was authorized by National Institute of Justice in D.C. Publication is called "State + Local Experience with Drug Paraphenalia Laws" by ABT Associates of Cambridge, Mass. about 300 pages.

Call Virginia Baldau to obtain copy @ (202) 724-2942.

Mr. Myers highly recommends publication for states

WHILE YOU WERE AWAY

FOR Senator DATE 2/18/88 TIME 11:00 A.M. P.M.

M Linda Adams

OF Ketchikan

PHONE X (800) 478-2273
AREA CODE NUMBER EXTENSION

MESSAGE re: drug paraphenalia laws

- ✓ TELEPHONED
- RETURNED YOUR CALL
- PLEASE CALL
- WILL CALL AGAIN
- CAME TO SEE YOU
- WANTS TO SEE YOU

SIGNED

TOPS FORM 4002

Model Drug Paraphernalia Act

Drafted by the

Drug Enforcement Administration

of the

United States Department of Justice

August, 1979

With

Prefatory Note and Comments

Model Drug Paraphernalia Act

Prefatory Note

The Uniform Controlled Substances Act, drafted by the National Conference of Commissioners on Uniform State Laws, has been enacted by all but a handful of states. The Uniform Act does not control the manufacture, advertisement, sale or use of so-called "Drug Paraphernalia." Other state laws aimed at controlling Drug Paraphernalia are often too vaguely worded and too limited in coverage to withstand constitutional attack or to be very effective. As a result, the availability of Drug Paraphernalia has reached epidemic levels. An entire industry has developed which promotes, even glamorizes, the illegal use of drugs by adults and children alike. Sales of Drug Paraphernalia are reported as high as three billion dollars a year. What was a small phenomenon at the time the Uniform Act was drafted has now mushroomed into an industry so well-entrenched that it has its own trade magazines and associations.

This Model Act was drafted, at the request of state authorities, to enable states and local jurisdictions to cope with the paraphernalia problem. The Act takes the form of suggested amendments to the Uniform Controlled Substances Act. The Uniform Act is extremely well-organized. It

ntains a definitional section, an offenses and penalties section, a civil forfeiture section, as well as miscellaneous sections on administration and enforcement. Instead of creating separate, independent paraphernalia laws, it seems desirable to control Drug Paraphernalia by amending existing sections of the Uniform Controlled Substances Act.

Article I provides a comprehensive definition of the term "Drug Paraphernalia" and includes particular descriptions of the most common forms of paraphernalia. Article I also outlines the more relevant factors a court or other authority should consider in determining whether an object comes within the definition.

Article II sets out four criminal offenses intended to prohibit the manufacture, advertisement, delivery or use of Drug Paraphernalia. The delivery of paraphernalia to a minor is made a special offense. Article II clearly defines what conduct is prohibited, and it specifies what criminal state of mind must accompany such conduct.

Article III provides for the civil seizure and forfeiture of Drug Paraphernalia. Civil forfeiture can be an effective deterrent, particularly to commercial suppliers whose capital is invested in inventory. Civil forfeiture can also be utilized in circumstances where criminal penalties seem unjustified.

ARTICLE I

(Definitions)

SECTION (insert designation of definitional section) of the Controlled Substances Act of this State is amended by adding the following after paragraph (insert designation of last definition in section):

"( ) The term 'Drug Paraphernalia' means all equipment, products and materials of any kind which are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing,

compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this Act (meaning the Controlled Substances Act of this State). It includes, but is not limited to:

(1) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

(2) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances;

(3) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance;

(4) Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness or purity of controlled substances;

(5) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances;

(6) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use, or designed for use in cutting controlled substances;

(7) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining, marihuanna;

(8) Blenders, bowls, containers, spoons and mixing devices used, intended for use, or designed for use in compounding controlled substances;

(9) Capsules, balloons, envelopes and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances;

(10) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances;

(11) Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body;

(12) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing marihuana, cocaine, hashish, or hashish oil into the human body, such as:

(a) Metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls;

(b) Water pipes;

(c) Carburetion tubes and devices;

(d) Smoking and carburetion masks;

(e) Roach clips: meaning objects used to hold burning material, such as a marihuana cigarette, that has become too small or too short to be held in the hand;

(f) Miniature cocaine spoons, and cocaine vials;

(g) Chamber pipes;

(h) Carburetor pipes;

(i) Electric pipes;

(j) Air-driven pipes;

(k) Chillums;

(l) Bongs;

(m) Ice pipes or chillers;

"In determining whether an object is Drug paraphernalia, a court or other authority should consider, in addition to all other logically relevant factors, the following:

(1) Statements by an owner or by anyone in control of the object concerning its use;

(2) Prior convictions, if any, of an owner, or of anyone in control of the object, under any State or Federal law relating to any controlled substance;

(3) The proximity of the object, in time and space, to a direct violation of this Act;

(4) The proximity of the object to controlled substances;

(5) The existence of any residue of controlled substances on the object;

(6) Direct or circumstantial evidence of the intent of an owner, or of anyone in control of the object, to deliver it to persons whom he knows, or should reasonably know, intend to use the object to facilitate a violation of this Act; the innocence of an owner, or of anyone in control of the object, as to a direct violation of this Act shall not prevent a finding that the object is intended for use, or designed for use as Drug paraphernalia;

(7) Instructions, oral or written, provided with the object concerning its use;

(8) Descriptive materials accompanying the object which explain or depict its use;

(9) National and local advertising concerning its use;

(10) The manner in which the object is displayed for sale;

(11) Whether the owner, or anyone in control of the object, is a legitimate supplier of like or related items to the community, such as a licensed distributor or dealer of tobacco products;

(12) Direct or circumstantial evidence of the ratio of sales of the object(s) to the total sales of the business enterprise;

(13) The existence and scope of legitimate uses for the object in the community;

(14) Expert testimony concerning its use."

ARTICLE II

(Offenses and Penalties)

SECTION (designation of offenses and penalties section) of the Controlled Substances Act of this State is amended by adding the following after (designation of last substantive offense):

"SECTION (A) (Possession of Drug Paraphernalia)

It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this Act. Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than ( ), fined not more than ( ), or both."

SECTION (B) (Manufacture or Delivery of Drug Paraphernalia)

It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this Act. Any person who violates this section is guilty of a crime and upon conviction may

be imprisoned for not more than ( ), fined not more than ( ), or both."

"SECTION (C) (Delivery of Drug Paraphernalia to a Minor)

Any person 18 years of age or over who violates Section (B) by delivering drug paraphernalia to a person under 18 years of age who is at least 3 years his junior is guilty of a special offense and upon conviction may be imprisoned for not more than ( ), fined not more than ( ), or both."

"SECTION (D) (Advertisement of Drug Paraphernalia)

It is unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia. Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than ( ), fined not more than ( ), or both."

ARTICLE III

(Civil Forfeiture)

SECTION (insert designation of civil forfeiture section) of the Controlled Substances Act of this State is amended to provide for the civil seizure and forfeiture of drug paraphernalia by adding the following after paragraph (insert designation of last category of forfeitable property):

"( ) all drug paraphernalia as defined by Section ( ) of this Act."

ARTICLE IV

(Severability)

If any provision of this Act or the application thereof to any person or circumstance is held invalid, the invalidity

does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

COMMENT [ARTICLE I]

Drug paraphernalia laws are most often attacked because they are too vaguely worded. They seldom explain what is meant by the term paraphernalia. They do not indicate whether it is the use, or the possession, or the sale of paraphernalia that is prohibited. Moreover, they are usually silent on the criminal state of mind that must accompany the prohibited conduct. This deprives an individual of fair warning as to what the law forbids. It also vests too much discretion in authorities to determine what property and what activities are controlled.

DEFINITION OF DRUG PARAPHERNALIA

Article I of the Model Act, in contrast, defines "drug paraphernalia" as equipment, products, and materials used, intended for use, or designed for use, essentially, to produce, package, store, test or use illicit drugs. The words "equipment, products and materials" should be interpreted according to their ordinary or dictionary meanings. They can apply to many forms of movable, tangible property. Real property, conveyances, monies, documents and intangible property are, on the other hand, not meant to be included within these terms.

Although this definition may appear too general in its wording, or too broad in its scope, there are so many forms of drug paraphernalia that any attempt to define the term in more specific language would guarantee major loopholes in the Act's coverage. The courts have repeatedly recognized that there are practical limitations in drafting legislation. Where the subject matter of a statute does not lend itself to exact description, the use of general language does not make the statute unconstitutionally vague. *United States v. Petrillo*, 332 U.S. 1, 67 S. Ct. 1538 (1947). And see *United States v. Ryan*, 284 U.S. [illegible] 52 S. Ct. 65 (1931).

To insure that innocently possessed objects are not classified as drug paraphernalia, Article I makes the knowledge or criminal intent of the person in control of an object a key element of the definition. Needless to say, inanimate objects are neither "good" nor "bad," neither "lawful" nor "unlawful." Inanimate objects do not commit crimes. But, when an object is controlled by people who use it illegally, or who intend to use it illegally, or who design or adapt it for illegal use, the object can be subject to control and the people subjected to prosecution. Article I requires, therefore, that an object be used, intended for use, or designed for use in connection with illicit drugs before it can be controlled as drug paraphernalia.

Hinging the definition of drug paraphernalia on a specific intent to violate, or to facilitate a violation of, the drug laws also provides "fair warning" to persons in possession of property potentially subject to this Act. A statute is not unconstitutionally vague, if it embodies a specific intent to violate the law. *Boyce Motor Lines, Inc. v. United States*, 342 U.S. 337, 72 S. Ct. 329 (1952); *Screws v. United States*, 325 U.S. 91, 65 S. Ct. 1031 (1945).

Consider the application of Article I to a spoon, a hypodermic syringe, and a length of surgical tubing. Each object has legitimate uses in the community. None is specifically designed for illegal use. Thus, when these objects are manufactured, delivered and possessed in lawful commerce, they are not considered paraphernalia. But, if these same objects are assembled and used by an addict to illegally melt heroin and inject it into his body, they become drug paraphernalia. As such they become forfeitable under Article III, and the addict becomes subject to prosecution under Section A of Article II.

Actual use of an object to produce, package, store, test or use illicit drugs need not always be shown. An object is considered to be drug paraphernalia whenever the person

in control intends it for use with illicit drugs. This intent may be a generalized one, not necessarily pinpointing a specific time and place of future use. See *Palmer v. State*, 14 Md. App. 159, 286 A.2d 572 (1972). It can be proved directly such as by admissions of the person in control, or indirectly through circumstantial evidence. It should be noted that the person in immediate control of an object need not intend to use it personally in connection with drugs. It is enough if he holds the object with the intent to make it available to persons whom he knows will use it illegally. See *United States v. 2265 One-Gallon Paraffined Tin Cans*, 260 F.2d 105 (5th Cir. 1958).

Objects whose sole, or at least dominant purpose is to produce, package, store, test or use illicit drugs are considered to be "designed" for such use. A rebuttable presumption exists that these objects are intended for use for the purpose for which they are designed. See *Israel v. United States*, 63 F.2d 345 (3rd Cir. 1933). As such, they are presumed to be drug paraphernalia. Isomerization devices designed for use in increasing the THC content of marihuana provide a good example.

Common Forms of Drug Paraphernalia

Article I includes a detailed description of common forms of property that can fall within the definition of drug paraphernalia if used, intended for use, or designed for use to violate the drug laws. This list is not intended to be inclusive. Several of these descriptions, such as "chillums" and "bongs," may seem foreign to the lay reader. Nevertheless, these terms are part of the jargon of the drug culture and are understood by both users and merchants of drug paraphernalia. They are not unconstitutionally vague. See *Hydgrade Provision Co. v. Sherman*, 266 U.S. 497, 45 S. Ct. 141 (1925).

Relevant Factors in Classifying Paraphernalia

In addition to defining drug paraphernalia and describing the common forms, Article I sets out some of the more relevant factors to consider in determining whether an

object is paraphernalia. The listing of these factors in the Model Act is not intended to be peremptory; a court or other authority is not obligated to hear evidence on, or to consider, every listed factor. Rather, the factors have been included to guide law enforcement officers, judges, and juries in their determination of what is controlled. Providing guidance on the practical application of the Act minimizes the risk of arbitrary and descriminatory enforcement, sometimes associated with even the most carefully drafted statutes. See *Interstate Circuit, Inc. v. City of Dallas*, 390 U.S. 676, 88 S. Ct. 1298 (1968).

Conversely, the listing of these factors is not meant to be inclusive. Any logically relevant factor may be considered.

Comment [Article II]

Possession of Drug Paraphernalia

Section A makes it a crime to: (i) possess an object; (ii) classifiable as drug paraphernalia; (iii) with the intent to use that object, essentially, to produce, package, store, test or use illicit drugs in violation of the Controlled Substances Act of the State. Section A does not make the mere possession of an object capable of use as drug paraphernalia a crime. Section A does not make the mere intent to violate the drug laws a crime. It is the possession of drug paraphernalia accompanied by an intent to use it to violate the drug laws that Section A forbids. Innocent citizens have nothing to fear from Section A.

It must be noted here that the activities of storing, testing and using illicit drugs are not in themselves violations of either the Uniform Controlled Substances Act or the federal Controlled Substances Act. But each activity necessarily includes the possession of illicit drugs, which is a violation of both laws.

Manufacture or Delivery of Drug Paraphernalia

Suppliers who furnish goods or services knowing they will be used to facilitate a crime are not immune from liability. There are no legal obstacles to punishing sup-

pliers who knowingly or recklessly aid their customers to commit crimes. This is true whether the objects or services are restricted, or peculiarly suited for illegal use, such as a still, a gun, morphine or stolen goods. See *Direct Sales Company* v. *United States*, 319 U.S. 703, 63 S. Ct. 1265 (1943); *Backun v. United States*, 112 F.2d 635 (4th Cir. 1940); *Israel v. United States*, 63 F.2d 345 (3rd Cir. 1933); *Weinstein v. United States*, 293 F. 388 (1 Cir. 1923); and *Commonwealth v. Stout*, 356 Mass. 237, 249 N.E.2d 12 (1969).

It is also true when the objects or services have widespread legitimate uses in the community, such as sugar, rye, yeast, grapejuice, rubbing alcohol or a telephone answering service. See *United States v. Ragland*, 306 F.2d 732 (4th Cir. 1962); *Chapman v. United States*, 271 F.2d 593 (5th Cir. 1959); *United Cigar Whelan Stores Corp. v. United States*, 113 F.2d 340 (9th Cir. 1940); *Vukich v. United States*, 28 F.2d 666 (9th Cir. 1928); *United States v. Burnett*, 53 F.2d 219 (W.D. Mo. 1931); and *People v. Lauria*, 251 Cal. App.2d. 471 (1967).

The reasonableness of this rule is clearly expressed in *Backun v. United States*:

> "To say that the sale of goods is a normally lawful transaction is beside the point. The seller may not ignore the purpose for which the purchase is made if he is advised of that purpose, or wash his hands of the aid that he has given the perpetrator of a felony by the plea that he has merely made a sale of merchandise. One who sells a gun to another knowing that he is buying it to commit a murder, would hardly escape conviction as an accessory to the murder by showing that he received full price for the gun; and no difference in principle can be drawn between such a case and any other case of a seller who knows that the purchaser intends to use the goods which he is purchasing in the commission of a felony. In any such case, not only does the act of the seller assist in the commission of the felony, but his will assents to its commission, since he could refuse to give the assistance by refusing to make the sale" 112 F.2d 635 (4th Cir. (1940)).

