Mr Ronald D Rasmussen,
4000 Cushman St
Fairbanks, AK 99701

452-4000

Distribution	Affiliation	Reg Voter
34		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			BUDGET

Division of Forestry: I strongly urge you to support the Division of Forestry's $280,000 increment calledovercoming limits to value - added timber sales". Sustainable forestry depends upon proper registration. The timber sale program has provided millions to the State Treasury. It is only right that some of these funds return to benefit the industry."

Email Address

Ms. Barbara A Johnson,
631 W 32nd Ave #133
Anchorage, AK 99503

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

Please support HB 112, requiring women be given full disclosure as too physical and psychological risk of abortion before choosing an abortion and information requiring fetal development. thank you for supporting pre-born life.

Email Address

Ms. Marvel G Lloyd,
Hc85 Box 9814
Eagle River, AK 99577

694-9179

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I urge your to vote for HB 122, because I feel for any optional medical procedure the patient should always be making an informed decision by knowing all the possible negative affects that the procedure might cause.

Email Address

Madonna R Singleton,
PO Box 4166
Palmer, AK 99645

746-6806

Distribution	Affiliation	Reg Voter
10		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I strongly support HB 112. Thanks

Email Address

Robert H Singleton,
PO Box 4166
Palmer, AK 99645

746-6806

Distribution	Affiliation	Reg Voter
10		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I strongly support HB 112. Thanks

Email Address

Ms. Lapriel C Stephan,
PO Box 112114
Anchorage, AK 99511

276-5733

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HJR 12	Supports	

I agree with With Representative Fred Dyson, that hunting and fishing and trapping are part of our heritage and must be preserved. I think your doing a good job.

Email Address

Ms Charis G Berry,
PO Box 1121
Valdez, AK 99686

835-2898

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

Please look at this bill. Please make sure all women are given full information about what abortion is and what it means.

Email Address

Ms. Geraldine I Boye,
52557 Geraldine St
Kenai, AK 99611

776-5419

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			ABORTION

Stress the separation of powers and in abortion especially. That the state is still funding it irritates me as they haven't asked my permission to do that. I don't think the courts are supposed to legislate. Please remember we need to be on the side of life.

Email Address

Mr. Dave N Syren,
1004 Beech Ln
Anchorage, AK 99501

274-9046

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N	HB 112	Supports	

I am in support of HB 112 and feel we need to have continued separation of powers in all decisions, especially relating to abortion.

Email Address

Mrs. Renate Kennedy,
326 Wedgewood Dr #E29
Fairbanks, AK 99701

452-1045

Distribution	Affiliation	Reg Voter
43		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			BUDGET

There is a tremendous need for substance abuse treatment throughout our community I work in this field and feel this workforce is understated and under paid. I could make $10,000/year more if I left this field, but I understand how it might impact our community.

Email Address Renate@gci.net

Ms. Rayetta L Calhoun,
1254 Loon Ln
North Pole, AK 99705

Distribution	Affiliation	Reg Voter
41	Ralph	V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	C			BUDGET

We can no longer do more for less. Jobs are plentiful and it is easier to do work somewhere else and get paid more. Please fund the substance abuse programs so staff can get adequate pay.

Email Address Rayetta@mail.com

March 8, 2001

House HESS Committee
State Capitol
Juneau, AK 99801-1182

Dear Mr. Chairman and Members of the Committee:

My name is Deatrich Sitchler, and I reside at 520 Glacier Bay Circle #B, Anchorage, AK 99508. I am writing to you to urge you to **oppose HB 112**. I understand that the bill is currently in the House HESS Committee, on which you sit. Please do everything in your power to stop this bill from becoming law.

I would like to share with you my personal reasons why this bill would be detrimental to many women. At the age of 14, I was diagnosed with hemophilia, a disease affecting the blood. As a result of this condition, it is medically dangerous for me to carry a pregnancy to term because the loss of blood during delivery could be potentially fatal to me. I am in a long-term committed relationship, and my partner and I are very careful, but as you know, no form of birth control is 100% effective. Were I to accidentally become pregnant, it may be in my best medical interest to terminate the pregnancy rather than carry the pregnancy to term.

I strongly feel that this is a decision between my partner and me, with the advice and consultation of my doctor. The government has no place in this personal, painful choice I would have to make. Furthermore, my partner and I would find it very painful to have to look at pictures of healthy fetuses in a brochure or to have to listen to a litany of "alternatives" to abortion – alternatives that are not actually in *our* best interest and that could actually threaten my life – before we could be deemed capable of consenting to an abortion. I might not fall under the "medical necessity" exception to HB 112 because having the abortion at that very moment would probably not be a life-saving measure or an emergency situation. Therefore, I would be subject to this extra "counseling" which would be wholly irrelevant to my individual circumstances.

I remind you that this decision would already be very painful for me, and that I would be terminating my pregnancy to save my life. Why should extra hurdles be placed before me that are not placed before any other patient seeking any other medical treatment?

My boyfriend and I live together at the above address. We both urge you to oppose HB 112.

Very truly yours,

Deatrich Sitchler

Deatrich M. Sitchler

To: House HESS Committee
From: Dr. Sharon Smith
Date: March 7, 2001
Re: HB 112

I am a family physician working in Anchorage. I care for pregnant woman, perform deliveries, and care for the children of my patients. I do not perform abortions.

I have concerns about HB 112. Specifically, the requirement that DHSS develop and make available a standard information pamphlet describing the development of an "unborn child." The bill calls for "nonjudgmental information that is accurate, scientific information." The term "unborn child" is disingenuous and inflammatory, has no scientific basis, and has no place in a medically oriented document. Furthermore, the only women who would be required to review the information would be those who are choosing to end their pregnancies.

You know, as a physician I perform procedures and obtain informed consent prior to all of them. Obtaining informed consent responsibly was an important part of my medical training. I am, frankly, insulted that legislators are comfortable dictating how consent be obtained for a specific procedure, that the bill's language implies physicians are not already obtaining informed consent, and that you find it within your duties to single out one procedure and place onerous requirements on a safe, simple medical procedure.

Sharon Smith, MD
6203 Green Tree Circle
Anchorage, AK 99516
346-3693

March 7, 2001

Rep. Fred Dyson

Rep. Peggy Wilson

Rep. John Coghill, Jr.

Rep. Vic Kohring

Rep. Gary Stevens

Rep. Sharon Cissna

Rep. Reggie Joule

I recently read House Bill No.112 proposed by Representatives Coghill and Dyson. I must object to this bill on multiple grounds. This bill is a thinly veiled attempt squarely aimed at making it more difficult for women of Alaska to receive abortions. It contains biased language throughout, and indirectly suggests placing new limitations on the availability of the abortion procedure.

The bill claims to be about informed consent. As physicians, we are quite familiar with informed consent. If there is a complication of a procedure and informed consent was not obtained, we are painfully aware of the consequences. Getting proper informed consent before an abortion is very high on my list of priorities. Contrary to what some people may think, there is no monetary gain in performing abortions to a physician who does both prenatal care and abortion. If a patient carries a pregnancy to term, our practice will see a much larger revenue stream than if the patient has an abortion. There is no incentive on our part to encourage abortion over an ongoing pregnancy.

The bill starts in a biased manner by saying that it is meant to "ensure informed consent before an abortion may be performed, except in the cases of medical emergency." A pregnancy has several possible outcomes including carrying and delivery, abortion, adoption, miscarriage, and ectopic pregnancy and others. There is no mention of giving informed consent to women regarding carrying a pregnancy to delivery, or giving the pregnancy up for adoption. In my practice as a physician, I perform abortions as well as multiple other procedures including both office and hospital procedures. The legislature has not chosen to pass a bill on how I obtain consent from a person for a C-Section, or hysterectomy – both of which carry far more risk to the patient than an abortion. Clearly, the abortion is being singled out, but not for medical reasons. This bill relates to politics and beliefs, not medicine or the safety of Alaska women.

Throughout the bill the term "unborn child" is used. A review of the 23rd edition of Stedman's medical dictionary reveals that the term "unborn" or phrase "unborn child" are not recognized. There are medical terms such as blastocyst, morula, embryo, fetus, and several others terms referring to the "conceptus." The term "unborn child" is included to incite only emotion. On page 2, line 25 the term "nonjudgmental" is used when the decidedly judgmental phrase "unborn child" is used in the very same sentence, a contradiction of terms.

In pages 1 line 1 through 3, line 23 a "standard pamphlet of information" is described, again using biased terms defined by the legislators, not terms recognized in science. Paragraph (7), page 2, lines 19-27 describes in detail the pictures that need to be included in this pamphlet. Why are these to be included? Are these meant to "educate" the patient regarding the fetal development when she is deciding whether to carry a pregnancy rather than to have an abortion? If so, where are the parallel photographs describing the complications of abortion as well as the complications

of carrying a pregnancy to term? Of what value are these pictures? When I counsel patients regarding an ongoing pregnancy or an abortion, should a patient ask me for drawings or photographs of a fetus at various stages of development, I have an encyclopedia containing the information, and I go over it with the patient, but I tailor the information to the needs of the patient. Each person is an individual, and a "standard information packet" alluded to by this bill leaves little room for patient individuality.

C. Everett Koop, and the American College of Obstetrics and Gynecology, after extensively reviewing the literature, concluded that there is no solid scientific data suggesting that there are long-term negative psychological effects from an abortion. Yet paragraph 8, page 2, line 31 refers to "possible psychological effects" that have been associated with having an abortion. Why should a patient be subjected to this concept when there is no proof that it exists, and will only serve to frighten the patient with false information? Informed consent should only involve only actual scientific information, not conjecture. ("Actual scientific information" is referred to in line 26, page 2.) If this reference remains in the bill, where is the comparable line referring to the possible psychological risks of adopting a baby out?

This bill is not about science, nor about medicine. This bill is not about information or informed consent. This bill is simple bias, placing more obstructions in the paths of women seeking an abortion. The suggested body of information is already available, and gathering it as suggested is a duplication of efforts. The requirements of HB 112 serve only as an obstacle intended to discourage patients from choosing a procedure that is recognized as one of the safest performed in medicine.

The persons being served are not the patients, but the legislators who wish to further obstruct abortion in Alaska.

Jan Whitefield Jan Whitefield, MD

Medical Director, Alaska Women's Health Services

Subject: TESTIMONY--HB112
Date: Sun, 22 Apr 2001 10:31:30 -0800
From: "R. Holmes Johnson" <drbob@keaconnect.net>
To: Representative_Fred_Dyson@legis.state.ak.us

Fred Dyson, Representative
State of Alaska
State Capitol
Juneau, Alaska 99801-1182

Dear Mr. Dyson,

When I had to leave before testifying at the Saturday teleconference on HB112, the LIO in Kodiak forwarded an article of mine that was published in the Kodiak Mirror when I was in practice. The "going public" in the initial paragraph refered to picketing that had just begun and therefore removed the need for secrecy. I was quite happy to "tell it like it is" to correct many misconceptions created by opponents of abortion.

I would urge you to read the article since it establishes my experience and thus qualifies me to testify on this proposed legislation.

HB112 is an unnecessary bill. It needn't have been introduced at all since: a) the Alaska Department of Health presently distributes much information on pregnancy and abortrion, since; b) *informed consent* has been reiterated so many times that no sane phyisian fails to explain whatever procedure is being considered and to obtain signed consent, and since; c) abortion should not be singled out as the *only procedure* in Alaska to be subject to such mandatory "extra" counseling.

Though making a studied effort toward objectivity, the details which serve as an impediment to free choice (of what one wants to know), and the use of the term *unborn child* in place of the proper term *fetus*, make it fairly obvious that this bill was written by those who do not approve abortion!