There are courts which have hesitated to hold a supplier guilty of conspiracy with, or of aiding and abetting a buyer. See *United States v. Falcone*, 311 U.S. 205, 61 S. Ct. 204 (1940); and *United States v. Peoni*, 100 F.2d 401 (2 Cir. 1938). A careful reading of these decisions makes clear that they were based upon the court's unwillingness to hold a supplier *equally* responsible with a buyer based simply upon the supplier's knowledge that the buyer intended to commit a crime. At common law, the punishment is the same for the co-conspirator and the aider and abetter as it is for the actual perpetrator. Nothing in these cases suggests, however, that a supplier enjoys complete immunity from punishment, or that a state cannot make the conduct of the supplier a separate offense. See Note, *Falcone Revisited: The Criminality of Sales to an Illegal Enterprise*, 53 Columbia Law Rev. 228 (1953).

Section B makes it a crime to: (i) deliver, possess with intent to deliver, or manufacture with intent to deliver an object; (ii) classifiable as drug paraphernalia, (iii) knowing, or under circumstances where one reasonably should know, that it will be used, essentially, to produce, package, store, test or use illicit drugs in violation of the Controlled Substances Act of the State. The term "deliver" has the same basic meaning attributed to it by the Uniform Controlled Substances Act; namely, the actual, constructive, or attempted transfer from one person to another, whether or not there is an agency relationship. The term "manufacture," appearing in the phrase "manufacture with intent to deliver," is used in a general sense to express the entire process by which an object is made ready for sale in open commerce, including designing, fabricating, assembling, packaging and labeling. See *Danovitz v. United States*, 281 U.S. 389, 50 S. Ct. 344 (1930).

The knowledge requirement of Section B is satisfied when a supplier: (i) has actual knowledge an object will be

used as drug paraphernalia; (ii) is aware of a high probability an object will be used as drug paraphernalia; or (iii) is aware of facts and circumstances from which he should reasonably conclude there is a high probability an object will be used as drug paraphernalia. Section B requires a supplier of potential paraphernalia to exercise a reasonable amount of care. He need not undertake an investigation into the intentions of every buyer, but he is not free to ignore the circumstances of a transaction. Suppliers of objects capable of use as paraphernalia may not deliver them indiscriminately. Since each element of Section B must be proven beyond a reasonable doubt, legitimate, prudent suppliers will not be affected by this section.

ADVERTISEMENT OF DRUG PARAPHERNALIA

Section D makes it a crime to: (i) advertise an object; (ii) classifiable as drug paraphernalia; (iii) knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement is to promote the sale of the object for use, essentially, to produce, package, store, test or use illicit drugs.

Only printed advertisements promoting the sale of objects for use as paraphernalia are prohibited. The non-printed media, including radio and television, is not affected. Printed matter criticising the drug laws, glorifying the drug culture, glamorizing the use of drugs, or providing information or instructions on illicit drugs is not affected. The target of this Section is commercial advertising.

Unlike so-called "printer's ink" statutes, which exempt printers and publishers from their coverage, Section D contains no exemptions. It applies to anyone who prints or publishes paraphernalia advertisements, and to anyone who causes these advertisements to be printed or published. For this reason, it uses the general terms "any person" and "to place."

The knowledge requirement of Section D is satisfied when the person placing the advertisement (i) has actual knowledge it is promoting the sale of objects for use as drug paraphernalia; (ii) is aware of a high probability it is promoting the sale of objects for use as drug paraphernalia; or (iii) is aware of facts and circumstances from which he should reasonably conclude there is a high probability the advertisement is promoting the sale of objects for use as drug paraphernalia. Whether an advertisement promotes the sale of objects for use as paraphernalia is to be determined from its content. Under Section D, one need not look beyond the face of the advertisement.

Section D does not compromise First Amendment rights. The sale of objects for use as drug paraphernalia is made illegal by Section B, and Section D simply prohibits advertisements promoting these sales. Commercial solicitation of illegal activities is not protected speech. *Pittsburgh Press Co. v. Pittsburgh Commission on Human Rights*, 413 U.S. 376, 93 S. Ct. 2553 (1973); and see *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 96 S. Ct. 1817 (1976).

COMMENT [ARTICLE III]

Civil forfeiture actions are directed against property and are totally independent of any criminal proceedings against individuals. Section 505 of the Uniform Controlled Substances Act provides for the seizure and civil forfeiture of: (1) illicit drugs; (2) equipment and materials used to make, deliver, import or export illicit drugs; (3) containers used to store illicit drugs; (4) conveyances involved in transporting illicit drugs; and (5) books, records and research connected with illicit drugs. States that have adopted Section 505 can seize these objects without making any compensation to the owners. The legality of civil forfeiture statutes, similar to 505, and their usefulness in helping deter crime, have been repeatedly recognized by virtually every state and federal court, including

the Supreme Court of the United States. *Calero-Toledo v. Pearson Yacht Leasing Co.*, 416 U.S. 663, 94 S. Ct. 2080 (1974).

Article III extends the civil forfeiture section of the Uniform Act to include drug paraphernalia. This allows states to keep and destroy drug paraphernalia, rather than returning it after criminal proceedings have ended. It also allows states to keep drug paraphernalia seized during an investigation, in cases where criminal proceedings are not initiated. Finally, since the standard of proof in a civil forfeiture action is simply "probable cause," or "reasonable cause," rather than "proof beyond a reasonable doubt," Article III permits states to seize and forfeit drug paraphernalia in circumstances where an arrest might not seem justified. For example, an officer who encounters a minor in possession of a hypodermic syringe, or in possession of a bong (a device especially designed for smoking marihuana), has reasonable cause to believe these objects are intended for use to introduce illicit drugs into the human body. Subjecting drug paraphernalia to civil forfeiture permits the officer to seize these objects, though he decides not to arrest the minor.

Civil forfeiture can also be an effective deterrent to commercial suppliers. See *Utley Wholesale Company v. United States*, 308 F.2d 157 (5th Cir. 1962); *United States v. 2265 One-Gallon Paraffined Tin Cans*, 260 F.2d 105 (5th Cir. 1958); *United States v. 1,922 Assorted Firearms, Etc.*, 330 F. Supp. 635 (ED Mo. 1971); *United States v. 600 Bags of Southcoast Jurbinado Brand Sugar*, 225 F. Supp. 705 (WD La. 1964); *Vinto Products Co. v. Goddard*, 43 F.2d 399 (D Minn. 1930); and *United States v. Roitman*, 36 F.2d 86 (ND Ill. 1929).

SB

339

Alaska State Legislature

SENATE

Office of the President

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

January 25, 1988

TO: Senator Paul Fischer, Chairman
Health, Education and Social Services Committee

FROM: Senator Jan Faiks
President of the Senate

SUBJECT: SB 339 "An Act relating to tobacco products."

Senate Bill 339 has been referred to your committee for consideration. The bill proposes changes to AS 11.76.100, relating to the offense of selling or giving tobacco to a minor.

Under current law, a person 19 years of age or older commits a violation if the person sells or gives cigars, cigarettes or tobacco to a person under 16 years of age.

There are several problems with current law. First, it only covers cigars, cigarettes and tobacco. It does not clearly prohibit adults from providing tobacco products such as snuff or certain other types of smokeless tobacco to underage individuals. As you know, these products are increasingly popular with our youth, and they pose clear health risks, such as cancer of the mouth, tongue and throat, as well as gum disease.

Second, while current law prohibits adults from providing tobacco to underage persons, it allows vending machines to dispense tobacco products. The predictable result of this is that most teenagers who smoke cigarettes obtain them from vending machines.

Third, current law allows the sale of tobacco to minors 16, 17 and 18 years of age.

SB 339 proposes to correct this situation. It repeals AS 11.76.100, and reenacts it as follows:

AS 11.76.100(a)(1): A person 19 years of age or older commits the offense of selling tobacco to a minor if the person knowingly sells, exchanges or gives a cigarette, a cigar, tobacco or a product containing tobacco to a person under 19 years of age.

AS 11.76.100(a)(2): A person 19 years of age or older commits the offense of selling tobacco to a minor if the person maintains a vending

machine that dispenses cigarettes, cigars, tobacco or tobacco products and that is accessible to persons under the age of 19.

AS 11.76.100(b): Selling or giving tobacco to a minor is a violation.

AS 11.76.100(c)(1): A person who maintains a vending machine is not in violation of this statute if only the person who owns or maintains the machine can operate the machine, either directly or through a remote control device that is inaccessible to the customer. As an example, vending machines behind the counter in a store or restaurant, or vending machines with a cut-off switch at the cash register would be allowed.

AS 11.76.100(c)(2): A person who maintains a vending machine is not in violation of this statute if the machine is located at a business establishment, place of employment or private club at which a person under the age of 19 is not employed and into which a person under 19 years of age is not allowed unless accompanied by a legal guardian 21 years of age or older. As an example, a machine in a bar would be deemed inaccessible to minors as a matter of law, as would a machine in a workplace where minors were not employed and which prohibited the entry of unaccompanied minors as a matter of company policy.

Please feel free to contact my office with questions or comments.

POSITION PAPER/Department of Health & Social Services

Position Paper

SB 339

For an Act entitled: "An Act relating to tobacco products."

This Act would repeal and reenact AS 11.76.100, which prohibits the selling or giving of tobacco to a minor. The Act prohibits maintaining a vending machine that dispenses tobacco products and that is readily accessible to minors, unless its operation is under the control of the owner of the machine or a person employed by the owner.

The purpose of this Act is to reduce the accessibility of tobacco products to minors under the age of 19 years.

Impact of Bill

Tobacco has been shown to be a highly addictive substance with numerous adverse health effects on the user. It has been cited by the Surgeon General of the United States Public Health Service as the number one cause of preventable disease in this country. The younger a person is when he/she begins the use of tobacco or other addictive substances, the more likely he/she is to abuse that product and suffer the adverse effects of that abuse.

Position

This bill should reduce significantly the accessibility of tobacco products to minors and reduce the resultant morbidity due to their use. The Department of Health and Social Services supports this legislation.

Recommended by: Elizabeth S. Ward

Elizabeth Ward, M.N.
Director
Division of Public Health

Date: January 22, 1988

Approved by: Myra M. Munson

Myra M. Munson
Commissioner
Department of Health and
Social Services

Date: January 25, 1988

Elementary Education

Lay Public Ignorant of Drug Prevention Success

by Mark S. Gold, M.D.

Everyone has an opinion about drug prevention. Some experts and journalists declare that prevention is impossible. Parents, acting on this theory, "look the other way" when their children "borrow" their liquor or return home smelling of alcohol or obviously having smoked marijuana.

Other parents, believing drug use to be inevitable and part of "normal" adolescence, try to procure the best, "clean" marijuana for their children, or they use drugs with their children. When drug use is considered by some experts to be normal, primary prevention becomes all the more difficult.

Primary prevention means prevention of drug use. To understand how primary prevention can work, we should study how it is already working. Lost in the shuffle of drug abuse statistics is the fact that 49 percent of United States high school seniors do not use, and have never used, marijuana. Eighty-three percent of high school seniors have never tried cocaine, even once, and 99 percent have never tried heroin!

Illicit drugs break down primary prevention efforts by pretending to be normative, but the use of them by the nation's young people is a real problem; it is neither normative nor normal.

A simple equation for conceptualization of prevention is: drug use/abuse/addiction = exposure X predisposition. Predisposition is the vulnerability to use and/or develop abnormal patterns of use when exposed to a particular drug. Predisposition is comprised of complex psychosocial and biological factors.

The vulnerability to develop alcoholism and abnormal use is inherited. The genetic predisposition is a biological (physical) vulnerability that is transmitted from parents to offspring. Evidence is growing that the genetic predisposition for alcohol extends to other drugs such as cocaine and marijuana.

The majority of alcoholics under the age of 30 are addicted to at least one other drug, most often marijuana and followed by cocaine. Cigarettes also may be included in this vulnerability since nicotine is a drug and cigarettes are commonly used by alcohol/drug users. The biological vulnerability most likely resides in the brain, and drug (and/or alcohol) addiction is in part a neurological disease.

> To prevent marijuana use we must prevent cigarette and alcohol use.

To prevent marijuana use we must prevent cigarette and alcohol use. To prevent cocaine use we must prevent cigarette, alcohol, and marijuana use. With 91 percent of high school seniors having tried alcohol—85 percent using in the past year, 65 percent using in the past month, and 4.8 percent using every day—it is obvious where secondary prevention efforts should be focused.

Prevention efforts have been somewhat successful in reducing cigarette smoking among adults and new adolescent smokers. From a peak in 1976 of 76 percent of high school seniors having ever tried a cigarette in their lifetime, currently 68 percent have ever tried smoking. Daily cigarette smoking among high school seniors has dropped during this decade from 28.8 percent to 18.7 percent.

Secondary prevention requires early identification and intervention. Early identification can be made by a pediatrician at an annual physical, or it can be made during a sports physical by the use of urinalysis.

Education with outpatient recovery programs can quickly help a drug-using adolescent and codependents when the diagnosis is made at an early phase of the illness.

Prevention programs in the schools should begin early in elementary schools with discussions of the body, the difference between medicine and drugs, and the proper way to fill, use, and discard prescription drugs. Shortly thereafter, the health effects of cigarette smoking and alcohol consumption should be stressed; this should include a discussion of the reasons why people start drinking or smoking. Children should be encouraged to help their parents stop smoking.

Educational prevention is the most effective when focusing elementary education first on cigarettes, then alcohol, then marijuana. Antidrug messages should be reinforced in biology and other subjects. The drug curricula should continue through senior high school, with an increase in experiential learning and exposure to real-life victims of addiction.

Children at risk (e.g. children with a family history of addiction, etc.) should be identified and receive additional individual and family prevention information. While drug prevention is not as precise a science as we would like, it is a lot more effective than professionals or the lay public recognize.

Mark S. Gold, M.D., is the author of the new "Facts About Drugs and Alcohol," Bantam Books, 1987.

AMERICAN LUNG ASSOCIATION
The Christmas Seal People

AMERICAN LUNG ASS'N. OF ALASKA
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This publication was made possible in part by your support of Christmas Seals® and other contributions to the American Lung Association.

Is There A Safe Tobacco?

Is there a way to use tobacco without risking your health and your life?

Should you switch from cigarettes to another form of tobacco use?

- **Snuff?** • **Cigars?** • **Pipes?**
- **Chewing Tobacco?**
- **Clove Cigarettes?**
- **Low-Yield Cigarettes?**

Take a look at

The Facts

SMOKELESS TOBACCO

As cigarette smoking becomes increasingly unpopular in American life, tobacco companies are trying hard to promote chewing tobacco and snuff.

They aim at two groups:

- Young people who may never have been regular smokers.
- Smokers and ex-smokers who want a substitute for cigarettes.

But how safe are these products?

> **Chewing tobacco** is leaf tobacco chewed by placing a wad—called a "quid" or "chaw"—between the cheek and the teeth, and sucking on it.
>
> **Snuff** is finely ground tobacco. It is "dipped" by placing a pinch between the lower lip and teeth. Although the practice is rare, it may also be breathed through the nose.

Chewing tobacco and snuff definitely are dangerous health hazards. Because they are not smoked, they increase the risk of disease in certain other parts of the body instead of the lungs.

The dangers of using smokeless tobacco stem from two facts:

- They can lead to nicotine addiction.
- They damage the delicate lining of the mouth and throat.

As a result, they can contribute to serious disease or death from oral cancers, heart disease, or stroke.

> **Some health problems linked to chewing tobacco and snuff**
>
> • Mouth cancer • Throat cancer • Gum disease
>
> **Other effects**
>
> • Bad breath • Stained teeth • Tooth loss • Slow healing of mouth wounds • Lowered sense of taste and smell • Excess saliva, need to spit

Smokeless tobacco companies want you to believe chewing tobacco or dipping snuff is the "in" thing to do—that it makes you more attractive.

CIGARS AND PIPES

Pipe and cigar smokers have death rates that are lower than those of cigarette smokers, but higher than non-smokers. Since they tend to smoke less and usually do not inhale, pipe and cigar smokers have less risk of heart and lung disease. Those who switch from cigarettes to pipes and cigars, however, may inhale more than those who originally smoked cigars and pipes—or smoke more often.

Smoking pipes or cigars is far from safe. Here are the facts:

- Pipe and cigar smoke contain many of the same harmful ingredients as cigarette smoke, often in much higher amounts.
- People who *inhale* pipe or cigar smoke have greater risks of death from lung or heart disease than do cigarette smokers.
- Cigarette smokers who switch to pipes or cigars are likely to inhale the smoke—often unintentionally.
- Little cigars are especially dangerous. People tend to use them like cigarettes—

smoking more and inhaling the smoke—but they have higher nicotine and tar levels than cigarettes.

- Cigar smokers have slightly higher early death rates than pipe smokers. But the rates for both go up if they:
  - —smoke more often.
  - —smoke over a longer period of years.
  - —begin at a young age.
  - —inhale often or deeply.
- Pipe smokers have an especially high risk of getting lip cancer.
- Compared with cigarette smokers, pipe and cigar smokers have higher risks of dying from cancer of the mouth, throat, or larynx (voice box).

THE LONELY SMOKERS

Pipe and cigar smokers have a special social problem. Their smoke is even more offensive and irritating to nonsmokers than cigarette smoke. It is banned in more places—including airlines—and can be disturbing to spouses, best friends, coworkers.

One study showed the smoke from one cigar polluted the air more than 42 cigarettes in a half hour. What's in that smoke? There are some 4,000 chemicals, and nearly 50 cancer-causing substances.

A few of the 4,000 pollutants in tobacco smoke

Carbon monoxide	Vinyl chloride
Nitrites	Hydrocarbons
Ammonia	Volatile alcohols
Nitrosamines	Urethane
Hydrogen cyanide	Formaldehyde
Sulfur compounds	Hydrazine

The pollution created by tobacco smoking is one of the major reasons why smokers are becoming an increasingly lonely minority.

CLOVE CIGARETTES

Like cigars or pipes, clove cigarettes (which are also known as "kreteks" and usually imported from Indonesia) have a pungent odor. Recently they've become popular among young people, many of whom seem to think that they're "safe" because they're allegedly made of cloves.

But in fact clove cigarettes are usually 60 percent tobacco and 40 percent ground cloves, clove oil (eugenol), and other additives. So they may be just as hazardous as other tobacco cigarettes. And some scientists think they are even more hazardous—that they may cause more immediate injury to the lungs.

LOW-YIELD CIGARETTES

More than half of cigarette smokers now use brands that promote low tar and nicotine. Those cigarettes may or may not be less dangerous. That depends on how smokers use them. Most smoke more to compensate—to achieve certain nicotine levels or taste more flavor, for instance.

What do the labels mean?

Tar and nicotine ratings are estimates of what a cigarette may deliver. Although a standard smoking machine is used to arrive at the numbers, the actual amounts can vary widely from those numbers.

Smokers breathe in a greater amount of these dangerous products if they:

- —inhale deeply.
- —take more than one puff a minute.
- —hold the smoke in their lungs longer.
- —smoke the cigarette down too far.
- —cover vent holes that are near the filter on some brands.

When smokers become addicted, their desire for nicotine often causes them to do these things unintentionally when they switch to lower-yield cigarette brands.

What's missing from cigarette labels?

What the labels fail to tell you may be as important to your health as what they say. More and more makers of low tar cigarettes are using additives to try to improve taste and burning quality. They are not required to list those additives on cigarette labels, and the health effects of many of them are unknown.

How do "ultra low tar" brands work?

These brands usually depend on mixing air with the smoke. A ring of tiny vent holes near the filter causes the smoker to draw air and smoke together.

Some people block the holes, purposely or accidentally, defeating the purpose. A cigarette rated at 1 mg tar can yield 12 mg of tar or more. People also tend to over-smoke these brands to satisfy their desire for nicotine.

Low tar brands also fail to reduce health hazards caused by side-stream smoke, which enters the air directly from the burning end of the cigarette and is not filtered.

> **Tar** is the weight of all the chemicals, less nicotine and moisture, that can be taken out of tobacco smoke. It is deposited in smokers' lungs. Some chemicals in tar are known to cause cancer.
>
> **Nicotine** is the addictive drug in cigarettes. Evidence suggests that nicotine intake raises the risk of death from heart disease and stroke. In its pure form, nicotine is a strong poison. A small dose of it, injected directly into the bloodstream, would kill a person within one hour.

If you are using low-yield cigarettes as a step to quitting, these tips may help:

- Smoke as few cigarettes as possible.
- Take fewer puffs per cigarette.
- Inhale fewer puffs, and don't inhale deeply.

- Leave longer butts.
- Do not block vent holes.
- Take the cigarette out of your mouth between puffs.
- Smoke the lowest yield cigarette you can tolerate. When you've had time to adjust, switch down again.
- Keep quitting as your final goal—and get to that goal as soon as you can.
- Ask your local American Lung Association for help in quitting smoking. They have self-help manuals, group programs, and new video techniques. Find out which one—or several—work best for you.

These are the facts: There is no safe tobacco, either smokeless or regular.

Take care of your lungs.
They're only human.

605 Barrow Street, Suite 2, P.O. Box 103056 Anchorage, Alaska 99510 (907) 276-5864

AMERICAN LUNG ASSOCIATION OF ALASKA

Dedicated to the prevention and control of lung disease

Sept. 9, 1987

Deborah Williams, Executive Director

UNDERAGE TOBACCO TEST FOLLOW-UP AND SUMMARY

In a two part study conducted by the American Lung Association of Alaska, two girls, both of whom were not old enough to legally purchase tobacco products, did successfully buy cigarettes 66 out of 6º attempts. The results of this test proved that the current laws regarding tobacco and minors are not adequate. Hopefully, based on the outcome of this experiment new legislation will be adopted, making the accessability of tobacco to anyone under 1º years of age impossible, and cigarette vending machines banned.

THE TEST

In the first part of the experiment, a 14 year old girl was instructed to attempt to buy cigarettes from store clerks or attendants. No attempt was made to make her appear older. She successfully purchased cigarettes 47 out of 4º attempts, mainly at convenience stores. All establishments were selected according to driving convenience and the names of the offending establishments were not released or made public, this information was considered confidential and treated accordingly.

The second part of the study involved a 10 year girl who was instructed to enter establishments and attempt to purchase cigarettes from vending machines. She succeeded in 1º of those 20 attempts. During this part of the test we gained the shocking knowledge that in some instances cigarettes were being sold in candy vending machines.

The test was conducted on August 6th and 10th, with a press conference taking place on August 11th to reveal the results of the findings. The press conference was covered by all three TV stations, and both local newspapers. At this writing, new legislation regarding this matter is being considered.

The current age of which one can legally purchase tobacco products in Alaska is 16.

605 Barrow Street, Suite 2, P.O. Box 103056 Anchorage, Alaska 99510 (907) 276-5864

AMERICAN LUNG ASSOCIATION OF ALASKA

Dedicated to the prevention and control of lung disease

Deborah Williams, Executive Director

August 11, 1987

UNDERAGE CIGARETTE BUYERS SUCCEED

On Monday August 10th, the American Lung Association of Alaska completed an important test. The test was conducted with two school-age girls: 14 year old Shelly Klingbell, a 9th grader at East High, and 10 year old Heather Timmerman, a 5th grader at Rabbit Creek Elementary School, neither were old enough to legally purchase cigarettes. In the first experiment, the 14 year old was instructed to attempt to purchase cigarettes from a clerk or store attendant. In the second part, the 10 year old was instructed to enter various establishments and attempt to buy cigarettes from a vending machine.

Shelly,14, attempted to purchase cigarettes at 49 different stores; she succeeded at 47 of those. Not only regular cashiers, but also assistant managers sold her cigarettes. Surprisingly, out of the 49 stores only 4 of them asked her to produce ID, when she stated that she left her ID at home 2 of those stores still sold to her.

Heather,10, attempted to buy cigarettes from vending machines at 20 establishments, and succeeded 19 times. At only 1 restaurant did a waitress tell her she couldn't buy. Heather stated at first she was nervous, but later in the test she said," It's so easy, I don't even think about it anymore, and a lot of the machines are supervised. Heather, however was surprised that 3 of the machines sold not only cigarettes but also candy.

"I was appalled when I found out that many establishments sold cigarettes to minors!" stated an astonished Deborah Williams, Executive Director of The American Lung Association of Alaska. "Something has to be done, this is totally unacceptable." She notes.

- MORE -

605 Barrow Street, Suite 2, P.O. Box 103056 Anchorage, Alaska 995?0 (907) 276-58(

AMERICAN LUNG ASSOCIATION OF ALASKA

Dedicated to the prevention and control of lung disease

Deborah Williams, Executive Director

"This test proves that the current laws regarding tobacco and minors are inadequate and unacceptable. New legislation must be adopted which will prohibit the sale of tobacco in vending machines and which will raise the age at which minors can purchase tobacco to 19.", stated Paul Wrzesinske, Public Relations Director of the Lung Association. The current age to legally purchase cigarettes in Alaska is 16.

"Prior to this test we had only anecdotal evidence about how easy it was for people under 16 to purchase tobacco. We wanted to do a more comprehensive test. Originally we were planning on doing 50 vending machines and 50 over-the-counter sales. We only did 20 vending machines because it got to the point where it was so easy for the 10 year old to purchase the cigarettes that we were just wasting money.", noted Deborah Williams." We have most definitely proved an important point, and we hope all Alaskans will join us in improving the laws on this matter." Cigarettes are the number one preventable cause of premature death and disability in the U.S., and 90% of all smokers people become addicted by the time they are 19 years old. 60% of all smokers start by the age of 14, studies show. The younger a person starts to smoke, the more likely one is to remain a smoker, smoke more heavily and die prematurely."The time to stop the improper flow of cigarettes to children under 16 is now."

- END -

QUALITY SERVICES

Date OCT 07 1987

Palmer Frontiersman

Client No. 0325

Youths find no problems in purchasing cigarettes

0325

On Monday, August 10, the American Lung Association of Alaska completed an important test. The test was conducted with two school-age girls: 14-year-old Shelley Klingbell, a 9th grader at East High in Anchorage, and 10-year-old Heather Timmerman, a 5th grader at Rabbit Creek Elementary in Anchorage. Neither were old enough to legally purchase cigarettes. In the first experiment, the 14-year-old was instructed to attempt to purchase cigarettes from a clerk or store attendant. In the second part, the 10-year-old was instructed to enter various establishments and attempt to buy cigarettes from a vending machine.

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Prior to this test we had only anecdotal evidence about how easy it was for people under 18 to purchase tobacco. We wanted to do a more comprehensive test. Originally we were planning on doing 50 vending machines and 50 over-the-counter sales. We only did 20 vending machines because it got to the point where it was so easy for the 10-year-old to purchase the cigarettes that we were just wasting money," noted Deborah Williams. "We have most definitely proved an important point, and we hope all Alaskans will join us in improving the laws on this matter. Cigarettes are the number one preventable cause of premature death and disability in the U.S., and 90% of all smokers become addicted by the time they are 19 years old. Sixty percent of all smokers start by the age of 14, studies show. The younger a person starts to smoke, the more likely one is to remain a smoker, smoke more heavily and die prematurely. "The time to stop the improper flow of cigarettes to children under 16 is now."

MAKING A MINOR POINT ABOUT CIGARETTES

Anchorage Daily News/Erik Hill

Shelly Klingbell, 14, and Heather Timmerman, 10, pose with some of their haul of cigarette packs.

Undercover youths smoke out illegal sales

By HAL SPENCER
Daily News reporter

Ten-year-old Heather Timmerman was pretty scared the first couple of times she dropped coins into a vending machine and sauntered out with a pack of cigarettes.

"Then it was easy," she said Tuesday. "After the first few times, it didn't bother me."

Heather, a dainty redhead with an angelic smile, told reporters who showed up at the American Lung Association of Alaska headquarters that she bought cigarettes at 19 different vending machines around Anchorage on Monday without so much as a peep from proprietors within.

Only one of 20 proprietors at hotels, gas stations and other establishments told the child, "Don't do that. Get out of here," said Heather, a fifth-grader at Rabbit Creek Elementary School. Three of the vending machines also dispensed candy, she said.

Heather was part of an experiment, the results of which lung association Executive Director Deborah Williams will use to push for state laws making it tougher for Alaskans under 19 to acquire and feed a nicotine habit.

"Studies have shown that if you're going to get the habit, your best chance of getting it is before age 18," Williams said.

Also part of Williams' experiment was 14-year-old Shelly Klingbell, a ninth-grader at East High School. Shelly last Thursday and on Monday graphically demonstrated that many Anchorage merchants don't much care about a state barring sale of cigarettes to youngster under 16.

Shelly visited 49 different stores — ranging from supermarkets to small convenience stores -- and was able to buy cigarettes over the counter at 47 of them, she said. Shelly sat beside Heather, both behind a tableful of the cigarettes they had purchased.

"Not only regular cashiers, but also assistant managers sold Shelly cigarettes," Williams said. Even more surprising, she said, only four cashiers asked the teen-ager for identification, and two of them accepted the girl's fib that she had left her ID at home.

She declined to name any of the stores or other establishments in which the children bought cigarettes, saying she didn't want to embarrass them.

Williams said she was shocked and dismayed at the ease with which minors can buy cigarettes.

"I think most people are aware they should not be selling to people under 16," she said. "There is clearly an economic motivation for selling to children."

Williams said the results of the experiment prove that Alaska's law against sale of cigarettes to minors is woefully inadequate.

Sale of cigarettes to youngsters under 16 in Alaska can result in fines of as much as $300.

The lung association, Williams said, is seeking changes in the law to ban the sale of cigarettes from vending machines, to raise the legal purchase age to 19, and to increase the penalties to stiffer fines and even jail time.

Williams said her organization, perhaps through Rep. Johnny Ellis, D-Anchorage, will push for changes in the law in the next legislative session.

Shelly and Heather likely will testify about their experiences before a legislative committee, she said.

And what about the $102 worth of cigarettes Shelly and Heather purchased with lung association money?

"We'll hang onto them" to display at future hearings, Williams said.

Anchorage Times

Client No. 0325

Youngsters go undercover to buy smokes, make a point

By Yereth Rosen
Times Writer 0325

Heather Timmerman doesn't look like your typical undercover agent.

She's red-haired and freckled and stands only 4 feet 6 inches tall. She's 10 years old and a rising fifth-grader at Rabbit Creek Elementary School.

She doesn't look like your typical cigarette smoker, either. But that didn't stop employees at 19 of 20 business establishments she visited Monday from allowing her to purchase cigarettes from vending machines.

On Monday, Heather and another girl, 14-year-old Shelly Klingbeil, took part in a sort of sting operation set up by the American Lung Association. While Heather worked the vending machines, Shelly managed to buy cigarettes over the counter at 47 of 49 stores she tested.

State law forbids children under 16 from purchasing cigarettes, while municipal codes limit purchase of cigarettes to those 18 and over. But the law, if Monday's test was any indication, is widely ignored.

Deborah Williams, executive director of Alaska's office of the American Lung Association, said she was expecting a 50 percent purchase-success rate and was shocked to learn how easy it is for children to buy cigarettes.

"I was horrified, particularly with Heather," she said Tuesday, when the association's sting operation was announced.