I heard testimony on SB91 a few days ago by a woman who quoted unbelievable complications of abortion, particularly serious psychological problems. Dr. C. Everett Koop, Surgeon General under President Reagan, himself *not in favor of abortion.* did an exhaustive study of abortion and found *no evidence* of psychological effects. My own experience supports Dr. Koop. This suggests that those who feel abortion is *murder* are so biased that they transmit this to those whom they interview and suceed in creating severe guilt feelings would be, indeed, complications, *but not of abortion.*

Please keep in mind that a woman, now, has the right to ask any question at all of her physician and he has the obligation to answer that question to the best of his ability. To have someone else, particularly legislators, dictate what she must know, is an insult to her intelligence and, furthermore, overlooks individual differences and individual needs.

In summary, this bill is redundant and should not have been introduced at all. It places an unnecessary impediment to the free exercise of choice which has been the legal right of women since Roe vs. Wade. Had it always been their legal right, we would not have seen the *serious complications* that *were* a result of back alley abortionists. To add impediments to free choice, as has already been done in a number of ways, is to chip away at one effective and necessary form of population control.

Realize that I am retired and have nothing to gain personally! I write in defense of women who

become unexpectedly pregnant who should be free to choose what they want to know about their options as well as which, among them, to select. This bill interferes with that freedom and should be buried!

Sincerely,

Dr. Bob Johnson,
drbob@keaconnect.net
Phone 907--486-5171
Box 945 Kodiak 99615

Alaska State Legislature

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Session:
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Representative John Coghill

Sponsor Statement
HB 112

Since the early 1970s, Alaska regulations have required physicians to advise patients seeking an abortion of the "medical implications and the possible emotional and physical sequelae of the procedure." (12 AAC 40.070). However, Alaska's informed consent regulation lacks specificity and is not uniform in its application.

HB 112 elevates Alaska's current informed consent requirement from regulation to statute. This legislation would ensure that a patient is given the appropriate information about an abortion procedure without obstructing a physician's ability to tailor information to the individual needs of the patient.

HB 112 also requires that the Department of Health and Social Services develop a pregnancy informational pamphlet to be made available to the public. The pamphlet would list factual, nonbiased information about pregnancy and abortion, as well as pregnancy and abortion alternative resources, and state services available to pregnant women in Alaska.

HB 112 reinforces the current ethical standards by protecting them from possible systematic abuse in the future, putting a statutory safeguard into place for both women and physicians.

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Representative John Coghill

Sectional analysis - HB 112

Section 1: Creates an information pamphlet that is designed for pregnant women which describes average fetal development and lists both non-profit and state pregnancy and pregnancy alternative resources and options.

Section 2: Amends AS.18.16.010 ("Abortions") to state that an abortion may not be performed unless the provisions of section 4 (AS 18.16.060) have been satisfied.

Section 3: Amends AS 18.16.010 ("Abortions") to include a subsection that states that, except in situations of medical emergency, if an abortion is performed in violation of section 4 (AS 18.16.060), the physician is civilly liable for compensatory and punitive damages.

Section 4: Amends AS 18.16.010 to include a section addressing informed consent requirements. An abortion may not be performed in this state unless the physician or referring physician orally informs the patient of

- The name of the physician performing the procedure.
- Gestational estimate of pregnancy at the time of the procedure.
- Nature and risks of undergoing or not undergoing the procedure, as pertinent to the patient's circumstances and medical history.

Written consent must be obtained from the patient confirming that the required information has been provided.

Section 5: Provides a severability clause. In the event that one or more of these provisions is found to be unconstitutional, the remaining provisions would continue in full force and effect.

CURRENT STANDARD:

ALASKA ADMINISTRATIVE CODE - ABORTION/INFORMED CONSENT

2 AAC 40.070

INFORMED CONSENT.

Unless otherwise provided in 12 AAC 40.060, a written informed consent shall be obtained from the patient or from any other person whose consent is required before termination of a pregnancy. Such written informed consent shall be on the patient's chart. The patient and other persons whose consent is required shall be advised of the medical implications and the possible emotional and physical sequelae of the procedure.

History -

Eff. 12/20/70, Register 36; am 8/29/73, Register 47

Authority -

AS 08.64.105
Sec. 08.64.105. Regulation of abortion procedures.

The board shall adopt regulations necessary to carry into effect the provisions of AS 18.16.010 and shall define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for facilities, equipment, and care of patients in the performance of an abortion.

CONCEPT BEHIND HB 112: REFINE AND ELEVATE ALASKA'S CURRENT ABORTION INFORMED CONSENT STANDARD

EXAMPLE:

AS 18.16. REGULATION OF ABORTIONS
AS.18.16.010. Abortions.

(a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on an unmarried, unemancipated woman under 17 years of age, consent has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;* and

(4) the woman is domiciled or physically present in the state for 30 days before the abortion.

HB 112 WOULD INSERT:

(a) Except in the case of a medical emergency, a person may not knowingly perform or induce an abortion without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced.

(b) Consent to an abortion is voluntary and informed when all of the following are true:

(1) before the abortion procedure, the physician who is to perform the abortion or the referring physician has orally informed the woman of the

(A) name of the physician who will perform the procedure;

(B) gestational estimation of the pregnancy at the time the abortion is to be performed; and

(C) nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a voluntary and informed decision of whether to undergo the procedure;

(2) before the abortion, the woman certifies in writing that the information required under (1) of this subsection has been provided; and

(3) the physician who is to perform the abortion or a representative of the physician receives a copy of the written certificate required under (2) of this subsection and retains a copy in the physician's file.

(c) The information required in (b)(1) of this section shall be provided to the woman individually and in a private setting to protect the woman's privacy, maintain the confidentiality of the woman's decision, ensure that the information focuses on the woman's individual circumstances, and ensure that the woman has an adequate opportunity to ask questions.

*Parental Consent/Judicial Waiver struck down - Planned Parenthood of Alaska, Inc. v. State, No. 3AN-97-6014 CI (10/5/98)

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Representative John Coghill

"INFORMED CONSENT FOR ABORTION" LAWS IN THE UNITED STATES

- 30 states, including Alaska, currently have laws detailing informed consent requirements for abortion procedures.

  AL, AK, CA, CT, DE, FL, ID, IN, KS, KY, LA, ME, MA, MI, MN, MS, MT, NE, NV, ND, OH, PA, RI, SC, SD, TN, UT, VA. WI

- 21 states have introduced legislation concerning this issue in 2001 to both initiate laws and to update current laws.

- Alaska is one of 12 states that have legislation in 2001 that would update the current state laws on abortion informed consent.

- Separate medical informed consent laws for abortion procedures have been upheld at the Federal level (U.S. Supreme Court *Casey*). 7 states currently have their laws enjoined due to state court rulings. The central issue behind these injunctions being that the laws also required a waiting period, which was ruled unconstitutional under the individual state constitutions.

- The determining factor for federal constitutionality of informed consent laws is the judgment of whether or not the laws pose an undue burden to a woman seeking an abortion.

  Note: Alaska's abortion laws are held to the more strict interpretation of Roe v. Wade, not the recent U.S. Supreme Court ruling in *Casey*.

TESTIMONY OF
VINCENT M. RUE, PH.D.

INSTITUTE FOR PREGNANCY LOSS
STRATHAM, NEW HAMPSHIRE

REGARDING
HB 112
BEFORE THE HOUSE
HESS COMMITTEE

JUNEAU, ALASKA

MARCH 2, 2001

By way of introduction, I am a traumatologist, psychotherapist and researcher. I have testified before several federal legislative committees in Washington and have provided testimony in numerous state abortion-related statutory challenges. I have provided testimony or consultation with 18 states regarding abortion decision making and the psychological aftereffects of abortion. In addition, I am a practicing psychotherapist and have treated hundreds of women who have elected abortions over the past 25 years. I am also an author, international lecturer and researcher on abortion related trauma and treatment.

One of the best kept secrets about induced abortion pertains to its emotional aftereffects. *Greater than any other single physical health risk, the psychological complications of abortion range from 5% - 60% depending on the study.* Even Planned Parenthood has acknowledged that abortion causes significant depression in 10% of women! Yet the mental health complications from abortion are underestimated and underreported by state health departments & the Centers for Disease Control, perhaps by a factor of 50%. In my opinion, women rarely return to the site of trauma to acknowledge their emotional injury and seek palliative care.

From the evidence presented below, it is apparent that the abortion decision is a complex and terrifying one, that the current practice of abortion counseling does not adequately address women's mental health care needs, that abortion carries certain and significant mental health risks, and that a statute enhancing informed consent is necessary to prevent further harm. I support HB 112 and believe such a bill would benefit Alaska women with unwanted pregnancies if enacted into law.

1. The Nature of the Abortion Decision

The process of informed consent and abortion decision making has all too often been left to the discretion of a non-professional, well-meaning, but likely misinformed "abortion counselor" whose typical job requirement is a "pro-choice" sentiment. The women of Alaska and throughout the United States deserve far more and better precautions for their mental and physical health.

The abortion decision is a unique one, complex in nature, necessitating due deliberation and the evaluation of considerable information, some of which may be emotionally trying. The U.S. Supreme Court has ruled: (1) "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." Harris v. McRae, 448 U.S. 297, 325 (1980); (2) that the decision whether or not to abort should be made "in light of all circumstances - psychological and emotional as well as physical - that might be relevant to the well being of the patient." Planned Parenthood v. Danforth 428 U.S. 52, 66 (1976); and (3) that the "medical, emotional and psychological consequences of an abortion are serious and can be lasting..." H.L. v. Matheson 450 U.S. 411 (1981).

Alaska is not alone in setting forth minimum standards of informed consent and abortion counseling. Because of the medical, moral, societal and psychological controversies surrounding abortion, some states are now insisting that reasoned and deliberate abortion decision making be legally mandated. In particular, women's "right to know" laws have been enacted that precisely

determine the content of information and the timing as to when information should be made available before an abortion may be performed.

In the United States today, the following elements of informed consent have been mandated in a number of states: (1) the medical risks associated with pregnancy termination; (2) the probable gestational age of the unborn child; (3) the alternative risks associated with carrying to term; (4) the medical assistance benefits if childbirth were elected; (5) the father's liability for financial assistance; (6) the opportunity to review printed information descriptive of fetal development; and (7) some waiting period for deliberation, usually 24-48 hours.

These informed consent requirements are additive in nature, insuring the woman has more rather than less information. These requirements do not appear to restrict the patient's decision making capacity - they enhance it. How is it possible for a woman to weigh the benefits and risks of electing an abortion if information regarding abortion alternatives are conspicuously absent in the "counseling process?" Indeed, if informed consent is not obtained prior to an abortion, then grounds for medical malpractice litigation are warranted based on personal injury.

Because the doctrine of informed consent is well established, courts and legislatures have consistently required physicians to provide a minimum of information to the patient prior to making a decision regarding treatment. This information is generally composed of a determined diagnosis, reasonable prognosis, the risks and benefits of proposed treatment and non treatment, all of which should be provided in terms that the patient can comprehend. The practice of abortion has been a lamentable and solitary exception to this standard of care.

2. The Known Deficiencies of Abortion Counseling

The two most common causes of action in abortion malpractice are: (1) negligence in evaluating/screening a patient preabortion; and (2) lack of informed consent which constitutes battery. Because abortion is a medical procedure, legally it is the physician's duty to evaluate, counsel and assess the patient beforehand.

Current abortion practice though severely limits physician-patient contact and instead preabortion counseling is most typically delegated to the physician's agent, i.e., the abortion counselor. Nevertheless, it is the physician who actually performs the abortion, and it is always his/her ultimate responsibility to (a) protect the patient's health; (b) to see to it that the patient's decision is firm, freely made, and duly thoughtful; and (c) that her consent is truly informed.

The Abortion Counselor

Abortion counseling in most countries suffers from obvious and serious conflicts of interest and procedural inadequacies. Abortion counseling between physician and patient is largely nonexistent. Instead, the patient is "counseled" by someone other than a physician, i.e., his agent, who most typically is not professionally trained and who receives "on the job training." In the U.S., abortion counselors as a "profession" are unlicensed and are unregulated in 95% of the states. "Professional background is considered less important than such personal attributes as warmth, caring, empathy and a commitment to the pro-choice cause."

Counselor bias can clearly be a negative force in the counseling process, particularly if the situation is compounded by a conflict of interest, i.e. pecuniary benefit in the outcome, namely,

abortion. All too often the abortion counselor has only a high school diploma, has herself had one or two abortions and feels compelled to assist others by affirming the abortion decision. She thereby affirms her own decision, unknown to her and her client. Because she may be in denial about the emotional aftereffects of her own abortion, she is either unaware of postabortion emotional trauma because she needs to be, or is simply uninformed.

One abortion counselor worked two days at the clinic and the remainder of her work week as a bartender at a "biker's bar." Another abortion counselor responded at her deposition when asked when human life began: "it begins at birth." Sadly, this kind of counselor and counseling may be more normative than the exception.

Duration of Preabortion Counseling

Contemporary abortion counseling is so time limited and volume oriented as to be impossibly tailored to the unique needs and circumstances of the individual patient. Indeed, thorough, thoughtful, and deliberative pregnancy outcome decision making is handicapped by existing abortion counseling procedures.

Several empirical studies in the U.S. have indicated the deficiencies of current abortion counseling practices with the majority of respondents reporting insufficient information provided by the abortion counselor, insensitive, unhelpful abortion clinic personnel with respect to providing assistance in decision making, and the provision of misinformation thereby contributing to increased anxiety, confusion and levels of post abortion depression and hostility.

Clearly, effective counseling that is empathic, durational and substantive in content benefits women considering abortion as a solution to an undesired pregnancy. On the other hand, biased "counseling" which is of 5-15 minutes duration, one outcome oriented, deficient of sufficient information and not allowing for multiple visits or time deliberation is harmful of women considering abortion.

Nature of Preabortion Counseling

Current standards of care for abortion counseling have appropriately been criticized in the U.S. on at least three counts: (1) the health profession inadequately fulfills women's needs for abortion counseling; (2) current laws, by not mandating or regulating the practice of abortion counseling, fail to address women's needs for abortion counseling, thus undermining maternal health; and (3) abortion counseling must of necessity expand and include assistance in remediating post procedural problems.

The value of nondirective crisis pregnancy counseling was underscored by Cook. She reported: "When women may act only within a short span of gestation, they may be denied the opportunity to consider their options fully and take necessary steps for continuation or termination. Women could thereby be denied the choice to continue a pregnancy and give birth. The agendas of both antichoice and prochoice activists may be served by affording women opportunities for nondirective counseling and planning, and not obliging them to make their decisions in haste."

Information Deficiencies

It is a tragic reality that abortion clinics go to great lengths to disguise, minimize, deny, disavow

or dissaude their patients' concerns about the humanity of the fetal child.

Not offering a woman the opportunity to receive fetal information is also not following good counseling procedures for, in the absence of such, a directive counseling environment is created. In the absence of an opportunity to receive fetal information, the woman's attention is focused on the limited information which the counselor chooses to disclose and her decision is thereby directed by the limited information she receives. In such a directive counseling situation, the woman is denied the opportunity to consider thoroughly all her options, as information that would allow such has been withheld by the counselor.

In addition, many women are not familiar with the facts of fetal development, but would consider information on fetal development to be important in making their abortion decision because they would not wish to have an abortion if their unborn child were sufficiently developed to have readily identifiable arms, legs, a beating heart, etc.

The provision of information on fetal development further insures that, in deciding whether or not to have an abortion, a woman has an opportunity to use her own personal values, including her view of the time at which human life begins. If she is informed about fetal development and concludes that the unborn child is indeed a human life, then given her legal options, she can act accordingly in light of her own values. If she concludes that either the product of conception or the aborted material is not human, and decides to abort it, then she will have minimized the risk of future potential psychological harm arising from post-operative reflection prompted by obtaining fetal information not made available to her before it took place.

If information causes discomfort or dissonance, this does not mean it is antithetical to the doctrine of informed consent. According to former U.S. Supreme Court Chief Justice Rehnquist and Justice White: "It is in the very nature of informed consent provisions that they may produce some anxiety in the patient and influence her in her choice. This is in fact their reason for existence, and - provided that the information required is accurate and nonmisleading - it is an entirely salutary reason."

Decision-Expediting & Non-Evaluating

One of the most important roles of the abortion counselor is to ascertain whether or not a woman's decision is indeed her own, made with sufficient information and reflection, is made voluntarily, and that undue pressure or coercion is not present. In addition, the counselor should obtain a psychosocial history as well as a medical history, and accordingly assess the risk for any postabortion negative emotional adjustment.

The current nature of preabortion counseling virtually insures the impossibility of achieving its objectives. This is so because of: (a) the lack of professional education and training on the part of the counselor; (b) the severe time constraints placed upon the session (5-15 minutes); (c) the often reliance upon group versus individual counseling; (d) the absence of objective information; (e) the non-exploration of alternatives; (f) the absence of information on fetal development; (g) the conflict of interest for the abortion counselor; and (h) the counselor biases.

3. Psychological Risk Factors for Postabortion Trauma

Research evidence is clear that certain women are predisposed to significant negative post

abortion adjustment. Existing biased abortion counseling places maternal health of these women at risk. These women are in need of **more** counseling, **more** information, exploration and deliberative time, and **more** assistance than others.

Abortion traumatization may in many cases be prevented or remediated if women who give evidence of documented risk factors receive adequate counsel to make a decision that fits their unique psychological and social needs.

Empirical evidence suggests emotional harm from abortion is probable when the following risk factors are present:

1. preabortion emotional maladjustment

2. immature interpersonal relationships

3. unstable, conflicted relationship with one's partner

4. history of a negative relationship with one's mother

5. conflicted abortion decision, including considerable ambivalence

6. when abortion violates personal beliefs, morals and values

7. single status, especially if one has not borne children

8. age, particularly adolescents versus adult women

9. mid or late-term abortions

10. abortion for genetic reasons, i.e., fetal anomaly

11. pressure or coercion to abort

12. prior abortion

13. prior children

14. maternal orientation

15. when the abortion choice is not duly considered, counseled or informed &

biased preabortion counseling

16. a secret abortion

17. when a woman perceives her uterine contents as "human" and a "child"

18. when the abortion event is perceived by the woman as violent and death producing

4. The Research Evidence of Postabortion Psychological harm

Extensive research has documented how traumatic stress can significantly alter individuals' lives. Traumatic stressors are strong predictors of PTSD (Foy, Osato, Houskempt & Neuman 1992).

While the prevalence of PTSD has been estimated to affect up to 12% of the U.S. population (Breslau, Davis, Andreski & Peterson 1991), limited research has examined the role of elective abortion as a traumatic stressor causing symptoms of PTSD.

Most trauma victims encounter feelings of horror or terror at the time of the traumatic episode. Bagarozzi has reported that women who came for mental health treatment were in complete denial that they had experienced an abortion and that indeed it was a traumatic and horrific experience for them. "This denial was seen as a major contributing factor to the development of post traumatic stress in these women" (1993:67). Clinical research findings highlighting the power of denial before, during and after an abortion have also been reported by Torre-Bueno (1996). As a pro-choice advocate and long-time Planned Parenthood abortion counselor, her assertion is all the more compelling:

> *"I believe passionately that I can be supportive of every woman's right to make her own pregnancy decisions, and still recognize the fact that her decision may cause her tremendous suffering. While many women do not have emotional or spiritual difficulty after an abortion. I know from twenty years of experience working with women before, during, and after abortions, that many women have more emotional and spiritual pain after abortion than the current research suggests."(1996:3)*

In another clinical study, pro-choice psychotherapists De Puy and Dovitch (1997:13-14) reported that 10% of women experience "severe emotional trauma" following abortion. According to these clinician/researchers: "Many women acknowledge a feeling of relief after their abortion, yet are understandably upset by facets of the experience that they had never anticipated. Many are distressed and unaware of the ways in which their choice has changed their lives and, sometimes, the lives of those around them."

In a study of 80 women in the U.S., Barnard (1990) used standardized posttraumatic stress disorder (PTSD) instruments and found: 3-5 years following the abortion, 18% of the sample met the full diagnostic criteria for posttraumatic stress disorder (PTSD) and 46% displayed high stress reactions to their abortion. Her findings were not explained by religiosity as 68% reported that at the time of the abortion they had little to no religious involvement.

Subsequently, similar findings were also reported by Hanley et al. (1992) in a comparison study of women distressed postabortion which also used standardized PTSD instruments and interviews. They found: "*Women who were distressed following an abortion scored significantly higher than the non-distressed group on PTSD symptoms of intrusion and avoidance.*" The investigators evaluated whether some women in outpatient mental health treatment with a presenting problem of postabortion distress met Diagnostic & Statistical Manual of Mental Disorders III Revised (DSM-III-R) criteria for the posttraumatic stress disorder (PTSD) categories of intrusion, avoidance, and hyperarousal. One hundred and five women were administered the SCID-PTSD module, the Impact of Event Scale, as well as the Social Support Questionnaire and the Interview for Recent Life Events, in addition to completing a semi-structured interview. The researchers concluded: "*the data from this study are suggestive that women can report abortion-related distress similar to classic PTSD symptoms of intrusion, avoidance and hyperarousal and that these symptoms can be present many years after the abortion.*"

Posttraumatic reexperiencing has also been documented in anniversary reactions. In a small study conducted by Franco et al. (1989:154), 30 out of 83 women reported experiencing anniversary reactions that included intense emotional psychosomatic pain. They noted: "Unresolved grief and preexisting dysphoria have been suggested as increasing the likelihood of anniversary reactions."

Another recent study compared two groups of 25 women who elected abortion: those who identified themselves as distressed (D) and those who reported more neutral or non-distressing responses (ND). PTSD symptomatology was found in the distressed group: changes in male-female relationships, suppression of feelings/thoughts about the abortion, reactions to catalytic events that aroused thoughts/feelings about the abortion, trying to get pregnant again, becoming promiscuous, and avoiding reminders of babies. More than two out of three women in Group D were distinguished by reports of "suppression" or "denial" of parts of the abortion experience or negative emotional reactions to it. Additionally, women in the distressed group were more than twice as likely to report abortion trauma related symptoms on the Impact of Event Scale than those in the non-distressed group (Congleton and Calhoun 1993).

In this same study, women who identified themselves as distressed postabortion indicated feeling: a sense of loss/emptiness (48%); shock/detachment (28%); anger toward partner/others (24%); depression (20%); loneliness, betrayal, loss of self-worth, and relief (16%); guilt and sorrow (12%); confusion (8%); fear of dying and suicidal thoughts (4%). Interestingly, in the group of women who elected abortion and did not believe they were distressed, 20% had symptoms of depression, an equivalent percentage experienced by the distressed group. The authors concluded: (1) for some women, abortion is a "critical event" which produces high levels of psychological distress; (2) informed consent should insure accurate information is conveyed about physical pain and possible negative and positive emotional reactions; and (3) when dealing with depression among women, exploring reproductive history for unresolved emotional reactions to pregnancy termination may prove beneficial.

In a large scale prospective cohort study (N=13,261, of whom 6410 experienced a pregnancy termination) conducted in the United Kingdom, Gilchrist et al. (1995) found evidence of the traumagenic nature of abortion when examining relative risks of suicidal behavior in women who had previously terminated their pregnancy, and who had no prior history of psychiatric illness. A recent study in Finland of all deaths of women of childbearing age concluded: "Our data clearly show, however, that women who have experienced an abortion have an increased risk of suicide which should be taken into account in the prevention of such deaths" (Gissler, Hemminki and Lönnqvist 1996:8).