The exercise with Heather and Shelly will be used to help the association lobby for two bills during the next legislative session, Williams said. The association wants Alaska legislators to raise the legal age for purchasing cigarettes to 19 and to ban the sale of cigarettes through vending machines.

Williams is optimistic about the chances of getting the legislation passed. Even though Alaska has a higher percentage of smokers than the nation as a whole, it has proved progressive in its adoption of smoking laws and ordinances, she said. And most adults, smokers or not,

See Minors, page B-2

Times photo by

Shelly Klingbeil, 14, left, and Heather Timmerman, 10, successfully purchased c

Continued from page B-1

don't want children to smoke, she said.

"What we have found with adults who smoke, I would say that probably 80 percent of them don't want kids to smoke," she said.

Studies show that 90 percent of the nation's adult smokers were addicted to the cancer-and disease-causing habit before they were 19, she said. By raising the legal age to 19, she said, the state will give youngsters an opportunity to escape the habit.

"We frankly feel that by the time you're 19, you appreciate the stupendous risks associated with cigarettes," Williams said.

Banning vending-machine cigarette sales might prove more difficult. No state currently bans the sale of cigarette by vending machine, Williams said, although Utah and Idaho place restrictions on where cigarette vending machines may be located.

But as Heather found Monday, it's a cinch for kids to buy cigarettes from vending machines.

"The first couple of times it was scary," Heather said. "But after a while it got really easy."

The only place she was prevented from buying a pack of cigarettes was the Lucky Wishbone restaurant. A waitress there appeared angry at the very thought of a grade-school child buying cigarettes, Heather said.

"She said, 'Don't do that, get out of here.'" Heather said.

ALASKA AREA SMOKELESS TOBACCO SURVEY RESULTS

Prepared by: Candy Schlife
August 12,1986

SMOKELESS TOBACCO USAGE IN RURAL ALASKA

Candy Schlife,R.D.H.
Dental Prevention Specialist
Alaska Area Native Health Service

INTRODUCTION

The use of smokeless tobacco products is increasing. Sales of smokeless tobacco products have increased about 11 percent each year since 1974 with an estimated 12 million users in the United States in 1985.

A recent national survey indicated that 16 percent of males between 12 and 25 years of age had used some form of smokeless tobacco within the past year. Several studies have reported 25 to 35 percent of adolescent males currently use these products (1).

The primary purpose of this survey was to determine the use of smokeless tobacco in the youth of rural Alaska both Native and non-Native. Amount used, number of years used and awareness of health problems associated with the use of these products was also assessed.

METHODS

In the spring of 1986, a nine-question survey was distributed by the Indian Health Service Dental Programs in eight rural regions of the state. These surveys were self-administered by students in grades kindergarten through twelve. Data from about 5,000 surveys was compiled and will be reported here. The method of sampling was based upon those school administrators and dental programs who chose to participate in the survey. (Not all schools in all areas were asked to participate due to time and energy restraints). The perceived problem of use of smokeless tobacco products may have influenced some to participate. A random sample method was not used. The school system was chosen to administer the survey, therefore the sample size was limited to only 5 to 18 year-old children. Students attending school out of their region i.e. boarders were obviously not included. Since school attendance was crucial for participation in the survey there was no attempt to survey those students who had dropped out of school.

RESULTS

The total number of male and female respondents was 2,511 and 2,454 respectively. Of the 4,965 respondents, 34 percent of the males and ~~38~~ 27 percent of the females indicated they used smokeless tobacco products. This is contrary to much data that supports substantially higher usage by male vs. female populations. According to a national survey only about two percent of the female population of all ages used smokeless tobacco products (1).

A user was defined as anyone who responded positively to the question, "Do you use smokeless tobacco products?". Our survey indicated that 24 percent of the males age 5-12 years were users and 45 percent of the 13-18 year-old male students were users. The percentage of females who regularly use was 22 percent for ages 5-12 years and 34 percent for ages 13-18. The highest user age group was 16 year-old males: 52.7 percent of this age population used. It is alarming to find that about 17 percent of the five-year old females and 10 percent of five-year old males are using these products and had been doing so for 1.3 - 1.5 years (Tables 2, 3).

Higher use was seen in Interior and Northern Alaska (Yukon-Kuskokwim Delta Region, Bristol Bay Area, Kotzebue Service Unit, Barrow and Anchorage Service Units). Lower usage was seen in Southeast Alaska, Mt. Edgecumbe and Annette Island Service Units (Table 6). The number of surveys completed from the service units with a higher usage was also indicative of a greater percentage of the population surveyed (Table 5).

According to the survey, 45 percent of the males and 43 percent of the females had tried smokeless tobacco products.

Another item of concern was how much of these products was being used. The average male used 1.4 cans per week and the average female used 1.1 cans per week. National average = 1 can per week.

Copenhagen was the brand selected most often when asked to list brands used. Eighty-four percent of the users chose Copenhagen as the brand or one of the brands used. Copenhagen is U.S. Tobacco's strongest product (2). High use of Copenhagen may indicate a sophisticated and experienced user population. Many home-made versions were also reported.

Respondents were also asked how long they had used these products. The answers ranged from 1.3 years for the five-year old female users to 7.9 years for the eighteen-year old female users. The males length of use varied from 1.0 years in the five-year old males to 6.5 years in eighteen-year old male users. In looking at the average number of years which these products were used, we see that females in general have used these products longer than the males (Tables 3, 4). Use of these products showed a linear progression for both males and females with no particular "target age" or sharp rise in use by an age group. There was a slight increase in use in females from age 8 to 9 and 12 to 13 (Table 4). The average 18 year-old student has used these products for almost seven or eight years. This is compared to a 5 year-old user today who may have 13 to 14 years of use by the time he/she reaches age eighteen.

Scientific evidence is strong that the use of smokeless tobacco can cause cancer in humans, especially oral cancer. The degree it affects depends on many factors such as type of smokeless tobacco product used, frequency, duration, and site of action. Leukoplakia, gingival recession (root caries), staining of teeth and tooth abrasion have also been reported.

Respondents were finally asked if they were aware of any health problems associated with the use of smokeless tobacco products. The majority (60.1 percent) responded positively. Ninety-three percent of those who responded positively to awareness of health problems listed "cancer" as their answer or one of their answers.

A five-year old child probably cannot really comprehend what "cancer" means but this response is an indication that there is some level of awareness. The correlation of awareness of health problems and high usage rate is of concern. It was sad for this surveyor to look at responses of young children who were asking for help in trying to quit their addiction and didn't know what to do.

DISCUSSION

Once usage has been established, the fact of addiction must be addressed and intervention methods must be used.

It has been reported that the blood nicotine levels are similar to that of cigarette smoking and therefore one might expect a similar addiction in smokeless tobacco users. There is also evidence that nicotine may play a role in coronary artery and peripheral vascular disease, hypertension, peptic ulcers and fetal mortality and morbidity (1).

It has been reported in other articles that the number one factor in getting started with smokeless tobacco products is peer pressure. Pressure from older siblings may also be influential. Parental role models may also be a factor (not documented). The advertising campaigns of tobacco companies have been very effective in getting kids trying and hooked.

The job of educating parents as well as the children about the health problems associated with smokeless tobacco products is an important task of all health care providers. Communities need to be presented with this information and allowed to make a decision as to their perspective of the problem. Once it is perceived as a problem (education and awareness) they can then become part of the solution. There is a much greater chance for health behavior changes made with this approach.

We have a unique opportunity to educate and prevent a known negative health behavior. A multi-disciplinary approach involving Community Health Aides, Public Health Nurses, Health Educators, Dental and Medical Personnel, as well as community members, can play an important role in reducing the high usage rate in the rural population in Alaska.

References:

1 U.S. Department of Health and Human Services, The Health Consequences of Using Smokeless Tobacco. A Report of the Advisory Committee to the Surgeon General, April, 1986.

2. Youth Use of Smokeless Tobacco: More Than A Pinch Of Trouble National Program Inspection. January 1986.

Special thanks:

Technical consultation	Dr. David B. Jones and Dr. Tom Kovaleski
Assistance in assembly of data	Dr. Horace Whitt
Survey distribution	Dr. Mike Cangemi Dr. Tom Johnson Dr. Carol Dalton Carmel Nelson, R.D.H. Dr. Bill Kohn Pam Grantham, R.D.H. Dr. Elizabeth Barrett Dr. Kevin Craig Dr. Bob Allen

Smokeless Tobacco Users

by Service Unit

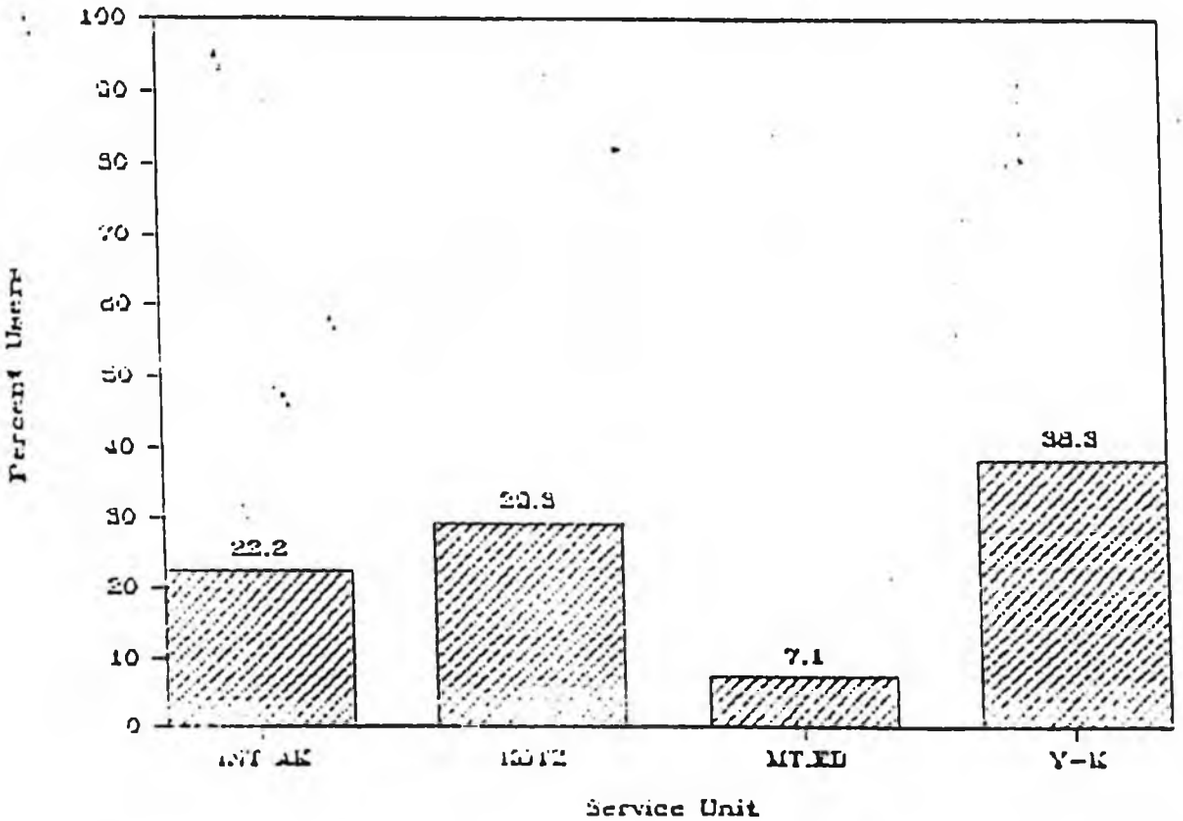


TABLE 5

SERVICE UNIT	NON-USERS	USERS	TOTAL	%USERS
ANCHORAGE	489	146	635	23.0
ANNETTE ISLAND	174	10	184	5.4
BARROW	316	94	410	22.9
BRISTOL BAY	284	127	411	30.9
INTERIOR AK*	443	126	576	22.2
KOTZEBUE	350	145	495	29.3
MT. EDGECUMBE	92	7	99	7.1
YUKON-KUSKOKWIM	1487	925	2412	38.3
TOTAL:	3640	1582	5222	30.3

* Numbers here represent total users and non-users. Sex was unintentionally left off on a majority of the surveys for Interior Alaska so these numbers are not included in any data which includes sex as a component of the results.

TABLE 4

Average Years Using Smokeless Tobacco

by Age and Sex

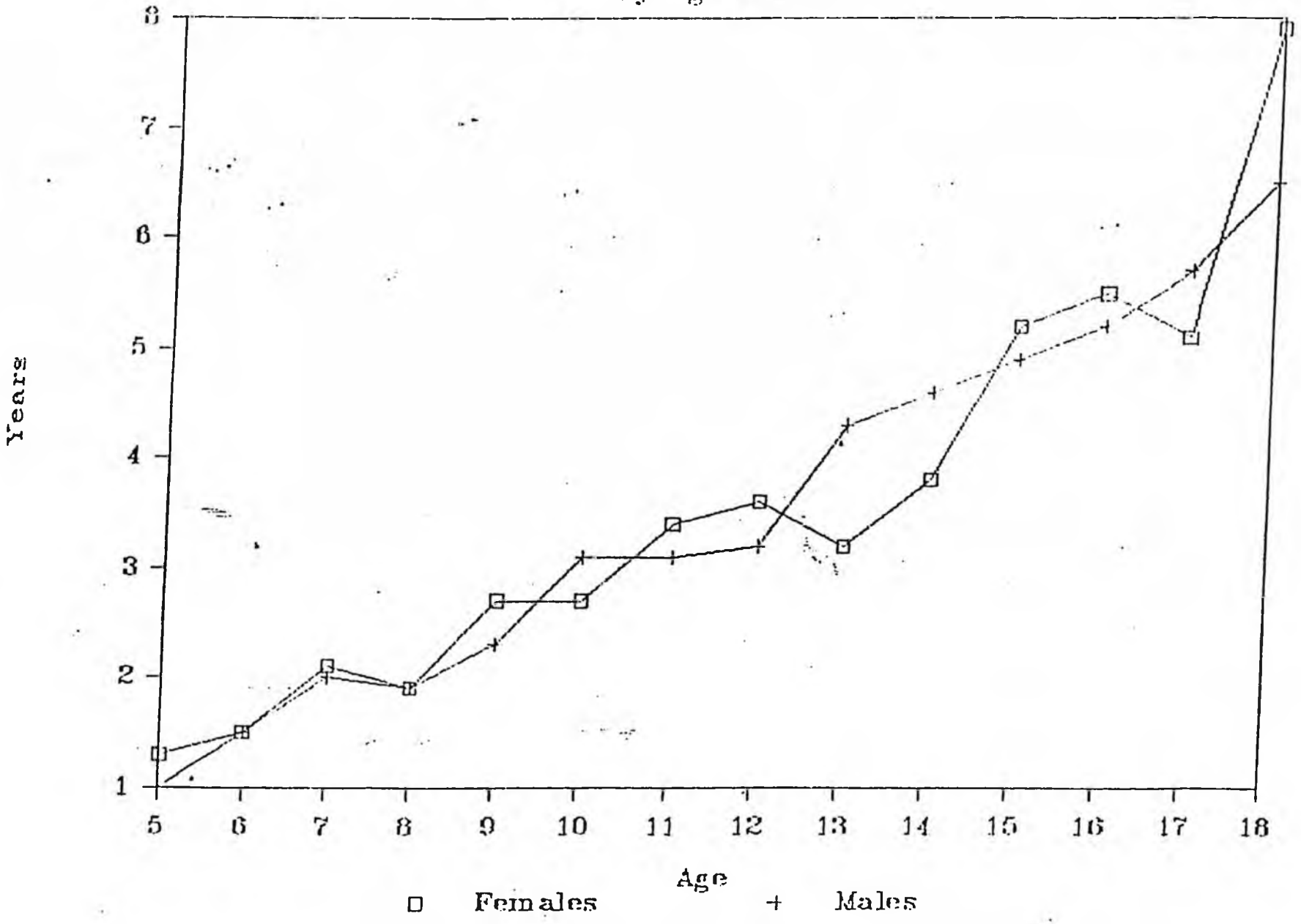


TABLE 3

AGE	SEX	NON-USERS	USERS	TOTAL	%USERS	CANS/WK	YRS USING
5	FEMALE	49	10	59	16.9	0.5	1.3
6	FEMALE	114	16	130	12.3	0.9	1.5
7	FEMALE	140	21	161	13.0	0.9	2.1
8	FEMALE	143	25	168	14.9	1.1	1.9
9	FEMALE	137	40	177	22.6	1.3	2.7
10	FEMALE	150	54	204	26.5	0.9	2.7
11	FEMALE	124	58	182	31.9	1.1	3.4
12	FEMALE	168	58	226	25.7	1.2	3.6
13	FEMALE	138	84	222	37.8	1	3.2
14	FEMALE	146	74	220	33.6	1.3	3.5
15	FEMALE	150	66	216	30.6	1.1	5.2
16	FEMALE	145	83	228	36.4	1.2	5.5
17	FEMALE	121	54	175	30.9	0.9	5.1
18	FEMALE	55	31	86	36.0	0.9	7.9
5	MALE	55	6	61	9.8	1.5	1
6	MALE	123	25	148	16.9	0.9	1.5
7	MALE	156	27	183	14.8	0.9	2
8	MALE	134	32	166	19.3	2.1	1.9
9	MALE	120	46	166	27.7	1.4	2.3
10	MALE	139	51	190	26.8	1.5	3.1
11	MALE	155	67	222	30.2	1.6	3.1
12	MALE	144	66	210	31.4	1.1	3.2
13	MALE	132	76	208	36.5	1.1	4.3
14	MALE	123	80	203	39.4	1.3	4.6
15	MALE	117	106	223	47.5	1.5	4.9
16	MALE	95	106	201	52.7	1.7	5.2
17	MALE	105	94	199	47.2	1.4	5.7
18	MALE	67	64	131	48.9	1.6	6.5