A recent Swedish study examined emotional distress (ranging from 1 month to 12 months follow-up) after abortion at a university hospital. Risk factors identified were: living alone, poor emotional support from family and friends, adverse postabortion change in relations with partner, underlying ambivalence or adverse attitude to abortion, and being actively religious. The researchers concluded: "Thus, 50-60% of women undergoing induced abortion experienced some measure of emotional distress, classified as severe in 30% of cases." (Soderberg, Janzon & Sjoberg, 1998:173)

In a study just published, Reardon & Ney (2000) examined the mental health risks of abortion relating to subsequent substance abuse. They found that women who aborted a first pregnancy

were five times more likely to report subsequent substance abuse than women who carried to term, and they were four times more likely to report substance abuse compared to those who suffered a natural loss of their first pregnancy due to miscarriage, ectopic pregnancy or stillbirth.

In addition to the above, there are a number of reviews of the literature on postabortion sequelae that are instructive (Speckhard & Rue, 1992; Rue, 1995; Speckard, 1997; Ney & Wickett, 1989; and Angelo, 1992).

5. The Need for Mandated Informed Consent & Waiting Period

The nature of an unwanted pregnancy suggests pressure and stress. There is considerable pressure on the woman to make a decision as quickly as possible. Women who make decisions in haste and without sufficient time for reflection are less likely to be satisfied with the quality of their decision making later on. Then too, many women change their minds regarding the outcome of the pregnancy a number of times due to the daily pressures of life, relationships and feelings. Reardon (1988) reported that 83% of women in his study felt "rushed" to make a decision. He also found the majority of women in his study were dissatisfied with the kind of preabortion counseling they received, 71% stating they believed the preabortion counseling at the abortion clinic was biased.

In a joint U.S. & Russian study, Rue et al. (2000) reported a number of factors women found disturbing in their preabortion counseling experiences. Specifically, in Table 1 several factors are identified by women who have had abortions that were contributory to postabortion emotional injury. These factors included lack of preabortion counseling, needing more time to decide, having sufficient opportunity to discuss alternatives, pressured abortion decision, preabortion counseling adequacy, uncertainty about abortion decision, etc. In this sample, 49% needed more time to make their decision. Sixty-two percent of the women studied felt pressured to abort. Only 89% of women who elected to abort were satisfed with the quality of the abortion counseling they received. Slightly more than one out of two women (52%) felt unsure about their decision at the time of their abortion. It is clear that a waiting period can benefit women who feel pressured; that counseling must be unbiased and include alternatives to abortion, and that decision certainty is critical before proceeding with what amounts to an irrevocable decision, one that can affect them for the rest of their lives.

In my opinion, HB 112 is a step in the right direction to help remedy these known deficiencies. HB 112 is critical in safeguarding Alaska women's health; it will help insure that women's abortion decisions are their own, that sufficient information is conveyed so as to be informative versus perfunctory, that women's abortion decisions be formed without pressure and bias, and that alternatives are objectively presented and considered. In the final analysis, if women choose to terminate their pregnancies, they deserve the best assistance we can offer them in their decision making process, and at the very least, provide the context and content of a consent that is voluntary and informed.

Table 1. Selected Preabortion Factors by Number & Percent of U.S. Women Who Have Aborted

(N = 320)*

	N	%
Received counseling beforehand	95	29.7
Needed more time to decide	157	49.1
Was counseled on alternatives	59	18.4
Felt pressure to abort	200	62.5

Preabortion counseling was adequate	36	11.3
Partner was supportive	77	24.1
Unsure about decision at time of abortion	166	51.9
Personal beliefs oppose abortion	151	47.2
Multiple emotional stressors preabortion	152	48.0
Kept pregnancy/ abortion a secret	121	37.8

REFERENCES

Angelo, J. (1992) Psychiatric sequelae of abortion: The many faces of Post-Abortion Grief. *Linacre Quarterly*, 59:2, 69-80.

Bagarozzi, D. (1993) Post traumatic stress disorders in women following abortion: Some considerations and implications for marital/couple therapy. *International Journal of Family and Marriage* 1:51-68.

Barnard, C. (1990) *The Long Term Psychosocial Effects of Abortion.* Institute for Pregnancy Loss. Stratham, New Hampshire.

Breslau, N., Davis, G., Andreski, P. & Peterson, E. (1991) Traumatic events & posttraumatic

stress disorder in an urban population of young adults. *Archives of General Psychiatry* **48:** 216-222.

Congleton, G. and Calhoun, L. (1993) Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations. *International Journal of Social Psychiatry* **39**:255-265.

Conklin, M. and O'Connor, B. (1995) Beliefs about the fetus as a moderator of postabortion psychological well-being. *Journal of Social Psychiatry* **39**: 76-81.

Foy, D., Osato, S., Houskamp, B. & Neuman, D. (1992) Etiology of posttraumatic stress disorder. In P. Saigh (ed.), *Posttraumatic Stress Disorder* (pp. 28-49). Boston: Allyn & Bacon.

Franco, K. et al. (1989) Anniversary reactions and due date responses following abortion. *Psychotherapy and Psychosomatics 52:151-154.*

Gilchrist, A., Hannaford, P., Frank, P., and Kay, C. (1995) Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry 167:243-248.*

Gissler, M., Hemminki, E., and Lönnqvist, J. (1996) Suicides after pregnancy in Finland, 1987-94: Register linkage. *British Medical Journal* **313**:1-11.

Ney, P. & Wickett, A. (1989) Mental health and abortion: Review and analysis. *Psychiatric Journal of the University of Ottawa,* 14:4, 506-516.

Reardon, D. ((1988). Aborted Women: Silent No More. Westchester, Ill.: Crossway.

Reardon, D. & Ney, P. (2000) Abortion and subsequent substance abuse. *American Journal of Drug and Alcohol Abuse.* 26:1, 61-75.

Rue, V. (1995) Post-Abortion Syndrome: A Variant of post-traumatic stress disorder. In P. Doherty (ed.) *Post-Abortion Syndrome: Its Wide Ramifications.* Dublin: Four Courts Press, 15-28.

Rue, V. et al. (forthcoming) Abortion & Trauma: Controversy, Diagnosis & Treatment. Unpublished manuscript.

Soderberg, H., Janzon, L. & Sjoberg, N. (1998) Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmo, Sweden. *European Journal of Obstetrics & Gynecology, 79, 173-178*

Speckhard, A. (1997) Traumatic death in pregnancy: The significance of meaning and attachment. In Figley, C., Bride, B. & Mazza, N. (Eds.) *Death & Trauma: The Traumatology of Grieving.* Washington, D.C.: Taylor & Francis, 67-100.

Speckhard, A. & Rue, V. (1992) Postabortion syndrome: An emerging public health concern. *Journal of Social Issues*, 48 95-120.

Torre-Bueno, A. (1996) *Peace after abortion.* San Diego: Pimpernel Press.

HB

113

22-LS0418\O
Ford
3/19/01

CS FOR HOUSE BILL NO. 113( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GREEN, Dyson

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

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

*** Section 1.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose certificate of authority was surrendered, suspended, or revoked during the year and the cause of surrender, suspension, or revocation;

(3) the name of each insurer authorized to do business in this state

against which delinquency or similar proceedings were instituted and, if against an insurer domiciled in this state, a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance or the office of director;

(7) statistical information regarding health insurance, including the number of individual and group policies sold or terminated in the state; this paragraph does not authorize the director to require an insurer to release proprietary information; [AND]

(8) **the annual percentage of health claims paid in the state that meets the requirements of AS 21.54.020(a) and (d); and**

(9) other pertinent information and matters the director considers proper.

* **Sec. 2.** AS 21.54.020 is repealed and reenacted to read:

Sec. 21.54.020. Required insurer payment for hospital and medical services. (a) A health care insurer shall pay indemnities under a group health insurance policy or subscriber benefits under a group hospital or medical service subscriber contract, whether or not services were provided by participant providers, within 30 calendar days after the health care insurer or a third-party administrator under contract with a health care insurer receives a clean claim.

(b) If a claim is not paid within 30 calendar days as required under (a) of this section, the health care insurer shall give notice of the specific items necessary for the claim to be adjudicated to the covered person and, if the claim was assigned or if the covered person elected direct payment under (e) of this section, to the provider of the hospital, nursing, medical, dental, or surgical services. Notice required under this subsection is required to be given by the date specified for payment of an indemnity under (a) of this section.

(c) If notice of the specific items necessary for a claim to be adjudicated is not given as required in (b) of this section, the claim is presumed to be a clean claim, and interest accrues beginning on the day following the day notice is due and shall be added to the claim until the claim is paid. The rate of interest required under this subsection is the maximum rate provided for the financing of premiums under AS 06.40.120. If a claim made is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(d) A claim for which a health care insurer provides appropriate notice of a deficiency under (b) of this section must be paid within 30 days after receipt of the claim or 15 calendar days after receipt of those items listed as being deficient, whichever period is longer. If payment is not made within the time period required under this subsection, the claim is presumed to be a clean claim, interest accrues at the rate allowed in (c) of this section, and the interest shall be added to the claim until the claim is paid. If a claim is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(e) Upon written request of a covered person, a health care insurer shall pay amounts due under (a), (b), (c), or (d) of this section directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the health care insurer makes a claim payment to the covered person after the covered person has given written notice electing direct payment to the provider of the service, the health care insurer shall also pay that amount to the provider of the service.

(f) A covered person may revoke an election of direct claim payment made under (e) of this section by giving written notice of the revocation to the health care insurer and to the provider of the service. The written notice of revocation to the health care insurer must certify that the covered person has given written notice of revocation to the provider of the service. Revocation of an election of direct claim payment is not effective until the notice of revocation is received by the health care

insurer and the provider of the service, whichever date is later.

(g) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred by a qualified domestic relations order to a person who is not the covered person. Rights under the qualified domestic relations order do not take effect until the order is received by the health care insurer. In this subsection, "qualified domestic relations order" means an order or judgment in a divorce or dissolution action under AS 25.24 that designates a person to determine to whom indemnities for a covered person should be paid under a health insurance policy.

(h) This section does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or a covered person.

(i) For the purpose of this section, a claim shall be considered paid on the day payment is either mailed or transmitted electronically.

(j) If interest is required to be added to a claim under (c) or (d) of this section, the amount added may not be included when calculating an applicable cap on benefits payable to the covered person or other person claiming payments under the health insurance policy.

(k) In this section, "clean claim" means a claim that does not have a defect, impropriety, or circumstance requiring special treatment that precludes timely payment on the claim.

* **Sec. 3.** AS 25.24.160(b) is amended to read:

(b) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the requirements of a qualified domestic relations order under the definition of that phrase that is applicable to those provisions.

* **Sec. 4.** AS 25.24.230(h) is amended to read:

(h) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the requirements of a qualified domestic relations order under the definition of that phrase

that is applicable to those provisions.

* **Sec. 5.** This Act takes effect January 1, 2002.

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: March 7, 2001 **FURTHER REFERRALS:**

Date of Committee Action: _____

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 113**

HOUSE BILL NO. 113 **HEALTH CARE INSURANCE PAYMENTS**

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

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

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

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

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

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

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
John Coghill	Coghill	a			
Gary Wilson	Wilson	V			
Vic Kohring	Kohring		X		
Tom Stevens	Stevens	✓			
Con Bunde	CISSNA	V			
Chair: Ethan Dyson	DYSON	✓			
Chair:					

D

HOUSE COMMITTEE REPORT

3.7.01

(7)

Date Referred to Committee: February 5, 2001 **FURTHER REFERRALS: HES**

Date of Committee Action: 2/28/01

The LABOR AND COMMERCE Committee considered: **HB 113**

HOUSE BILL NO. 113 **HEALTH CARE INSURANCE PAYMENTS**

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

Recommends it be replaced with ____CS HB113 (L+C) [X] **Same Title** [ ] **New Title**

*For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR*____

[ ] attach amendments

[ ] add new referral to _____ Committee

[ ] Letter of Intent _____Committee

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

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

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

Signing with recommendations	Printed Last Name	DP (3)	DNP	NR (2)	AM (1)
	HALCRO			✓	
	CRAWFORD	✓			
	HAYES	✓			
	Meyer	✓			
	Rokeberg				✓
				=	
Chair:					
Chair:	MurKowski			✓	

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MEMBER, MILITARY & VETERAN AFFAIRS

BUDGET SUBCOMMITTEES
ALASKA COURT SYSTEM
DEPT. OF CORRECTIONS
DEPT. OF LAW

Representative Joe Green
District 10

MEMORANDUM

To: The Honorable Fred Dyson, Chair
House Health, Education and Social Services Committee

From: Representative Joe Green

Date: March 2, 2001

Subject: HB 113
"Prompt pay for health care insurance payments"

I respectfully request that you schedule HB 113 for a hearing before the House Health, Education and Social Services Committee at your earliest convenience.

Attached are:

1. CS for House Bill 113 (L&C)
2. Sponsor Statement
3. Back-up materials

Thank you for your consideration of this request.

Alaska State Legislature

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Representative Joe Green
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SPONSOR STATEMENT

HOUSE BILL 113

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

House Bill 113 builds upon a national trend to develop fair payment provisions that enable health insurance companies to make sound business decisions while ensuring that patients receive benefit payments in an appropriate time frame. This concept of "prompt pay" legislation has been successfully adopted and implemented by 39 states.

House Bill 113 requires health insurers to pay benefits within thirty calendar days of receiving a "clean claim". If a payment is not made on time, the insurer is charged interest on the outstanding claim. HB 113 also establishes a definition for "clean claim" that recognizes an insurance company's need to make payment decisions based upon complete and accurate information.

22-LS0418\L
Ford
3/14/01

CS FOR HOUSE BILL NO. 113( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GREEN, Dyson

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

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

*** Section 1.** AS 21.06.087(a) is amended to read:

(a) The director shall require reporting of and shall compile information necessary to

(1) evaluate the effect of the measures enacted in chapter 26, SLA 1997, on the availability and cost of insurance in the state; and

(2) implement the claims reporting requirements under AS 21.54.020(i).

*** Sec. 2.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing,

with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose certificate of authority was surrendered, suspended, or revoked during the year and the cause of surrender, suspension, or revocation;

(3) the name of each insurer authorized to do business in this state against which delinquency or similar proceedings were instituted and, if against an insurer domiciled in this state, a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance or the office of director;

(7) statistical information regarding health insurance, including the number of individual and group policies sold or terminated in the state; this paragraph does not authorize the director to require an insurer to release proprietary information; [AND]

(8) **the annual percentage of health claims paid in the state that meets the requirements of AS 21.54.020(a) and (d); and**

(9) other pertinent information and matters the director considers proper.

*** Sec. 3.** AS 21.54.020 is repealed and reenacted to read:

Sec. 21.54.020. Required insurer payment for hospital and medical services. (a) A health care insurer shall pay indemnities under a group health insurance policy or subscriber benefits under a group hospital or medical service subscriber contract, whether or not services were provided by participant providers, within 30 calendar days after the health care insurer or a third-party administrator under contract with a health care insurer receives a clean claim.

(b) If a claim is not paid as required under (a) of this section, the health care insurer shall give notice of the specific items necessary for the claim to be adjudicated to the covered person and, if the claim was assigned or if the covered person elected direct payment under (e) of this section, to the provider of the hospital, nursing, medical, dental, or surgical services. Notice required under this subsection is required to be given by the date specified for payment of an indemnity under (a) of this section.

(c) If notice of the specific items necessary for a claim to be adjudicated is not given as required in (b) of this section, the claim is presumed to be a clean claim, and interest accrues beginning on the day following the day notice is due and shall be added to the claim until the claim is paid. The rate of interest required under this subsection is the maximum rate provided for the financing of premiums under AS 06.40.120. If a claim made is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(d) A claim for which a health care insurer provides appropriate notice of a deficiency under (b) of this section must be paid within 30 days after receipt of the claim or 15 calendar days after receipt of those items listed as being deficient, whichever period is longer. If payment is not made within the time period required under this subsection, the claim is presumed to be a clean claim, interest accrues at the rate allowed in (c) of this section, and the interest shall be added to the claim until the claim is paid. If a claim is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(e) Upon written request of a covered person, a health care insurer shall pay amounts due under (a), (b), (c), or (d) of this section directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the health care insurer makes a claim payment to the covered person after the covered person has given written notice electing direct payment to the provider of the service, the health care insurer shall also pay that amount to the provider of the service.

(f) A covered person may revoke an election of direct claim payment made under (e) of this section by giving written notice of the revocation to the health care insurer and to the provider of the service. The written notice of revocation to the health care insurer must certify that the covered person has given written notice of revocation to the provider of the service. Revocation of an election of direct claim payment is not effective until the notice of revocation is received by the health care insurer and the provider of the service, whichever date is later.

(g) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred by a qualified domestic relations order to a person who is not the covered person. Rights under the qualified domestic relations order do not take effect until the order is received by the health care insurer. In this subsection, "qualified domestic relations order" means an order or judgment in a divorce or dissolution action under AS 25.24 that designates a person to determine to whom indemnities for a covered person should be paid under a health insurance policy.

(h) This section does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or a covered person.

(i) Within 30 working days after the end of each calendar quarter, a health care insurer shall file with the director a report that shows, for the previous calendar quarter, the percentage of claims paid in this state during that quarter that meets the time limits imposed under (a) and (d) of this section.

(j) For the purpose of this section, a claim shall be considered paid on the day payment is either mailed or transmitted electronically.

(k) If interest is required to be added to a claim under (c) or (d) of this section, the amount added may not be included when calculating an applicable cap on benefits payable to the covered person or other person claiming payments under the health insurance policy.

(l) In this section,

(1) "calendar quarter" has the meaning given in AS 23.20.520;

(2) "clean claim" means a claim that does not have a defect, impropriety, or circumstance requiring special treatment that precludes timely

payment on the claim.

* **Sec. 4.** AS 25.24.160(b) is amended to read:

(b) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the requirements of a qualified domestic relations order under the definition of that phrase that is applicable to those provisions.

* **Sec. 5.** AS 25.24.230(h) is amended to read:

(h) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the requirements of a qualified domestic relations order under the definition of that phrase that is applicable to those provisions.

* **Sec. 6.** This Act takes effect January 1, 2002.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSHB 113(L&C)
(H) Publish Date: 3/7/01

Revision Date/Time (Note if correction): _____
Dept. Affected: Administration
Title: An Act relating to health care insurance payments for hospital or medical...
BRU: Centralized Administrative Services
Component: Retirement and Benefits
Sponsor: Representative Green
Requester: L&C
Component Number: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2001) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation requires an insurer to pay "clean claims" within 10 or 20 working days of receipt, depending on filing method. If not, interest is assessed. The bill would also require an insurer who mistakenly pays a member instead of the provider to make a second payment to the provider and then attempt recovery from the member. These changes could increase administrative overhead and claims costs. We currently require Aetna, our third party administrator, to pay 80% of claims within 12 calendar days. If not, penalties are assessed on Aetna for late payment. The penalties come to the plan (not providers).

Continued on page 2

Prepared by: Guy Bell, Director
Phone 465-4471
Division Retirement and Benefits
Date/Time February 23, 2001
Approved by: Commissioner Jim Duncan
Date February 23, 2001
Agency Department of Administration

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COMMITTEE COPY

Fiscal Note HB 113 (L & C) – Continued

In addition, the bill does not clearly define a "clean claim." Without a clear definition, we are concerned about added administrative overhead.

The State's contribution as an employer is capped by collective bargaining agreements and by statute for non covered employees. Any increase in cost will be borne by employees.

COMMITTEE:HOUSE HEALTH, EDUCATION & SOCIAL SERVICES	SUBJECT: HB 113-HEALTH CARE INSURANCE PAYMENTS

DATE: March 20, 2001

PLEASE SIGN IN

PLEASE PRINT: NAME & TITLE	ADDRESS (MAILING & ZIP)	PHONE	REPRESENTING (No Acronyms, Please)	DO YOU WANT TO TESTIFY ?
[redacted]	[redacted]	[redacted]	[redacted]	
Jim Henkelman	YKHC- 2957 Ych Dr Ank	230-6693	Yukon Kuskokwim Health Corp	
Katie Campbell	Div of Ins	465-4607	Div of Ins	

HB

114

Representative Mary Sattler Kapsner
State Capitol • Juneau, Alaska 99801-1182
Phone: (907) 465-4942 • Fax: (907) 465-4589
E-Mail: Representative Mary_Kapsner@legis.state.ak.us

House District 39
Lower Kuskokwim and Upper Bristol Bay

Resources Committee
Fisheries Committee
Regulation Review Committee

Akiachak
Akiak
Aleknagik
Atmautluak
Bethel
Chefornak
Clarks Point
Dillingham
Eek
Ekuk
Ekwok
Goodnews Bay
Kasigluk
Kipnuk
Kolignanek
Kongiganak
Kwethluk
Kwigillingok
Manokotak
Napakiak
Napaskiak
New Stuyahok
Nunapitchuk
Oscarville
Platinum
Portage Creek
Quinhagak
Togiak
Tuntutuliak
Twin Hills

MEMORANDUM

TO: REPRESENTATIVE FRED DYSON
Chairman-HESS Committee

FROM: REPRESENTATIVE MARY KAPSNER

DATE: February 19, 2001

RE: HESS Hearing on HOUSE BILL 114 "An Act related to abuse of inhalants."

I would like to request an initial hearing on House Bill 114, "An Act related to abuse of Inhalants" in the Health, Education & Social Services Committee. I have attached a copy of the bill and my sponsor statement for your review. Additional supportive material will be forthcoming later in the week.

As you may be aware, I introduced this bill last session and it passed both the HESS and Judiciary Committees and was on its way to Finance at session's end. I have reintroduced the bill again and HESS is the first committee assignment. Feel free to contact me or my staff if you have any questions.

Thank you.

22-LS0130\C.3
Luckhaupt
3/14/01

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 114

Page 5, lines 26 - 31:

Delete

"(1) "alcoholic **or inhalant** or drug abuser" means a person who demonstrates increased tolerance to alcohol**, inhalants,** or drugs, who suffers from withdrawal when alcohol**, inhalants,** or drugs are not ava'lable, whose habitual lack of self-control concerning the use of alcohol**, inhalants,** or drugs causes significant hazard to the person's health, and who continues to use alcohol**, inhalants,** or drugs despite the adverse consequences;"

Insert

"(1) "alcoholic **or inhalant** or drug abuser" means a person who

(A) demonstrates increased tolerance to alcohol**, inhalants,** or drugs, who suffers from withdrawal when alcohol**, inhalants,** or drugs are not available, whose habitual lack of self-control concerning the use of alcohol**, inhalants,** or drugs causes significant hazard to the person's health, and who continues to use alcohol**, inhalants,** or drugs despite the adverse consequences; **or**

(B) uses inhalants on a more than occasional basis, whose use of inhalants has caused significant adverse consequences to the person's health or whose use of inhalants is likely to cause a significant hazard to the person's life or health, and whose use of inhalants impairs the person's judgment to such a degree that the person continues to use inhalants despite the adverse consequences or hazards;"

22-LS0130\C.2
Luckhaupt
3/13/01

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE KAPSNER

TO: HB 114

Page 1, line 1, following "**inhalants**":

Insert "**; and relating to minors under the influence of alcohol, inhalants, or drugs**"

Page 2, following line 3:

Insert a new bill section to read:

"* **Sec. 2.** AS 47.10 is amended by adding a new section to read:

Sec. 47.10.137. Intoxicated minors. (a) A peace officer shall take into protective custody a minor who the peace officer has reasonable cause to believe is under the influence of alcohol, inhalants, or drugs if the minor is not otherwise subject to arrest or detention.