TABLE 1

Percent Users by Sex

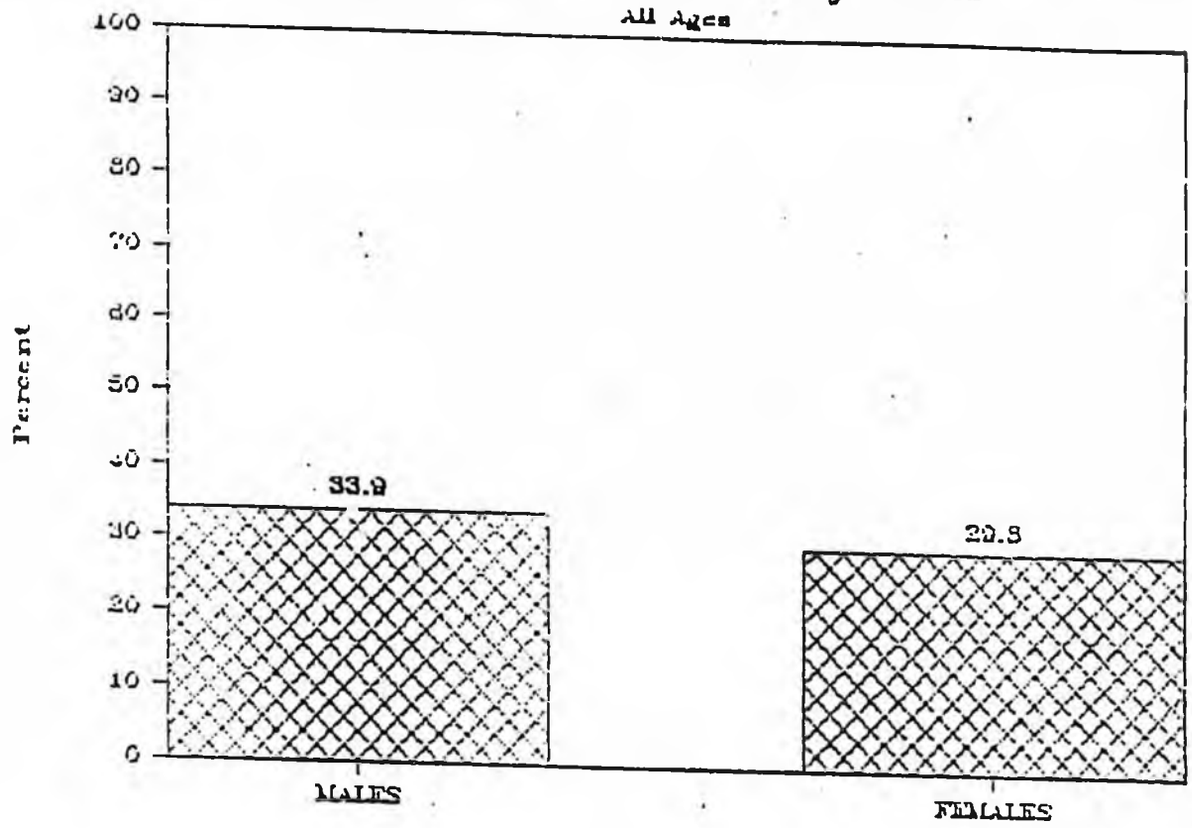
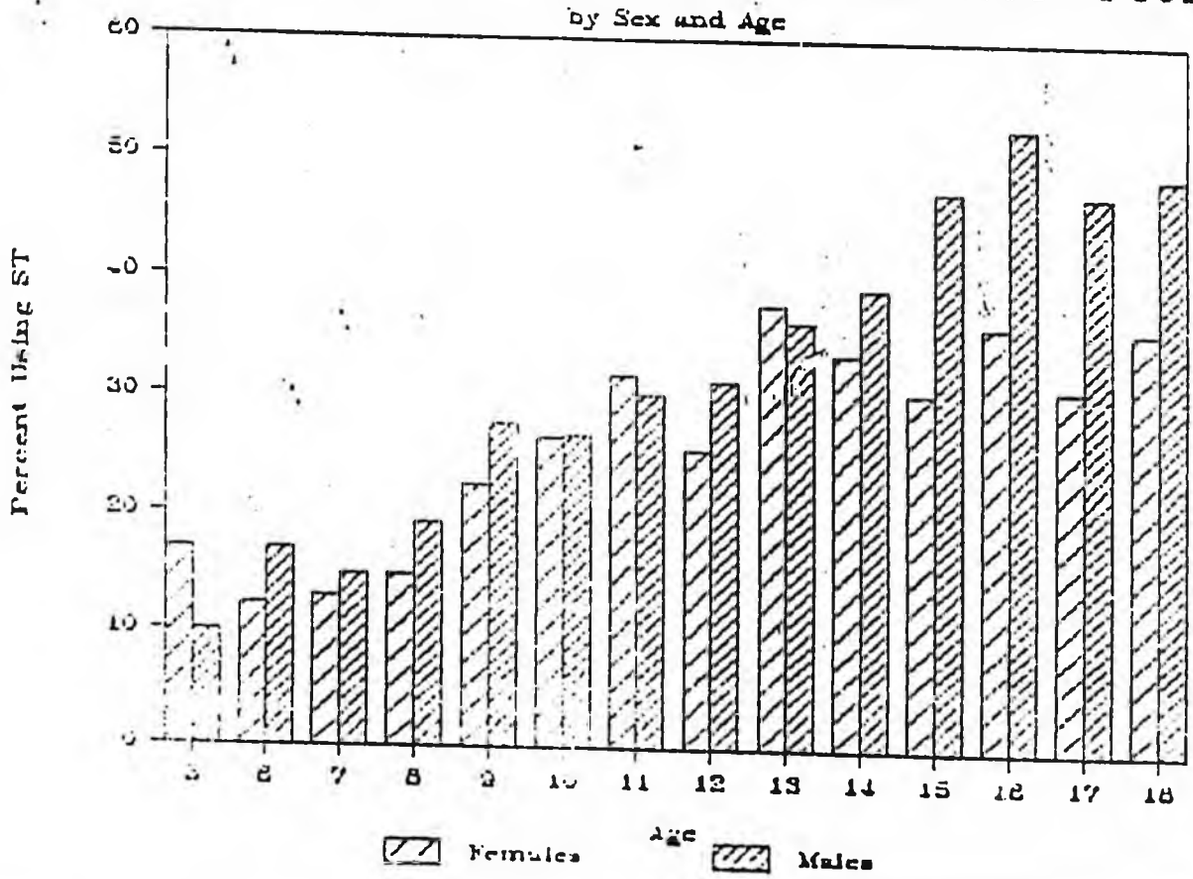


TABLE 2

Percentage of Smokeless Tobacco Users



(2)

TYLER DISTRIBUTING CO., INC.

VENDING, NOVELTY & WHOLESALE

BOX 96

KENAI, ALASKA 99611

Honorable Paul Fischer
P.O. Box V
Juneau, Alaska 99811

January 26, 1988

Dear Sir,

Senate Bill 339, An Act relating to tobacco products, has just come to my attention. As presented, the Bill raises several concerns. It would effectively prohibit the placement of cigarette Vending machines anywhere that was not a bar, private club, or attendant operated location. I feel this is a gross over-reaction to a problem that is:

A. Minor in scope. According to the National Automatic Merchandising Association, only 7% of the total annual domestic cigarette sales are transacted through vending machines. First, reduce this by those sales from machines inaccessible to teenagers. When you further subtract the legitimate sales of cigarettes to adults from machines that are openly accessible, it becomes apparent that the image of an adolescent surreptitiously buying cigarettes from a machine is more folklore than fact. Statistically speaking, outlawing cigarette machines will not seriously contribute to stemming teenage smoking.

B. Already Being Addressed, both by law and from within the vending industry itself. It is already illegal to sell cigarettes to minors, period. Surely it makes more sense to target and prosecute those isolated examples of machines that are allowed to make a significant number of sales to minors than it does to cripple an entire industry. Toward that end, the industry itself, by publishing advisories, statistics and materials, has been instrumental in helping vending operators deal with the problem. (See attachment as an example of an Industry Circular).

In addition to the above specific reservations, there are other broader considerations to be kept in mind.

I think you will agree that little-by-little, layer-by-layer, law-by-law, we have deepened the bureaucratic seas to the point that we are all in danger of foundering in them. Since sales of tobacco products to minors is already illegal, and since most "19 and under" establishments already discourage the sale of such products, I believe the proposed statute to be legally unnecessary and/or redundant.

(3)

TYLER DISTRIBUTING CO., INC.

VENDING, NOVELTY & WHOLESALE

BOX 96
KENAI, ALASKA 99611

Anytime a salcable product is regulated, there are economic ramifications. After reading the Senate Bill 339 proposal, it is apparent its impact as presented on our company alone would result in the loss of 1½ jobs (payroll loss of approx. $38,000.00), concommitent loss of City, Borough and State revenues from those jobs, and the direct loss to the State of possibly $16,000.00 in taxes.

Frankly, I must question the spirit and handling of this proposal. I do not believe the sponsors of this Bill have allowed adequate time for public input. Though it may be fashionable to ally oneself with the Lung Association, this Bill does so at the expense of the convenience of rational, responsible, decision-making adults. I do not believe they should be penalized by an ill-concieved, ineffective law.

Thanks for your attention. If I may be on any help during the committee process, please don't hestiate to call.

Sincerely,

M. Wayne Prentice
V. President
Tyler Distributing, Inc.

(4)

The 6-Step Self-Regulation Program For Cigarette Machine Operators

The sale of cigarettes to minors is prohibited by State law in all but a few of the States. Complete observance of the law is a "must".

Each operator should:

1. Survey his entire cigarette operation to determine the location of those machines to which minors are likely to have access.

   As part of this survey maintain a permanent file record for each machine on location.

2. Post "Minors Are Forbidden" decals conspicuously on all machines.

3. Post on each machine the name, address, and phone number of the operator.

4. Solicit the location owner's cooperation to prevent minors from purchasing from machines to which minors have access. Re-position machines, where necessary, to assure adequate supervision.

5. Remove machines from locations where the sale of cigarettes to minors cannot be prevented.

6. Cooperate with competitors to achieve area-wide compliance of preventing the purchase of cigarettes by minors from vending machines. (As part of this step, establish local group liaison with police officials and offer cooperation in the enforcement of "sales to minors" laws.)

Published by National Automatic Merchandising Association.
3.15861b

SB

351

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI
Chairman, Senate Community and Regional Affairs Committee
Vice-Chairman, Senate Judiciary Committee
Member, Senate Resources Committee

295 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99501

Write to:
P. O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

M E M O R A N D U M 10 February 1988

TO: Senator Paul Fischer
Chairman, Senate HESS Committee

FROM: Senator Arliss Sturgulewski AS

RE: Senate Bill 351 - "An Act relating to arbitration of medical malpractice claims."

Senate Bill 351 - "An Act relating to arbitration of medical malpractice claims" is designed to make it more clear that of the arbitration agreements that patients sign with doctors and with hospitals, only the agreement signed with a hospital needs to be re-executed each time a patient enters a hospital.

Hospitals wish to have this clarified so that they are not obliged to perform the paperwork necessary to re-execute an agreement between a patient and a doctor when a patient enters the hospital.

I am attaching a sample of the documents used for arbitration agreements, a copy of the current statute governing medical arbitration, and a letter of support for this bill from the Health Association of Alaska. I am also attaching a letter from Janet K. Temple, a Soldotna attorney who made the original bill request, outlining the concerns of some physicians in the Soldotna area.

Jay Livey, Legislative Liaison for the Department of Health & Social Services says this bill is not applicable to that department.

Please call Melissa Fouse of my staff at 465-3818 if you have any questions.

JANET K. TEMPEL
Attorney at Law
P.O. Box 2073
Soldotna, Alaska 99669
Telephone (907) 262-4604

January 27, 1988

Senator Arliss Sturgulewski
2957 Sheldon Jackson
Anchorage, Alaska 99508

Dear Senator Sturgulewski:

On behalf of Marcus C. Deede, M.D., I previously requested that AS 09.55.535(e) be amended so as to clarify that this particular provision applied only to an arbitration agreement between a patient and a hospital, and not to an agreement between a patient and a physician.

There are at least two physicians in the Soldotna area who have been routinely using patient/physician arbitration agreements for a considerable period of time. Routinely, the patients sign the agreements at the doctor's offices during their initial visits. The agreements are then in effect until revoked by the patients, under the guidelines set out in the statute.

As long as the patients are not hospitalized, there would be no controversy concerning the interpretation of AS 09.55.535(e). However, if patients are hospitalized, the statute as written is unclear whether the requirement to re-execute an arbitration agreement is solely applied to patient/hospital agreements (which seems to be the intent) or whether it also applies to patient/physician agreements.

Since most people are rarely hospitalized, it is logical and desirable to require a new patient/hospital agreement on each admittance, if the hospital is using the agreements. A previously signed agreement between a patient and a physician, however, contemplates that all future care provided by the physician, including hospitalizations, would be governed by the existing agreement. Having to present a new agreement on each hospitalization, therefore, is not only confusing to the patient, but generates unnecessary paperwork and expense, and requires administrative personnel from the doctor's office (or the hospital) to take additional time to re-explain the agreement and obtain new signatures.