(b) A peace officer taking into protective custody a minor under (a) of this section shall

(1) return the minor to the minor's parent or guardian or, if the minor's parent or guardian is unknown or unavailable, take the child to a relative or to a shelter, program, or facility suitable for the minor;

(2) use the procedures provided in AS 47.37.170 for a person incapacitated by alcohol, inhalants, or drugs if the minor appears to be incapacitated, and the peace officer may use the procedures provided in AS 47.37.170 for an intoxicated person if the minor appears to be intoxicated; in this paragraph, "incapacitated by alcohol, inhalants, or drugs" and "intoxicated person" have the meanings given in AS 47.37.270;

(3) deliver the minor to another suitable location and promptly notify the Department of Health and Social Services of the placement."

Renumber the following bill sections accordingly.

22-LS0130\C.1
Luckhaupt
2/28/01

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 114

Page 1, line 5:

Delete "crime"

Insert "offense"

Page 2, lines 1 – 3:

Delete all material and insert:

"(d) Abuse of inhalants is a violation."

Representative Mary Sattler Kapsner
State Capitol • Juneau, Alaska 99801-1182
Phone: (907) 465-4942 • Fax: (907) 465-4589
E-Mail: Representative Mary_Kapsner@legis.state.ak.us

House District 39
Lower Kuskowkim and Upper Bristol Bay

Resources Committee
Fisheries Committee
Regulation Review Committee

Akiachak
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Goodnews Bay
Kasigluk
Kipnuk
Kolignanek
Kongiganak
Kwethluk
Kwigillingok
Manokotak
Napakiak
Napaskiak
New Stuyahok
Nunapitchuk
Oscarville
Platinum
Portage Creek
Quinhagak
Togiak
Tuntutuliak
Twin Hills

Sponsor Statement

HOUSE BILL NO. 114
"An Act relating to the abuse of Inhalants"

House Bill 114 targets a problem in Alaska that has been neglected for many years. It will provide public safety officials, medical personnel and the courts leverage to place individuals who use and abuse inhalants into rehabilitation. I introduced HB 114 after listening to the concerns of many providers working with young people and to VPSO's who feel they have no tools to intervene when they see someone huffing.

Although the abuse of inhalants is not a new problem, it is reaching rampant proportions throughout Alaska and among youth across the nation. As of January 1999, twenty-four states have passed laws addressing inhalant problems. These laws vary greatly in content, ranging from sending individuals to treatment to criminalizing the behavior.

One of the problems in forging a direction to deal with inhalant abuse is the lack of appropriate treatment facilities. Most substance abuse treatment programs are geared toward problems of alcohol and drugs. Nationally, there are only two residential treatment facilities designed for inhalant abusers, in Texas and South Dakota. Thanks to the efforts of Senators Frank Murkowski and Ted Stevens, the Yukon Kuskokwim Health Corporation in Southwest Alaska received a grant in 1999 to build an inhalant abuse treatment facility. Construction of the facility is presently underway with completion scheduled for August 2001.

A 1998 survey by the YKHC found that during 1996 and 1997, 161 Alaskan sought treatment for inhalant abuse at drug and alcohol programs. During the same period they found 46 people with a history of inhalant abuse died. A 1993 study by the Indian Health Service in Alaska looked at the cost to society if inhalant abusers are left untreated. That study found that a 19 year old with a chronic history of inhalant abuse and significant brain or organic damage will cost society $1.4 million over a lifetime of treatment, medical care, social services, law enforcement and court costs.

We are fortunate in Alaska to be at a threshold of a new era in addressing inhalant abuse with the coming residential treatment facility. I would hope the legislature takes a pro-active look at ways in which we can raise awareness and address statutory needs to complete a package approach that includes prevention, intervention and treatment.

Thank you for your consideration.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

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

MEMORANDUM February 22, 2001

SUBJECT: Sectional Summary of HB 114

TO: Representative Mary Kapsner
Attn: Trim Nick

FROM: Gerald P. Luckhaupt
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill - the bill itself is the best statement of its contents.

Section 1 and 2 of the bill deal with the new crime of abuse of inhalants. Section 1 creates the crime of abuse of inhalants, AS 11.76.200, and specifies the penalty for violation of that section as a class B misdemeanor.[1] This section further provides that a court "suspend the imposition of sentence [SIS], place the defendant on probation under AS 12.55.085, and require the defendant to successfully complete an inhalant abuse treatment program." If the defendant successfully completes the probation the SIS will result in the defendant not having a criminal conviction. Section 2 of the bill amends AS 47.12.030(b) to provide that minors who are accused of violating AS 11.76.200 will not be subject to the jurisdiction of the juvenile court but will be subject to the jurisdiction of the district court like juveniles charged with alcohol, tobacco, traffic, fish and game, parks, and curfew violations.

Sections 3 - 15 of the bill amend the Uniform Alcoholism and Intoxication Treatment Act, AS 47.37 by providing for intervention for those abusing, intoxicated by, or incapacitated by inhalants in the same manner as for those abusing, intoxicated by, or incapacitated by alcohol or drugs.

GPL:glc
01-191.glc

[1] The period of incarceration authorized for a class B misdemeanor may be found at AS 12.55.135. The fine authorized for a class B misdemeanor may be found at AS 12.55.035.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 114
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: Relating to abuse of inhalants
BRU: Juvenile Justice
Component: Probation Services
Sponsor: Representative Kapsner
Requester: House HES
Component Number: 2134

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	***	***	***	***	***	***
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	***	***	***	***	***	***

Estimate of any current year (FY2001) cost: 0.0

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

POSITIONS

Full-time						
Part-time						
Temporary						

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

***The Division has been unable to obtain any estimates as to the number of juvenile inhalant abusers we might expect to see sentenced to periods of incarceration for violation of this offense. Without an understanding of the extent of the problem, there is no reasonable way to estimate the fiscal impact on the youth facility budgets throughout the state. Because of the possibility of significant neurological impairment associated with inhalant abuse, even a small number of these offenders may tax the resources of our youth facilities. The Division is submitting an indeterminate fiscal note to indicate we believe there would be a fiscal impact, but there are too many unknowns to be able to calculate what that impact might be.

Amending this bill to make inhalant abuse a violation rather than a misdemeanor would negate the concern for the fiscal impact this bill would have on youth detention center services.

Prepared by: George Buhite
Phone 465-2212
Division Juvenile Justice
Date/Time 2/15/01 4:23 PM
Approved by: Elmer A. Lindstrom, Special Assistant
Date 2/22/01 8:41 AM
Agency Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 114
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: An Act relating to abuse of inhalants
BRU: Alcohol and Drug Abuse Svcs
Component: Alcohol and Drug Abuse Grants
Sponsor: Kapsner
Requester: House HESS
Component Number: 1239

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual	75.0	75.0				
Supplies						
Equipment						
Land & Structures						
Grants & Claims	289.0	289.0	289.0	289.0	289.0	289.0
Miscellaneous						
TOTAL OPERATING	**364.0**	**364.0**	**289.0**	**289.0**	**289.0**	**289.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	364.0	364.0	289.0	289.0	289.0	289.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**364.0**	**364.0**	**289.0**	**289.0**	**289.0**	**289.0**

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

If HB 114 is not amended it mandates treatment that is not available in many areas of the state. If not amended it is estimated that no more than 30 adults and 30 juveniles would required to enter treatment and have their sentence suspended in any given year. In a survey of persons in substance abuse treatment in August 1998 they found that 175 (31%) of 550 clients had a history of use of inhalants. It is difficult to determine from this how many might be arrested and sent to treatment in a given year. We feel that the numbers above represent a reasonable estimate.

Based on this number we would estimate a cost of 212.0 a year in added treatment costs. This is based on using intensive outpatient level of care and mandating contact with the person for at least one year. On the next page is the calculation for this cost.

Prepared by: Ernest Turner, Director
Phone 465-2071
Division: Alcoholism and Drug Abuse
Date/Time 2/20/ 01 4:45pm
Approved by: Elmer A. Lindstrom, Special Assistant
Date 2/22/01 8:37 AM
Agency: Department of Health & Social Services

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(Rev 11/2000 OMB)

ANALYSIS: (continued)

In addition, many programs would need specific training for providing this level of care to adult inhalant abusers. The estimated costs would be $75.0 for FY02 and FY03 for training to bring someone with appropriate expertise in both adult and adolescent treatment to Alaska, provide training in several rural sites and cover costs of follow-up visits to reinforce training. This would also leave us with trained persons, a developed curriculum and allow for future training to be done by persons already trained in Alaska.

Phase I Intensive Outpatient 6 weeks	
Assessment	$100
10 Hours intensive outpatient/week @$45	$2,700
Two written reports for courts	$60
Total Phase I costs	$2,860
Phase II Continuing Care 20/weeks	
1 group per week @$20	$400
Five care coordination of 30 min.	$75
Five written reports for courts	$150
Total Phase II costs	$625
Phase III Extended Continuing Care 26 weeks	
1 group every 2 weeks @$20	$260
Six care coordination of 30 min.	$90
Six written reports for courts	$180
Total Phase III costs	$530

Total 12 month costs including indirect costs @20% $4,818

States with Current Inhalant Statutes

Confirmed as of January 1999

Arizona	13-3403—Possession and sale of a vapor releasing substance containing a toxic substance; regulation of sale; exceptions; classification.
Arkansas	5-64-12—Nitrous Oxide-possession, distribution, exemptions.
California	Penal Code. Title 10. Sec 380-1.—Regulates toluene.
Colorado	18-18-412—Abusing toxic vapors-prohibited.
Florida	877.111—Inhalation, ingestion, possession, sale purchase or transfer of harmful chemical substances; penalties.
Hawaii	712-1250—Promoting intoxicating compounds.
Idaho	18-1502B—Possession of inhalants by minors.
Indiana	35-46-6—Glue Sniffing.
Kentucky	217.900—Volatile substance defined-Inhalation unlawful. 217.902—Repackaging volatile substances.
Louisiana	§93.1—Model glue; use of; abuse of toxic vapors; unlawful sales to minors; penalties.
Maine	22§2383-C—Unlawful use or possession of inhalants.
Maryland	27-301—"It is unlawful for any person to deliberately smell or inhale substances or chemicals..."
Massachusetts	270-18— Substances having property off releasing toxic vapors; sale, possession and use; 270-19—Sale of glue or cement to minors; smelling deterrent ingredients; register.
Nebraska	28-419—Inhaling or drinking certain compounds; unlawful. 28-420—Selling and offering for sale certain compounds; use; knowledge of seller; unlawful. 28-421—Act, exceptions. 28-422—Selling or offering for sale certain compounds; register; maintain for one year. 28-423—Inducing or enticing; violation. 28-424—Violations; penalty.

Nevada	454.346—Use or possession with intent to use drug, chemical, poison or organic solvent to induce euphoria or hallucinations unlawful; exception.
New Hampshire	644.5a—Inhaling toxic vapors for effect.
New Jersey	2C:35-10.4—Toxic chemicals.
North Carolina	90-113.8A through 113.14—North Carolina Toxic Vapors Act
Ohio	2925.31—harmful intoxicant 2925.32—nitrous oxide
Oregon	1999 Ch. 229. (HB 3276)—Relating to inhalants; and declaring an emergency.
Rhode Island	Ch. 11-48—Substances releasing toxic vapors.
Texas	Health and Safety Code Chapter 484—Inhalants. Chapter 485—Abusable glues and aerosol paints.
Virginia	18.2-264—Inhaling drugs or other noxious chemical substances or causing, etc., others to do so.
Wisconsin	134.63—Nitrous oxide; restrictions on sales; records of certain sales; labeling. 346.935—Intoxicants in motor vehicles. 941.315—Possession, distribution or delivery of nitrous oxide.