As I indicated to you in a prior letter dated May 5, 1987, it appears that MICA, as well as the Attorney General's Office is of the understanding that the legislative intent was to have subsection (e) apply only to patient/hospital agreements, and not to patient/physician agreements. (Copy enclosed for your information.) Based on this, the local physicians have not been having their patients with existing arbitration agreements execute new agreements on admission to the hospital. The local physicians are concerned, however, that the existing language in subsection (e) leaves a loophole if a patient later attempts to void the agreement.

I hope this letter will be of assistance to you. Please let me know if I can assist further. Thank you for your consideration and assistance in this matter.

Yours truly,

Janet K. Tempel

Janet K. Tempel
Attorney at Law

JKT/rmc

cc: Marcus C. Deede, M.D.

Michael Lockwood, Administrator
Central Peninsula General Hospital

PLEASE READ THIS DOCUMENT CAREFULLY

ARBITRATION AGREEMENT
FOR
PHYSICIANS AND PATIENTS

1. EXECUTION OF THIS AGREEMENT IS NOT A PREREQUISITE FOR YOU, THE PATIENT, TO RECEIVE MEDICAL CARE OR TREATMENT.

2. The attending physician will provide medical care and services to the patient to the best of his skill or knowledge, which medical care in the light of circumstances is pssible and practical. The patient will cooperate fully with the attending physician by obtaining such medications as are prescribed, by following the instruments or the attending physician, by adhering to such treatment regimen or course of action as may be set forth, and by paying all fees and charges in full as billed or as provided by prior special arrangement.

3. In the event that any malpractice claim or other dispute, controversy or issue may arise out of the rendition of care or treatment by the undersigned physician, during the period that this Agreement is in force, it is hereby agreed that such will be submitted to an arbitration board selected and governed by rule as hereinafter provided.

4. This arbitration agreement may be revoked by the person receiving the rendition of care or treatment within thirty (30) days after the execution of this Agreement by notifying the undersigned physician in writing. The thirty (30) day period of revocation is extended by any period that you are physically unable to execute a revocation. The physician is not entitled to revoke this Agreement.

5. The arbitration board shall consist of three arbitrators: One designated by the physician; one designated by the party claiming malpractice by the physician; one to be selected by mutual agreement between the physician and the party claiming malpractice. If mutual agreement on the third arbitrator cannot be reached, the Superior Court in the district in which the doctor is a resident, pursuant to A.S. 09.55.535(f), shall provide a choice of three or more persons who might serve. The party claiming malpractice and the physician may each alternatively strike one or more names until one remains, thereby providing a basis for final selection by the court. The third arbitrator selected pursuant to this procedure shall serve as the chairman of the arbitration board.

6. The provisions of the Uniform Arbitration Act as contained in A.S. 09.43.010 -.180, and A.S. 09.55.535, shall apply to arbitration pursuant to this agreement, if not in conflict with specific provisions of this agreement. The arbitration board shall render its decision in accordance with the laws and legal precedence of the State of Alaska. Discovery shall be afforded to the parties pursuant to the Alaska Rules of Civil Procedure and the hearing shall be conducted according to the Rules of Evidence as they are applied by the courts of Alaska. A.S. 09.55.540 -.548 and .554 -.560 and A.S. 09.65.090 shall apply to the arbitration procedure in addition to the other laws, legal precedence, Rules of Civil Procedure and Rules of Evidence of the State of Alaska.

7. The undersigned parties hereby acknowledge that they have read the foregoing arbitration agreement and understand the provisions contained therein.

8. This agreement is to remain in full force for all disputes, controversies, issues, or claims by the undersigned parties relating to care or treatment for the foregoing:

_____

_____

9. Wherever used, the term "physician" includes the physician and all employees, agents and associates of the physic

This agreement terminates when the above-described care and treatment has been completed or on the ___ day of _____, 19___, whichever occurs first.

DATED this ____ day of _____, 19___.

_____
PATIENT

_____
PHYSICIAN

This form is hereby approved by the Office of the Attorney General for the State of Alaska.

DATED this 29 day of March, 1978.

OFFICE OF THE ATTORNEY GENERAL

By Robert M Maynard

PLEASE READ THIS DOCUMENT CAREFULLY

ARBITRATION AGREEMENT
FOR
HOSPITALS OR CLINICS AND PATIENTS

1. EXECUTION OF THIS AGREEMENT IS NOT A PREREQUISITE FOR YOU, THE PATIENT, TO RECEIVE MEDICAL CARE OR TREATMENT. THIS AGREEMENT MUST BE RE-EXECUTED EACH TIME YOU ARE ADMITTED TO THE HOSPITAL.

2. The health care provider will provide medical care and services to the patient to the best of his skill and knowledge, which medical care in the light of circumstances is possible and practical. The patient will cooperate fully with the health care provider by obtaining such medications as are prescribed, by following the instructions of the health care provider, by adhering to such treatment regimen or course of action as may be set forth, and by paying all fees and charges in full as billed or as provided by prior special arrangement.

3. In the event that any malpractice claim or other dispute, controversy or issue may arise out of the rendition of care or treatment by the undersigned health care provider, during the period that this agreement is in force, it is hereby agreed that such will be submitted to an arbitration board selected and governed by rules as hereinafter provided.

4. This arbitration agreement may be revoked by the person receiving the rendition of care or treatment within thirty (30) days after the execution of this agreement by notifying the undersigned health care provider in writing. The thirty (30) day period of revocation is extended by any period that you are physically unable to execute a revocation. The health care provider is not entitled to revoke this agreement.

5. The arbitration board shall consist of three arbitrators: One designated by the health care provider; one designated by the party claiming malpractice by the health care provider; one to be selected by mutual agreement between the health care provider and the party claiming malpractice. If mutual agreement on the third arbitrator cannot be reached, the Superior Court in the district in which the health care provider is situated pursuant to A.S. 09.55.535(f), shall provide a choice of three or more persons who might serve. The party claiming malpractice and the health care provider may each alternatively strike one or more names until one remains, thereby providing a basis for final selection by the court. The third arbitrator selected pursuant to this procedure shall serve as the chairman of the arbitration board.

6. The provisions of the Uniform Arbitration Act as contained in A.S. 09.43.010 -.180, and A.S. 09.55.535, shall apply to arbitration pursuant to this agreement, if not in conflict with specific provisions of this agreement. The arbitration board shall render its decision in accordance with the laws and legal precedence of the State of Alaska. Discovery shall be afforded to the parties pursuant to the Alaska Rules of Civil Procedure and the hearing shall be conducted according to the Rules of Evidence as they are applied by the courts of Alaska. A.S. 09.55.540 -.548 and .554 -.560 and A.S. 09.65.090 shall apply to the arbitration procedure in addition to the other laws, legal precedence, Rules of Civil Procedure and Rules of Evidence of the State of Alaska.

SS AND HOLMES
TORNEYS AT LAW
An Association of
Regional Corporations
CHRISTENSEN DRIVE
ORAGE, ALASKA 99501
EPHONE (907) 277 6566

7. The undersigned parties hereby acknowledge that they have read the foregoing arbitration agreement and understand the provisions contained therein.

8. This agreement is to remain in force for all disputes, controversies, issues, or claims by the undersigned parties relating to care or treatment for the following:

_____

_____

9. The term "health care provider" includes the hospital or clinic and all agents, employees, servants, officers and directors of the hospital or clinic and physicians employed by or associated with the hospital or clinic.

This agreement terminates when the above-described care or treatment has been completed or on the ____ day of _____, 19___, whichever occurs first.

DATED this ___ day of _____, 19___.

_____
PATIENT

_____
HEALTH CARE PROVIDER

This agreement is extended to apply to outpatient care for the treatment described in paragraph 8 of this agreement.

DATED this ___ day of _____, 19___.

_____
PATIENT

_____
HEALTH CARE PROVIDER

This form is hereby approved by the Office of the Attorney General for the State of Alaska.

DATED this 29 day of March, 1978.

OFFICE OF THE ATTORNEY GENERAL

By _____

.SS AND HOLMES
TORNEYS AT LAW
AN ASSOCIATION OF
FESSIONAL CORPORATIONS
ST NATIONAL BUILDING
425 G STREET
ORAGE, ALASKA 99501

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

January 22, 1987

Memo To: Senator Arliss Sturgulewski

From: Harlan R. Knudson
Executive Director
Health Association of Alaska

Subject: Support - SB 351, Amending Arbitration Act

The Health Association of Alaska has reviewed and supports SB 351, amending the arbitration act to require that the arbitration agreement between the patient and the hospital be re-executed at each admission.

# # #

SB
363

Senator Johne Binkley

Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

MEMORANDUM February 1, 1988

TO: Senator Paul Fischer, Chairman
Senate Health, Education and Social Services Committee

FROM: Senator Johne Binkley

RE: Senate Bill 363 - An Act relating to insurance coverage for treatment of alcoholism or drug abuse.

Sectional Analysis:

Section 1 - Establishes an exception in the statute that prohibits discrimination against a person who provides a service covered under a group disability insurance policy. This drug provision is necessary in order to require alcoholism or drug treatment at an approved treatment facility.

Section 2 - Requires certain insurers to offer coverage for treatment of alcoholism and drug abuse, and specifies the minimum benefits to be provided. Requires the benefits to be adjusted annually and imposes specific limitations on the coverage offered by the insurer. Defines various terms relating to the insurance coverage required by law.

Section 3 - Specifies that AS 21.42.365 also applies to service corporations, as insurers.

Section 4 - Applicability section.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB 363
PUBLISH DATE: 1/22/88

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: Insurance coverage for treatment of alcoholism or drug abuse
Sponsor: Binkley, et al.
Requestor: Senate HESS Committe

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: (Attach a separate page if necessary)

There is no fiscal impact to the Division of Insurance.

Prepared by: John L. George, Director
Phone: 465-2515
Division: Insurance
Date: 1/29/88

Approved by Commissioner: J. Anthony Smith Kathy Marshall for
Date: 1/29/88
Agency: Commerce & Economic Development

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Funding Mechanism — Hold 1 week

Senator Johne Binkley

Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

Treatment (State funded programs)

MEMORANDUM Insurance January 19, 1988

TO: Senator Paul Fischer

FROM: Senator Johne Binkley

RE: "An Act relating to insurance coverage for treatment of alcoholism or drug abuse."

Chemical dependency is defined by professionals as a disease of the body, the mind, and the spirit. The affects of chemical dependency on the individual are widely recognized. In recent years a new understanding of the impacts on relatives and friends has emerged. The January 18 issue of Newsweek headlines the scars that are often left on children of alcoholics. The Anchorage Daily News is concluding this week a special report, *A People in Peril*, on the ravages of alcohol in the state.

In 1985 the State Office of Alcohol and Drug Abuse calculated the net cost to the state of drug and alcohol abuse at more than $170 million. At that time we were spending $12.69 on services for each $1.00 of revenue collected for alcohol products. Chemical dependency costs us all.

Alcohol and drug abuse can, with appropriate treatment and support, be arrested. Individuals in recovery become healthy and productive members of society; families can mend and grow; demands on community and state social services decrease; we all benefit.

Attached is a draft of legislation which would require providers of health insurance to include alcohol and drug abuse treatment.

Section 1 of the bill restricts the provider of services to those approved by the State Office of Alcohol and Drug Abuse.

Section 2 requires providers of health insurance to include treatment for drug and alcohol abuses. It establishes minimums of $7,000 over a two year period and $14,000 for lifetime coverage and ties these caps to the Consumer Price Index (Anchorage). It further restricts insurance companies from requiring a higher deductible or co-payment than is required for another illness, or other requirements that have the effect of delaying or limiting treatment. The definition section includes detox and outpatient treatment.

Section 3 conforms these sections with other statutory provisions.

Section 4 establishes an effective date of January 1, 1989. Existing policies would be grandfathered in until they are renewed or renegotiated.

Thirty-four states have enacted similar legislation. Studies have shown that general health care costs for families decline when alcohol is covered and treated. I invite you to join me in co-sponsoring this legislation. Please call my office before **4:00 on Thursday, January 21**, and let Pat Jackson know if you would like to have your name included.

IN THE SENATE BY BINKLEY

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for treatment of alcoholism or drug abuse."

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

* Section 1. AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, naturopath, physical therapist, or occupational therapist.

* Sec. 2. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.365. COVERAGE FOR TREATMENT OF ALCOHOLISM OR DRUG ABUSE. (a) An insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a disability insurance policy for medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a subscriber's contract for medical coverage in the state, shall provide the insured or subscriber the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $7,000 over two consecutive benefit years; and

(2) lifetime benefits of at least $14,000.

(b) The benefits specified in (a)(1) and (2) of this section shall be adjusted yearly, by the director, to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the computation shall be the first full calendar year for which insurance is obtained under this section.

(c) The insurer or service corporation providing coverage under this section may not

(1) require that the insured or subscriber pay a higher deductible or co-payment for the cost of treating alcoholism or drug abuse than for the cost of treating another condition or illness;

(2) require prenotification of treatment, a second opinion, limit coverage on an inpatient or outpatient basis, or require a specific form of treatment;

(3) exclude from coverage the cost of medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(4) deny coverage solely because treatment was interrupted or not completed.

(d) In this section

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self control in using alcoholic beverages or controlled substances to the extent that the

person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "co-payment" means the portion of the cost to be paid by the insured or subscriber;

(4) "cost" means the lesser of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse; or

(B) the usual, customary, and reasonable charge for the treatment;

(5) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

* Sec. 3. AS 21.87.340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) <u>AS 21.42.345 - 21.42.365</u> [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 2 of this Act, applies to disability insurance policies and to hospital or medical service subscriber contracts entered into or renewed after January 1, 1989.

RETREAT FROM AFGHANISTAN
Will Moscow Really Pull Out?

Newsweek

Alcohol and the Family

Growing Up With Alcoholic Parents Can Leave Scars For Life

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18201
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Alcohol and the Family

The children of problem drinkers are coming to grips with their feelings of fear, guilt and rage

Believe it or not, there are still people who think that the worst thing about drinking is a hangover.

Oh, yeah, on New Year's Day I had a hangover that . . .

No. Forget hangovers.

Huh? So what should we talk about? Cirrhosis?

If you wish, but the liver, with its amazing powers of regeneration, usually lasts longer than the spouse, who tends to fall apart relatively early in the drinker's decline.

You're making it hard for a man to drink in peace.

Sorry, but even if spouses do not abuse alcohol, they can come to resemble drunks, since their anger and fear are enormous: way beyond what you'd find in a truly sober person.

I know, I know, it's terrible what goes on behind closed doors.

You make it sound like there are no witnesses. You're forgetting the children. They grow up watching one out-of-control person trying to control another, and they don't know what "normal" is.

I suppose it's hard for the kids, until they move out.

They may move out, but they never leave their parents behind.

Hmm. Listen, can we talk?

We already are. A lot of people already are.

We are, just now, learning more about heavy drinking, and, simultaneously, putting behind us the notion that what alcoholism amounts to is just odd intervals of strange, and sometimes comic, behavior: W. C. Fields, Dean Martin, Foster Brooks. Since 1935 the members of Alcoholics Anonymous have been telling us, with awesome simplicity, that drinking made their lives unmanageable; Al-Anon brought us the news that relatives and friends of drinkers can suffer in harmony; and then came Alateen and even Alatot, where one picture of a stick person holding a beer can is worth a thousand slurred words. The Children of Alcoholics (COAs)—loosely organized but rapidly growing throughout the United States—reaffirm all of the previous grass-roots movements and bring us new insight into alcoholism's effects on the more than 28 million Americans who have seen at least one parent in the throes of the affliction. The bad news from COAs: alcohol is even more insidious than previously thought. The good news: with the right kind of help, the terrible damage it does to nonalcohol-

LEIF SKOOGFORS—WOODFIN CAMP

Exorcising old demons: *Gill (rear) undergoes grief therapy at Caron Family Services*

SAATCHI COLLECTION, LONDON; COURTESY MARY BOONE GALLERY

■ Shame, embarrassment and sadness: Fischl's 'Time for Bed'

ics need not be permanent.

Imagine a child who lives in a chaotic house, rides around with a drunk driver and has no one to talk to about the terror. Don't think it doesn't happen: more than 10 million people in the United States are addicted to alcohol, and most of them have children. "I grew up in a little Vietnam," says one child of an alcoholic. "I didn't know why I was there; I didn't know who the enemy was." Decades after their parents die, children of alcoholics can find it difficult to have intimate relationships ("You learn to trust no one") or experience joy ("I hid in the closet"). They are haunted—sometimes despite worldwide acclaim, as in the case of artist Eric Fischl—by a sense of failure for not having saved Mommy or Daddy from drink. And they are prone to marry alcoholics or other severely troubled people because, for one reason, they're willing to accept unacceptable behavior. Many, indeed, have become addicted to domestic turmoil.

'Hurting so bad': Children of alcoholics are people who've been robbed of their childhood—"I've seen five-year-olds running entire families," says Janet Geringer Woititz, one of the movement's founding mothers. Nevertheless, the children of alcoholics often display a kind of childish loyalty even when such loyalty is clearly undeserved. They have a nagging feeling that they are different from other people, Woititz points out, and that may be because, as some recent scientific studies show, they are. Brain scans done by Dr. Henri Begleiter of the State University of New York College of Medicine in Brooklyn reveal that COAs often have deficiencies in the areas of the brain associated with emotion and memory. In this sense and in several other ways—their often obsessive personalities, their tendency to have a poor self-image—the children of alcoholics closely resemble alcoholics. In fact, one in four becomes an alcoholic, as compared with one in 10 out of the general population.

The anger of a COA cannot be seen by brain scans. But at a therapy session at Caron Family Services in Wernersville, Pa., Ken Gill, a 49-year-old IBM salesman, recently took a padded bat and walloped a couch cushion hard enough to wake up sleeping demons. "I came because I was hurting so bad and I didn't know why," he says. "A lot of things were going wrong. I

There's a Problem in the House

In "Adult Children of Alcoholics," Janet Geringer Woititz discusses 13 traits that most children from alcoholic households experience to some degree. These symptoms, she says, can pose lifelong problems.

Adult children of alcoholics . . .

- guess what normal behavior is.
- have difficulty following a project from beginning to end.
- lie when it would be just as easy to tell the truth.
- judge themselves without mercy.
- have difficulty having fun.
- take themselves very seriously.
- have difficulty with intimate relationships.
- overreact to changes over which they have no control.
- constantly seek approval and affirmation.
- feel that they are different from other people.
- are super-responsible or super-irresponsible.
- are extremely loyal, even in the face of evidence that the loyalty is undeserved.
- tend to lock themselves into a course of action without giving consideration to consequences.

A [illegible]ear-old's nightmare: Living in denial COURTESY CLAUDIA BLACK

was a wor[illegible] neglected my family." It took Gill only a few hours of exposure to the idea that he might be an "adult child," he says, to realize that his failings as a parent may be if not excused, then at least explained. Like a lot of kids who grew up in an alcoholic household, Gill, who is also a recovering alcoholic, never got what even rats and monkeys get: exposure, at an impressionable age, to the sight and sound of functioning parents. Suzanne Somers, the actress and singer, spent years working out her anger in the form of a just published book called "Keeping Secrets." "I decided that this disease took the first half of my life, and goddam it," she says, "it wasn't going to take the second half of it."

'Control freak': Not every COA has all of the 13 traits (chart, page 63) ascribed to them by Woititz in her landmark work, "Adult Children of Alcoholics" *(1983. Health Communications, Inc.)*, and not all have been scarred. (President Reagan, who has written of sometimes finding his father passed out drunk on the front porch, does not appear, from his famous management style, to suffer from any tendency to be a "control freak," a most common COA complaint.) Some children of alcoholics are grossly overweight from compulsive eating while others are as dressed for success as, well, Somers. A few COAs are immobilized by depression. Another runs TV's "Old Time Gospel Hour." What these people *do* have in common is a basic agreement with George Vaillant, a Dartmouth Medical School professor who says that it is important to think of alcoholism not as an illness that affects bodily organs but as "an illness that affects families. Perhaps the worst single feature of alcoholism," Vaillant adds, "is that it causes people to be unreasonably angry at the people that they most love."

The movement is only about six years old, but expanding so rapidly that figures, could they be gathered for such a basically unstructured and anonymous group, would be outdated as soon as they appeared. We do know, though, that five years ago there were 21 people in an organization called the National Association for Children of Alcoholics; today there are more than 7,000. The 14 Al-Anon-affiliated children-of-alcoholics groups meeting in the early '80s have increased to 1,100. With only word-of-mouth advertising, Woititz's book has sold about a million copies; indeed, "Adult Children of Alcoholics" reached the number-three spot on The New York Times paperback best-seller list long before it was available in any bookstore—at a time, in other words, when getting a copy meant collaring a clerk to put in an order and *saying the title out loud.*

"We turned on the phones in 1982," says Migs Woodside, founder and president of the Children of Alcoholics Foundation in New York, "and the calls are still coming in 24 hours a day." The COAs Foundation sponsors a traveling art show that features the work of young and adult COAs; often, says Woodside, an attendee will stand mesmerized before a crude depiction of domestic violence or parental apathy ("Mom at noon," it says beneath the picture of someone huddling beneath the bedcovers)—and will then go directly to a pay phone to find help. "The newcomers all tend to say the same thing," says Woodside. "'Wait a minute—that's my story, that's *me!*'"

"It's private pain transformed into a public statement," says James Garbarino, president of the Erikson Institute for Advanced Study in Child Development, in Chicago, "a fascinating movement." But when you consider that denial is the primary symptom of alcoholism and that COAs tend by nature to take on more than their share of blame for whatever mess they happen to find themselves in, the rapid growth of the COAs movement seems just short of miraculous—something akin to a drunken stockbroker named Bill Wilson cofounding AA, now *the* model for a vast majority of self-help programs throughout the United States. After all, who would want to spill the family's darkest secret after years of telling teachers, employers and friends that everything was fine? ("A child of an alcoholic will always say 'Fine'," says Rokelle Lerner, a counselor who specializes in young COAs. "They get punished if they say otherwise.") Who would voluntarily identify themselves with a group whose female members, according to some reports, have an above-average number of gynecological problems, possibly due to stress—and whose men are prone to frequent surgery for problems, doctors say, that may be basically psychosomatic?

The answer is, only someone who had, in some sense, bottomed out, just the way a drinker does before he turns to AA.

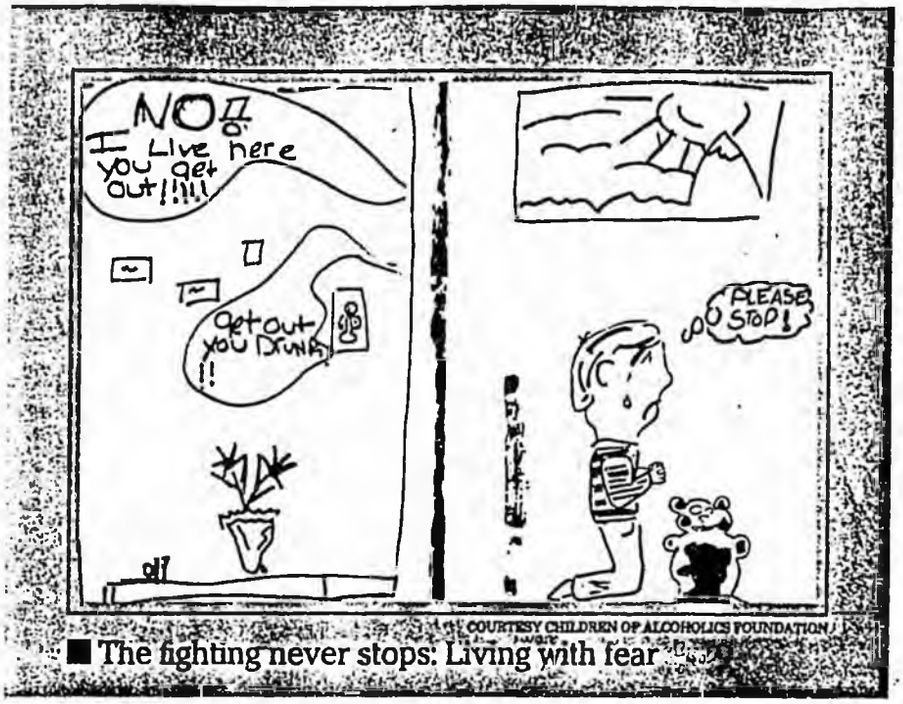
The concept of codependency is at the center of the COAs movement. Eleanor Williams, who works with COAs at the Charter Peachford Hospital in Atlanta, defines codependency as "unconscious addiction to another person's dysfunctional behavior." Woititz, in a recent Changes magazine interview, referred to it more simply as a tendency to "put other people's

Talking and playing their way to a healthy state of mind:

needs before my own." A codependent family member may suspect that he has driven the alcoholic to drink (though that is impossible, according to virtually all experts in the field); he almost certainly thinks that he can cure or at least control the drinker's troublesome behavior. "I actually thought that I could make a difference by cooking my husband better meals and by taking the kids out for drives on weekends [so he could rest]," says Ella S., a Westchester, N.Y., woman. "For all I know, it's a deeply ingrained psychological, and possibly genetic, disease, and here I am going at it with a lamb chop."

Mental movies: Obsessed with her husband's increasingly self-destructive behavior, Ella's next step, in typical codependent fashion, was to hide Bob's six-packs, which made him, to put it mildly, angry. Soon they were fighting almost daily and Ella was running mental movies of their scenes from a marriage all night long. "I was wasting a lot of time and energy trying to change the past, while he kept getting worse," she says. "There was a kind of awkward violence between him and me all the time; our hearts weren't really in it, but it wasn't until he had an affair with an alcoholism counselor *that I got him to* that I left." If you're wondering about children, Ella has a seven-year-old daughter, Ann. Her omission is significant. If life were a horse race, then Ann has been, as they say on the past performance charts, "shuffled back" among the also-rans.

What COAs—all people affected by alcohol—need to learn is that the race is fixed: when there is no program of recovery—either through the support of a group or the self-imposed abstinence of an individual—the abused substance will always win, handily, no matter what the competition. The first step of AA begins, "We admitted we were powerless . . ." But what will become of Ann, who is codependent on *two* people? Perhaps, sensing that she is not exactly the center of attention, she will reach adulthood with a need for constant approval, a common COA symptom. Or maybe she will, even as a child, react to the chaos by trying to keep everything in her life under control, and thus give the impression that she is, despite everything, quite a trouper, a golden child.



COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

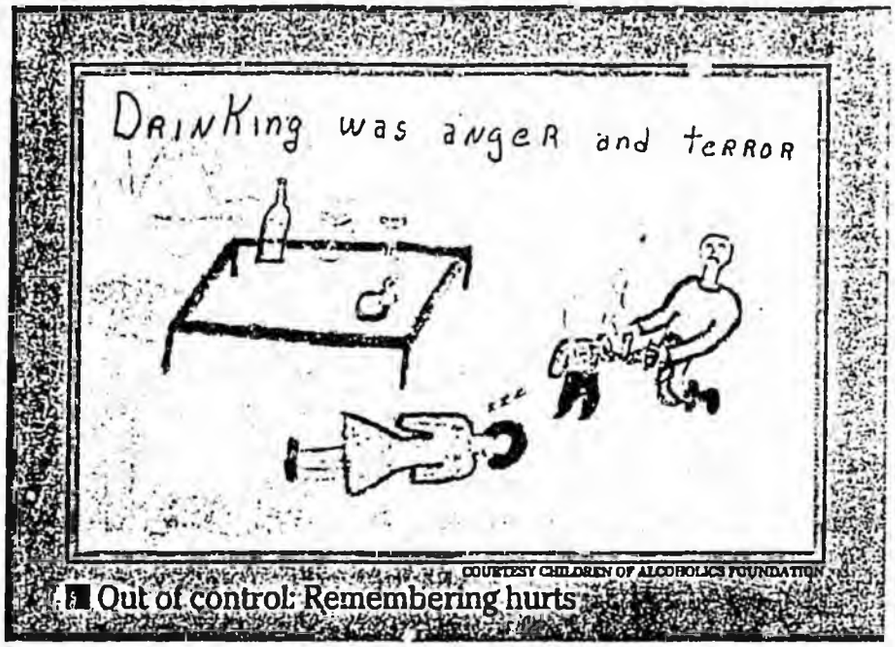
■ The fighting never stops: Living with fear

"[Some] don't fall apart until they're in their 20s or 30s," says Woititz, and in some cases, especially those marked by violence or incest and sexual abuse (three times more common in alcoholic households than in the general population), that's the wonder of it all. One eight-year-old patient at Woititz's Verona, N.J., counseling center woke up in the middle of the night to see her alcoholic mother shoot herself in the head. "The child called the 911 emergency number, got her mother to the hospital and basically saved her mother's life," says Woititz. "When I saw her she was having

The board game Sobriety (left), Brooks with a father and son at her California counseling center

TOM IVES

RICK RICKMAN



COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

Out of control: Remembering hurts

nightmares—that she wouldn't wake up and witness this suicide attempt. This is not a normal nightmare. The child had become mother to her own mother."

Each unhappy family, as Tolstoy said, is unhappy in its own way. Artist Eric Fischl, 39, in a short videotape he made for the COAs Foundation called "Trying to Find Normal," speaks of stepping over his passed-out mother, in their comfortable-looking (from the outside) Port Washington, N.Y., home and seeing her "lying in her own piss." His work, which has been the subject of a one-man show at the Whitney Museum in New York, is not autobiographical, he says, and yet "the tone [of it] has everything to do with my childhood." His painting "Time for Bed" (page 63) "relates to my memory of all hell breaking loose," he says. "I guess you could say the boy is me and his shame, embarrassment and sadness is mine as well. The little boy's Superman pajamas are on backwards, so it's like looking in a mirror. I painted the woman standing on a glass table with spiked heels on to give it a sense of fragility and danger. The man only has one arm because I wanted a sense of impotence."

Alcohol leaves every alcoholic and codependent who does not admit his powerlessness over the substance in a constant state of longing. Fischl didn't realize how sad he'd been until his mother died, in an alcohol-related car accident, in 1970. "The thing about having a sick parent is that you think it's your problem," he says. "You feel like a failure because you can't save her." Even when there is no incest, there is seduction. Fischl's mother kept "signaling," he says, "that if you could just come a little bit further with me in this, you can save me."

Some of the other things that alcohol ruins, before it gets to the liver: family meals ("Alcohol fills you up. My father was never interested in eating with us"); gloriously run-of-the-mill evenings around the hearth ("Alcohol makes you tired. My father was in bed most nights at 8"). When enough C_2H_5HO is added to a home, vases may start to fly across the room and crash

Heredity and Drinking: How Strong Is the Link?

Research on the genetics of alcoholism took a curious turn a few weeks ago when Lawrence Lumeng analyzed his DNA to demonstrate why he can't tolerate liquor. Lumeng, a biochemist at the Indiana University School of Medicine, is among the 30 to 45 percent of Asians whose response to spirited beverages is a reddened face, headaches or nausea. This "Oriental flush," past studies have shown, arises in those who have an inefficient version of a liver enzyme that is crucial to the body's breakdown of alcohol; this "lazy" enzyme allows the buildup of an alcohol product, acetaldehyde, which is sickening and leads many Asians to shun alcohol. Working with biochemist Ting-Kai Li, Lumeng says that he pinpointed the gene that instructs cells to make the odd enzyme. The experiment offers dramatic evidence that a bodily response to alcohol is genetically dictated—and is thus inherited as surely as eye color.