STATE INHALANT LEGISLATION

NOTE: The following information was compiled by the National Conference on State Legislatures and may not be a complete report on legislative efforts.

* indicates state which provides a fine, jail time or treatment option for violation of inhalant laws

State	Law Prohibits	Substances Prohibited	Fine	Jail	Treatment
Arizona	sale, transfer, or offer to sell to minor	vapor releasing substance containing toxic substance	*	*	
California	sale, distribution, dispensation, possession to minor	toluene, materials containing toluene, nitrous oxide	*	*	
Colorado	inhaling certain compounds for intoxication	general prohibition of inhalable compounds			
Connecticut	sale, distribution to minor	nitrous oxide, including "whippet kits"	*		
Georgia	general inhalants; also prosecutes inhalants under DUI law	general prohibition of inhalable compounds	*	*	
Florida	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
Hawaii	knowingly selling tolulol or inhalable compounds to minors	liquid/chemical containing toluol, inhalable substances			
Idaho	possession by minors or use of inhalant for intoxification	aerosol spray, other inhalant	*	*	
Illinois	knowingly sell, offer or deliver to minor	liquid/chemical containing toluol, inhalable substances			
Iowa	sale, distribution or use for the purpose of intoxification	nitrous oxide	*	*	
Kentucky	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
Louisiana	prohibits sale or transfer of possession to minor	model glue, inhalable toluene substances	*	*	
New Mexico	sale to minors; inhaling or possessing for intoxification	model glue, aerosol spray, & chemicals for intoxication	*	*	*

Maine	inhaling toxic vapors for effect; sale or distribution for purpose of intoxification to minor	general prohibition of inhalable compounds	*		*
Maryland	distribution, instruction to minor; sale or distribution to minor	drugs/noxious substances, including butyl nitrite & butane	*	*	
Massachusetts	retailers must require ID for sale and maintain register of minors which is available for police inspection; inhalants are required to have noxious deterrents against intoxification	glue or cement	*	*	
Michigan	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
Minnesota	sale to minors; use and possession for intoxification; businesses must post signs stating it is illegal to sell butane/butane lighters to minors	general inhalable compounds, butane/butane lighters			
Mississippi	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
Nebraska	nhaling certain compounds for intoxification; retailers must maintain registry of sale	general inhalable compounds			
New Hampshire	inhaling certain compounds for intoxification	toxic vapors, not including anesthesia			*
New Jersey	sell or offer to sell to minors	product containing chlorofluorocarbon that is used in refrigerant			
Nevada	sale or offer to give to minors	aerosol paint, glue, cement containing toluene	*		
North Carolina	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
North Dakota	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			
Ohio	inhaling certain compounds for intoxification	general prohibition of inhalable compounds			

Oklahoma	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
Oregon	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
Pennsylvania	inhaling certain compounds for intoxification	general prohibition of inhalable compounds; butane/canisters		
Rhode Island	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
South Carolina	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
South Dakota	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
Tennessee	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
Texas	possess, sell or buy; businesses required to post warning signage & pay license fees designated for prevention fund	abusable volatile chemicals	*	*
Utah	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		
Vermont	inhaling fumes for effect	certain hazardous inhalants, glues	*	
Virginia	inhaling certain compounds for intoxification	general prohibition of inhalable compounds		

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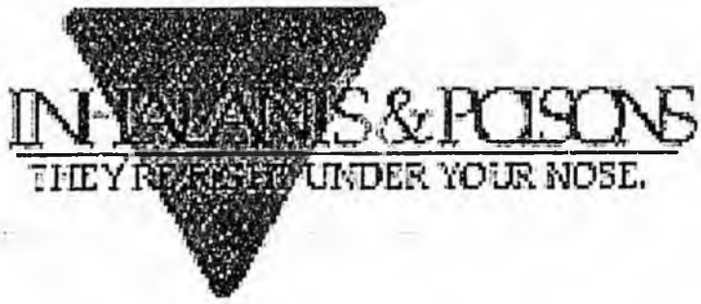


Inhalants FACT SHEET
February 20, 2001

- Inhalants are not drugs. They are toxic chemicals that when used inappropriately, such as by sniffing or "huffing" the vapors, can cause toxic effects, similar to the "high" obtained with drugs.
- Inhalants can kill the very first time they are used. Death is usually from heart failure or suffocation.
- Inhalant highs are the result of intensive penetration of toxic chemicals into the brain tissue, where they are capable of causing irreversible damage.
- In addition to brain, liver, lung and bone marrow damage, there is evidence that chronic abuse of some inhalants causes chromosome and fetal damage.
- Inhalants are the fourth most abused substance after alcohol, tobacco, and marijuana among high school students.
- A 1999 nationwide survey of students indicates that 19.5% of eighth graders have used inhalants compared to 22% who have used marijuana/hashish.
- However, there are Alaska communities where it is reported that up to 90% of the elementary school students have tried or are using inhalants.
- Chronic inhalant users can suffer severe and permanent brain damage; some die the first time they try it; other possible risks include loss of consciousness and irreversible damage to the liver, kidneys and bone marrow.
- Inhalants are often a "gateway" to the abuse of other illicit substances. 70% of one group of substance abusers, in treatment, indicated they had started with inhalants and 50% of those indicated they would go back to inhalants (primarily gas) if alcohol was not available.
- More than 1,400 common, useful and legal household, office and classroom products can be used to "get high".
- Every year kids die from inhalant use, but many parents and educators remain ignorant of this silent epidemic.
- Because the chemicals in inhalants enter the lungs in such high concentrations, they have a more formidable toxic profile than other types of abused drugs.
- Inhalant treatment is significantly more complex than most drug abuse treatment. The toxic chemicals remain in the body tissues for extended periods of time, resulting in the need for a four to six week period of detoxification, prior to actual intensive treatment having much positive effect.
- Youth with a history of chronic inhalant use have strikingly high rates of relapse. Because of the difficult problems associated with inhalant abuse treatment, these youth are often excluded from some drug abuse programs.
- Chronic inhalant users may suffer withdrawal symptoms, including: hand tremors, chronic headaches, nervousness, anxiety and excessive sweating.

National Inhalant Prevention Coalition
2904 Kerby Lane, Austin, Texas 78703 ▼ phone: 800.269.4237 ▼ fax: 512.477.3932 ▼ e-mail: nipc@io.com

Signs of Use	*Harmful Effects*
There is a common link between inhalant abuse and problems in school – failing grades, chronic absences and general apathy. Other signs include the following:	Potential long-term effects of inhalant use include:
▼ Paint or stains on body, clothing, rags or bags ▼ Spots or sores around the mouth ▼ Red or runny eyes or nose ▼ Chemical breath odor ▼ Drunk, dazed or dizzy appearance ▼ Nausea, loss of appetite ▼ Anxiety, excitability, irritability ▼ Restlessness or unexplained moodiness and anger outbursts ▼ Missing abusable household items ▼ Slurred or disoriented speech	▼ Short-term memory loss ▼ Hearing loss ▼ Limb spasms ▼ Permanent brain damage ▼ Bone marrow damage ▼ Liver and kidney damage ▼ Possible fetal effects similar to fetal alcohol syndrome ▼ Intoxication ▼ Death
Typical Profile of an Inhalant Abuser	*RESOURCES*
There is no typical profile of an inhalant abuser. Sniffers and huffers are represented by both sexes and all socioeconomic groups throughout the country and Alaska. It is not unusual to see elementary and middle-school age youth involved with inhalant abuse. Although often typified as a "rural" problem, the misuse of inhalable products, besides gas, is, unfortunately, very common in schools and homes throughout both urban and rural Alaska.	Local Substance Abuse Programs Local Community Mental Health Services Programs Yukon-Kuskokwim Health Corporation Inhalant Intervention Project, Bethel, Alaska - Jim Henkelman, Statewide Outreach Coordinator - Toll Free: 866-HUFFING [483-3464] - Or: 907-230-6693 National Inhalant Prevention Coalition 1-800-269-4237, or on the World Wide Web at: http://www.inhalants.org National Drug and Alcohol Treatment Referral Service – 1-800-662-HELP National Clearinghouse for Alcohol and Drug Information – 1-800-729-6686 http://www.health.org

Inhalant Abuse in Alaska
Fast Facts

- The Division on Alcoholism and Drug Abuse convened an Inhalant Abuse Steering Committee March 12, 1998. The Committee was composed of representatives from, The Alaska Rural and Native Drug and Alcohol Programs (ARANDAP), the Substance Abuse Directors Association (SADA), the Yukon Kuskokwim Health Corporation, the Advisory Board on Alcoholism and Drug Abuse, the Department of Education, and the Division of Alcoholism and Drug Abuse. The Committee submitted its Preliminary Report and Recommendations, October 30, 1998.

- Potential data sources were identified, including The Alaska Trauma Registry, Vital Statistics-Death Certificates, the Youth Risk Behavior Survey, and ADA's Management Information System - Treatment Client Admission data. Additionally, data was sought from the Tribal Courts and the Youth Courts within the State of Alaska. All data sources had limitations.

- The Alaska Trauma Registry collects information on all injuries resulting in admission to an Alaska hospital. Therefore it does not include patients stabilized without hospitalization or those served by clinics. The data goes back to 1991. However, they only began collecting poisoning data as of July 1993. For the time period July 1993 – December 1996 for people under the age of 20, only two cases were found. They were, one 12-year-old sniffing gas in 1993, and one 15-year-old huffing gas with friends in 1995.

- Vital Statistics data from Death Certificates indicated 9 deaths attributable to inhalants in the past ten years. Age at time of death ranged from 12 to 62 years. The major limitation of the Death Certificate data is the manner in which deaths are coded. For example if someone inhaled gasoline while in a boat, got high, fell overboard, and drowned, it would be coded as a drowning accident.

- The Youth Risk Behavior Survey (YRBS) for 1995 indicates that 22.2% of high school students indicated that they had ever sniffed glue, breathed the contents of spray cans or inhaled paints or sprays to get high, as compared to 20.3% nationally. Middle School (7-8th grade) students surveyed indicated that 19.6% of students reported ever using inhalants.

- Client Treatment Admission data for the past six years was reviewed for primary, secondary, and tertiary problem. The data for FY 98 indicates that 46 admissions had inhalants as a primary problem, 18 as a secondary problem, and 34 as a tertiary problem upon admission to treatment. The major limitation of this Treatment Admission data is that up until July 1998 only the Primary Problem data field was required. Up until that time a secondary or tertiary problem with inhalants might not have been indicated.

- To supplement the existing data, the Steering Committee designed two separate survey instruments, one for youth and one for adults. The protocol called for the survey to be

distributed to all division funded treatment programs for administration to all active clients during one seven day period. The week selected (by convenience) was August 9-15, 1998. This was a "snap shot" sample, which can be compared to data gathered in the future. From the distribution of the surveys, 550 adult and 91 youth responses were captured, representing better than 80% of active clients during the survey week.

- Of the 550 adults responding (age 18 and above), 175 (31.8%) said they had used an inhalant at some time. Of those who had said yes to use, 16 (9.1%) reported having used an inhalant within the past 12 months. The youngest reported age of use was four and the oldest reported age of use was 61. The average number of years using an inhalant reported was 5.8, with a range of using from less than 1 year to using inhalants for 28 years. Also, of the adults who reported having used and inhalant (175) at some point, only 41 (23.4%) reported using only one or two times. Leaving 134 (76.6%) with a reported history of use beyond experimentation.