There is no evidence for the opposite proposition: that a specific gene makes a person *crave* alcohol. Considering the wide variety of reasons why people consume the stuff, it seems unlikely that a "drinking gene" exists. But researchers have firmly established that, compared with other children, an alcoholic's offspring are around four times more likely to develop the problem, even if they were raised by other, nonalcoholic parents. In families with a history of alcoholism, explains C. Robert Cloninger, a psychiatrist and geneticist at Washington University in St. Louis, "what is inherited is not the fact that you are destined to become an alcoholic but varying degrees of susceptibility" to the disorder. So real is the predisposition that many researchers advise adult children of alcoholics (COAs) to drink no alcohol whatsoever.

Even the brains of COAs show faint signs of unusual activity, according to controversial studies by psychiatrist Henri Begleiter of the State University of New York in Brooklyn. Begleiter has found that young boys who have never consumed alcohol produce the slightly distorted brain-wave patterns typical of their alcoholic fathers. Such signature brain waves, he says, may mark the son of an alcoholic as likely to develop a drinking problem and perhaps alert him to the risk. However, it

MARY ANN CARTER

Probing for genes: *Lumeng*

into walls. All kinds of paper—court-issued Orders of Protection, divorce decrees, bounced checks—come fluttering down. The lights go on and off. Does that mean Daddy's forgotten to pay the bill again, or that the second act is starting?

Every alcoholic household is, in fact, a pathetic little play in which each of the members takes on a role. This is not an idea that arrived with the COAs movement; a 17-page booklet called "Alcoholism: A Merry-Go-Round Named Denial" has been distributed free of charge by Al-Anon for almost 20 years. Written by the Rev. Joseph L. Kellerman, the former director of the Charlotte, N.C., Council on Alcoholism, "Merry-Go-Round" takes note of the uncanny consistency with which certain characters appear in alcoholic situations. These include the Enabler ("a 'helpful' Mr. Clean . . . [who] conditions [the drinker] to believe there will always be a protector who will come to his rescue"); the Victim ("the person who is responsible for getting the work done if the alcoholic is absent") and the Provoker (usually the spouse or parent of the alcoholic, this is "the key person . . . who is hurt and upset by repeated drinking episodes, but she holds the family together . . . In turn, she feeds back into the marriage her bitterness, resentment, fear and hurt . . . She controls, she tries to force the changes she wants; she sacrifices, adjusts, never gives up, never gives in, but never forgets").

■ Trauma: Parental neglect

Some of the earliest books in the COAs movement explored the drama metaphor more deeply and defined the roles that children play. Sharon Wegscheider-Cruse, in her 1981 book, "Another Chance" *(Science and Behavior Books, Inc. Palo Alto, Calif.)*, wrote about the Family Hero, who is usually the firstborn. A high achiever in school, the Hero always does what's right, often discounting himself by putting others first. The Lost Child, meanwhile, is withdrawn, a loner on his way to a joyless adulthood, and thus, in some ways, very different from the Scapegoat, who appears hostile and defiant but inside feels hurt and angry. (It is the Scapegoat, says Wegscheider-Cruse, who gets attention through "negative behavior" and is likely to be involved in alcohol or other drugs later.) Last and least—in his own mind—is the Mascot, fragile and immature yet charming: the family clown.

'Good-looking' kids: Virtually no one was publishing those kinds of thoughts when Claudia Black, a Laguna Beach, Calif., therapist, began searching for literature on the subject of the alcohol-affected family in the late '70s. "Half of my adult [alcoholic] patients had kids my age and older," she remembers, "but all I found was stuff on fetal alcohol syndrome and kids prone to juvenile delinquency." One thing that fascinated her about young COAs, she says, was that despite their developmental problems "they were all 'good-looking' kids"—presentable and responsible albeit

remains to be seen whether such brain scans are sufficiently reliable and informative to distinguish potential social drinkers from future alcoholics. The technique, comments psychologist Robert Pandina, scientific director of the Center of Alcohol Studies at Rutgers University, is "at this time not any more valuable" as a predictor of future drinking behavior "than collecting a good family history on an individual."

Other studies show that many COAs respond uniquely to booze. Marc Schuckit, a psychiatrist at the Veterans Administration Hospital in San Diego, has found that college-age sons of alcoholics often react less to a few drinks than other college men; in his studies, the drinkers' sons were generally not as euphoric or tipsy after three to five cocktails. Schuckit believes that this lower sensitivity makes it harder for the alcoholics' sons to know when to stop drinking, starting them down the road to alcohol problems. Preliminary experiments by Barbara Lex of McLean Hospital in Belmont, Mass., confirm that daughters of alcoholics respond similarly. Women from families with a history of alcohol abuse tend to keep their balance better on a wobbly platform after having a drink. Apparently women, too, can inherit traits that might predispose them to addiction, although there are far fewer female than male alcoholics.

Half a beer: The key unresolved issue, of course, is why some individuals from alcohol-scarred families succumb to alcoholism while others don't. Genes play some role in the development, most notably in abstinence. "People say that whether you drink or not has to do only with willpower," explains Indiana's Lumeng, "but the reason I can drink only half a beer is biological."

Yet heredity alone obviously isn't to blame for alcoholism's appalling toll. In fact, about 60 percent of the nation's alcohol abusers are from families with *no* history of the disorder. How much people drink is influenced by factors as prosaic as cost; partly to curb consumption, the National Council on Alcoholism is lobbying to raise federal excise taxes on beer and wine, which haven't changed since 1951. Social influences like cost and peer pressure "are just as important as genes," says Dartmouth psychiatrist George Vaillant. "All the genes do is make it easier for you to become an alcoholic." For now, the value of genetic studies is to warn COAs that they may well have a real handicap in the struggle against the family trouble.

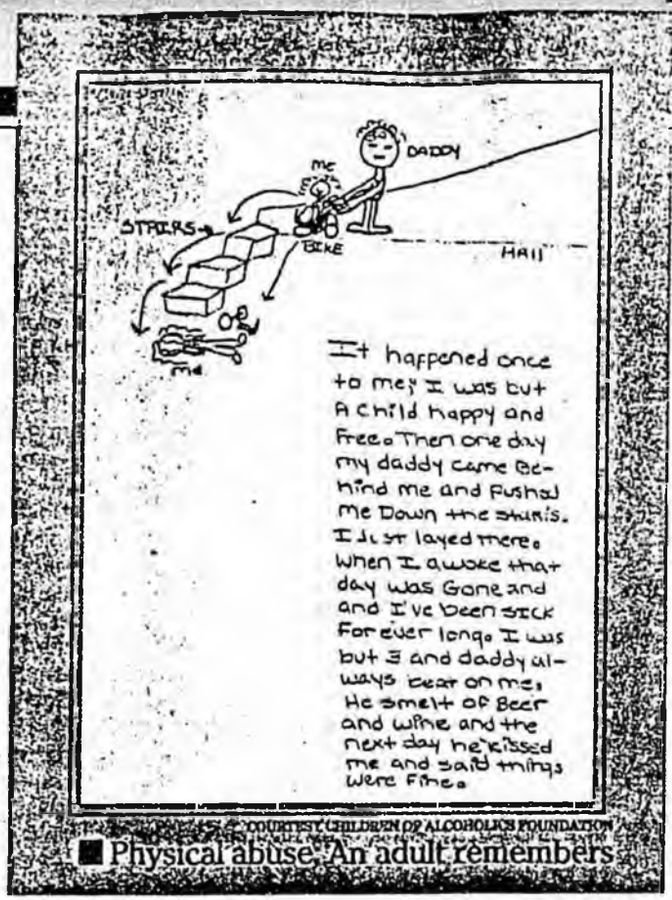
TERENCE MONMANEY *with* KAREN SPRINGEN *in New York and* MARY HAGER *in Washington*


RICHARD SOBOL

Tipsy? *Lab demonstration*

not terribly verbal. "They had friends but weren't honest with them. Everything was 'fine and dandy'."

The title of Black's important 1981 book, "It Will Never Happen to Me" *(M.A.C. Denver, Colo.)*, reflects the typical codependent's mix of denial and false bravado. In it, she makes the point that the children in an alcoholic household never have an environment that is consistent and structured, two of the things they need most—and she, too, talks of such stock juvenile "roles" as the Responsible One and the Adjuster. Her unique warning was that children who survive a parent's alcoholism by displaying unusual coping behavior often experience "emotional and psychological deficits" later on. They are also likely to become alcoholics, says Black, because "alcohol helps these persons become less rigid, loosen up and relax. When they drink, they aren't quite so serious." Though those things happen to almost everyone who imbibes, Black says that "for those who are stuck in unhealthy patterns, alcohol may be the *only* thing that can provide relief."



■ Physical abuse: An adult remembers

Well, she guessed wrong there: a movement, manifested by often joyous meetings, has come along in the interim. At hundreds of COAs gatherings around the country tonight, people will talk and listen to each other's stories, to cry, to laugh and generally, as Ken Gill says, "recharge their batteries." "This program kept me from being an alcoholic myself," said a woman named Heather at a gathering in an affluent section of San Francisco last week. "Because I was the oldest, everything was always my fault. It's like when you make your parents breakfast and you bring them one scrambled egg and one fried egg—in my house I always scrambled the wrong egg." Heads bobbed in agreement. Who else but COAs could identify with a story about what happens when kids cook for their own mother and father?

Discovering self-esteem: Talking and listening: this is the way we've learned to deal with problem drinking. And though it sounds wimpy, don't knock it; it's the surest way to alleviate not just the imbibing but the whole range of symptoms we call alcoholism. A woman named Nina stood up at a meeting in Boston last week, practically glossed over the fact that both her parents were alcoholics—and proceeded to speak about how well she was feeling and doing. COAs meetings and literature, she said, had allowed her to discover self-esteem. At another meeting, Carolyn told a story of complaining to her doctor about depression—and hearing the doctor shoot back a question about whether one of her parents was an alcoholic. "I was shocked," she said, and well she might be. Doctors, as a group, have yet to play a major role in helping mitigate the effects of alcohol, perhaps because the average medical-school student spends a grand total of between zero and 10 hours studying the affliction that kills 100,000 people annually.

An avalanche of information is coming, nevertheless, from another kind of M.D.—call them the Masters of Disaster, the people who've lived with alcoholism or worked with alcoholics so closely that they might as well be their kin. Robert Ackerman, a professor of sociology at Indiana University of Pennsylvania, has been studying the children of alcoholics for an exceedingly long time by the standards of the movement—since the early '70s. In his recent book "Let Go and Grow" *(Health Communications, Inc.)*, he reports on a survey he took to test the validity of Woititz's 13 generalizations about COAs, as well as seven more observations of his own. What he found was that "adult children of alcoholics identified about 20 percent more with these characteristics" than did the general population. Other professionals are reporting success with therapies involving hugging, acting out unresolved scenes from long ago and even playing one of several board games for children of alcoholics called Family Happenings and Sobriety. Cathleen Brooks, executive director of a program called Next Step in San Diego, reports that her clients often make life-changing strides after six to 18 months of primary treatment and make the decision never to drink or take drugs.

A founding mother of the movement: *Woititz*
BERNARD GOTFRYD—NEWSWEEK

The 7 million COAs who are under the age of 18 are harder to help, if only because their parents' denial tends to keep them out of treatment. For these children who never know what to expect when they come home from school each day, life, says Woititz, "is a state of constant anxiety." Some pediatricians think there is a link between such anxiety and childhood ulcers, chronic nausea, sleeping problems, eating disorders and dermatitis. Migs Woodside, from the COAs Foundation, says that the trained teacher can pick the child of an alcoholic out of a crowded classroom. "Sometimes you can tell by the way they are dressed or by the fact that they never have their lunch money," she says. "Sometimes you can tell by the way they suddenly pay attention when the teacher talks about drinking, and sometimes you can tell by their pictures."

Someday, 20 or 30 years from now, those children may feel a vague sense of failure or depression and be hard pressed to explain why. In the meantime, it's their Crayolas that are hard pressed. Beer cans—and not liquor or wine bottles—form a leitmotif in the work of young children of alcoholics. Occasionally, Woodside says, looking a little sad, the big stick figures can be seen tipping the cans into the mouths of the little stick figures.

CHARLES LEERHSEN *with* TESSA NAMUTH
and bureau reports

SB

372

Alaska State Legislature

Committees:

Chair-State Affairs
V. Chair-Judiciary
Telecommunications
Special Ethics
Legislative Council
Finance Subcommittee
for the University of Alaska
Joint Committee
on Economic Recovery

REPRESENTATIVE FRAN ULMER

P.O. Box V
Juneau, Alaska 99811
(907) 465-4947

MEMORANDUM

February 24, 1988

TO: All Members of the House

FROM: Representative Fran Ulmer

SUBJECT: House Bill 372

House Bill 372, "An Act prohibiting the suspended imposition of sentence for a person convicted of a sexual offense", adds sex offenses to the list of crimes for which offenders may not receive a suspended imposition of sentence. Current law provides that driving while intoxicated, murder, kidnapping and other crimes which require a presumptive sentence, are treated in this manner.

House Bill 372 recognizes that sex offenses are very serious offenses and that people who are convicted of these crimes will receive a permanent criminal history. This is important for employment background checks, as well as for future sentencing if the person re-offends and is convicted.

This legislation is supported by the Anchorage Sexual Assault Task Force, the Council on Domestic Violence, the Department of Public Safety, the Department of Law and the Public Defender's Office. There is no opposition and no fiscal impact.

I would appreciate your support of this legislation.

SECTIONAL ANALYSIS

STATE OF ALASKA 1988 LEGISLATIVE SESSION
FISCAL NOTE

REQUEST: Bill Version: HB 372
Publish Date: HOUSE 2/10/88

Revision Date: 1-26-88
Title: An act prohibiting suspended imposition of sentence...sexual offense
Sponsor: Ulmer
Requestor: House HESS

Agency Affected: Alaska Court System
BRU: Trial Courts
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
Personal Services	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Travel	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Contractual	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Supplies	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Equipment	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Land & Structures	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Grants & Claims	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
REVENUE	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .

FUNDING: (Thousands of Dollars)						
General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Other	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:						
Full-time	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Part-time	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Temporary	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact.

Prepared by: Dan Strandberg, General Counsel Phone: 264-8215
Division: Alaska Court System Date: 1-26-88

Approved by: Arthur H. Snowden, II, Administrative Director Date: 1-26-88
Agency: Alaska Court System

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management & Budget
Impacted Agency(ies)
Senate Secretary

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB [illegible]
PUBLISH DATE: HOUSE [illegible]

FISCAL NOTE

REQUEST:

Revision Date:
Title: "An Act prohibiting suspended imposition of sentence."
Sponsor: Representative Ulmer
Requestor:

Agency Affected: Department of Corrections
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This legislation will have minimal impact on the Department of Corrections. We estimate that it will affect approximately 45 sex offenders per year, and they will receive jail sentences no greater than 6 months. This is

Susan E. Knighton

Susan E. Knighton, Director

Prepared by: 465-3376
Phone:
Division: Administrative Services
Date: 1-28-88

Approved by Commissioner: Susan Humphrey-Barnett
Date: 1-28-88
Agency: Department of Corrections

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Fiscal Note cont.

Analysis:

based upon current practice of only giving an SIS to persons with the least risk of recidivating. These people will now be required to serve some jail time, but it will be minimal.