- Of the 91 youth (age 17 and below) responding, 48 (52.7%) said they had used an inhalant at some time. Of those who had said yes to use, 29 (60.4%) reported having used an inhalant within the past 12 months. The youngest reported age of use was eight and the oldest reported age of use was 17. Of all those who responded to the survey (whether answering yes or no to use) 67.8% reported having friends who used inhalants, and 32.2% reported having friends who were experiencing problems related to inhalant use.

- July 1, 1989 the powers and duties of the Division of Alcoholism and Drug Abuse were extended to include programs and activities relating to the misuse of hazardous volatile substances by inhalant abusers. This was done through an amendment to Title 47. Since that time, the Division has funded three public information campaigns designed specifically to educate parents and children about the harmful effects of inhalants.

- The Division does not fund any treatment programs that address inhalant abusers only. Several of the treatment programs however, have internal expertise for this population and address these client needs in the larger milieu. There are only two specialized treatment programs in the nation, both of which were initially federally funded as demonstration projects. One is for adults (Texas) and the other is for adolescents (South Dakota).

- The Steering Committee had four recommendations addressing the need for good data upon which to make better-informed decisions.

The prevention recommendations included:

- In partnership with the Department of Education, local school districts, the Alaska Association of School Boards, SADA, and ARANDAP support the implementation of age appropriate education and skill building curricula for preschool and elementary students.

- Support initiatives that educate parents and enhance local communities' capacity for local problem solving.

- Develop and distribute educational materials for merchants, including strategies on product placement of commonly abused products.

- In partnership with the Department of Public Safety, support the implementation of training for Village Public Safety Officer's and Alaska State Troopers on the signs and symptoms of inhalant use and on reporting of use in investigations where not currently included, such as accidents and drowning.

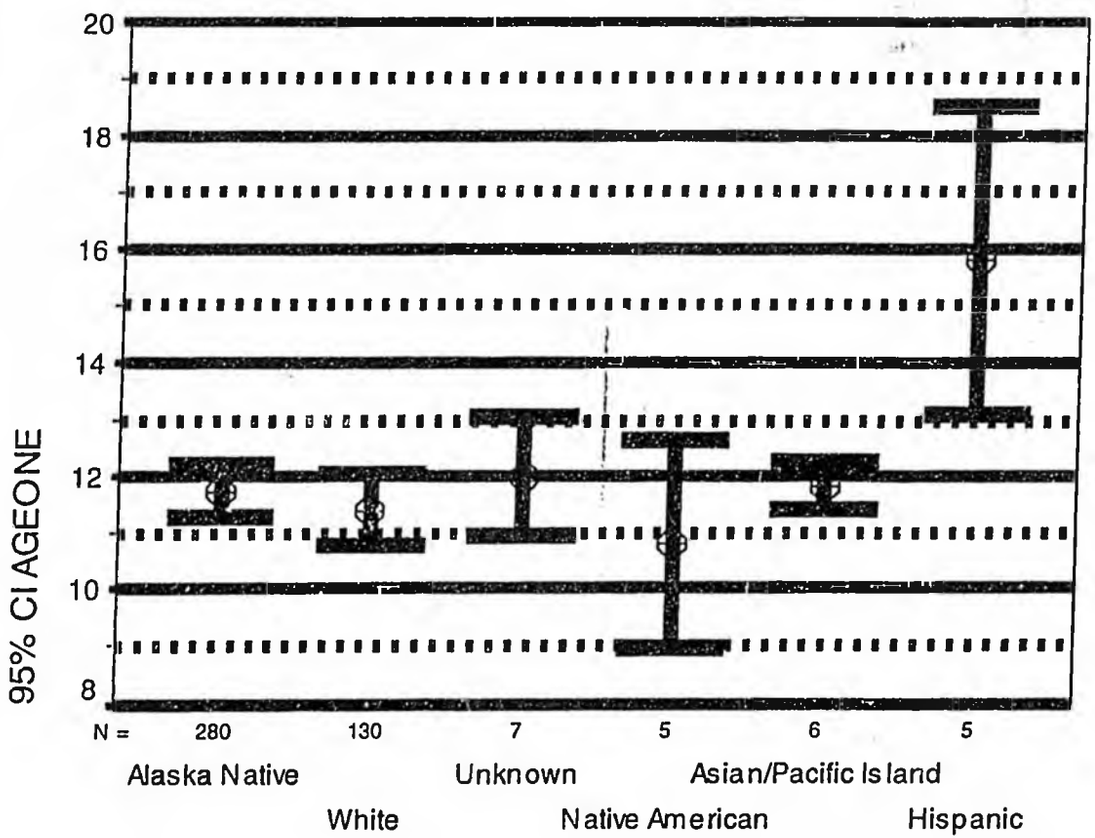
In regard to treatment there were two recommendations:

- Support the development and dissemination of in-service training materials on inhalants and inhalant abuse for clinical and diagnostic use at the regional and local program level.

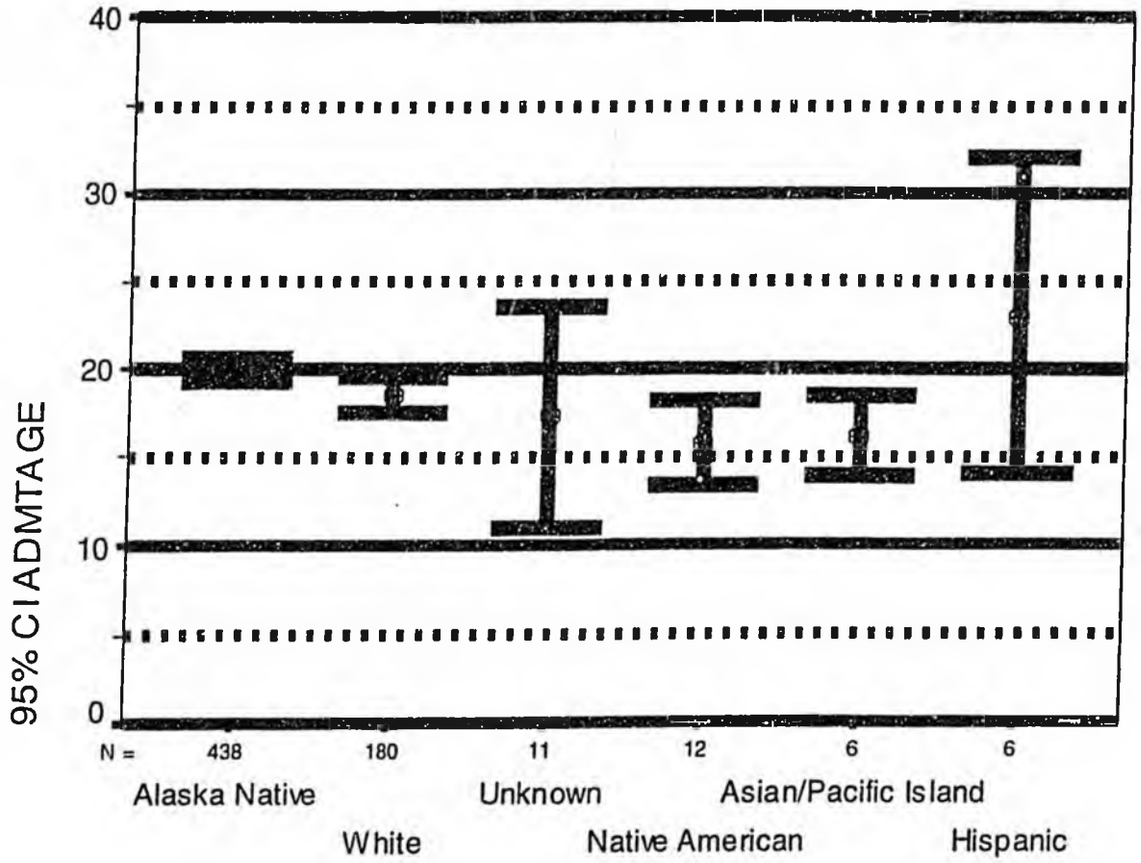
- Enhance the knowledge and skill level of current practitioners (both prevention and treatment) through the inclusion of inhalant abuse training at statewide training events.

The Steering Committee is scheduled to reconvene in the Spring of 2000 to review the recommendations and progress made.

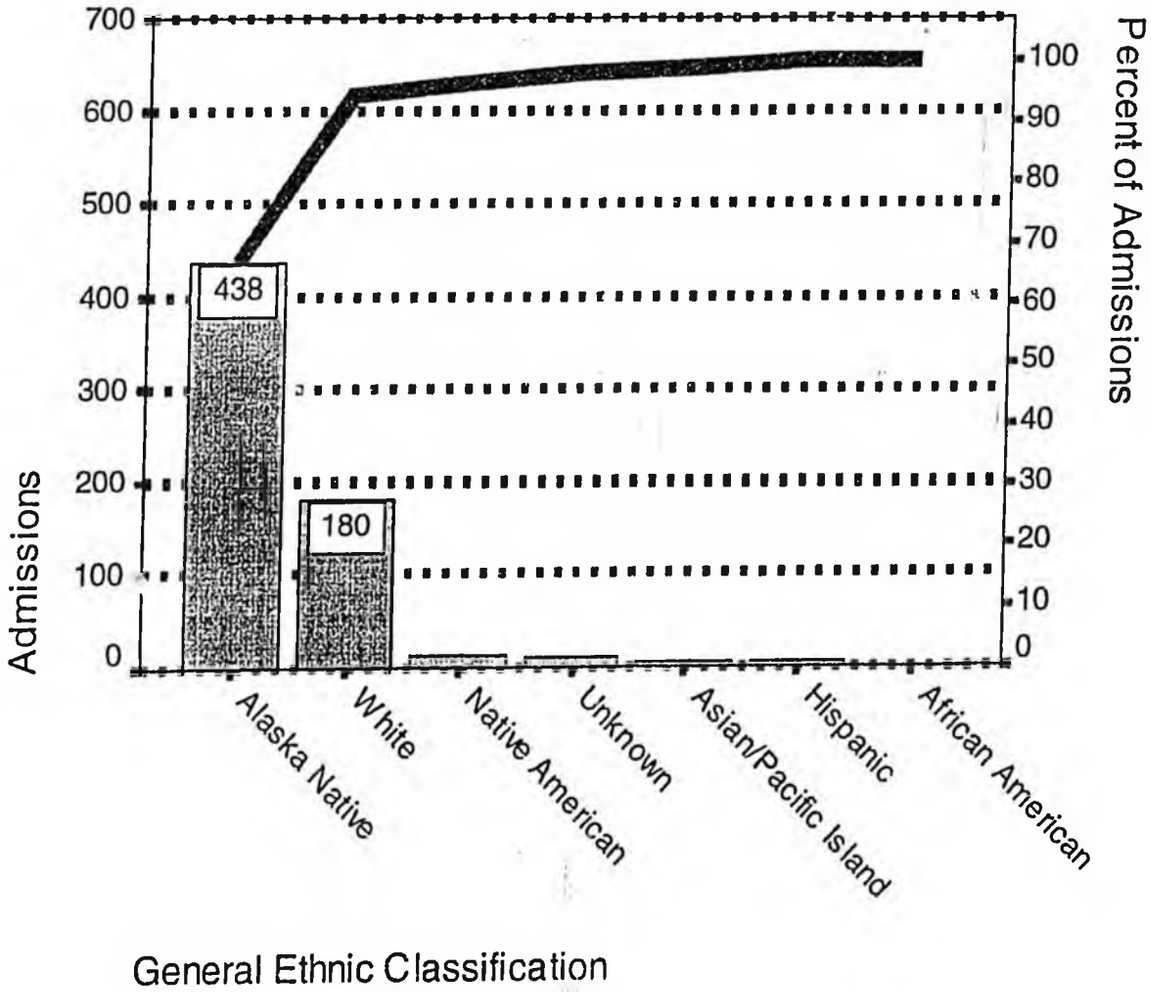
Inhalant Abuse: Average Age of First Use - Alaska
MIS 1988-1999



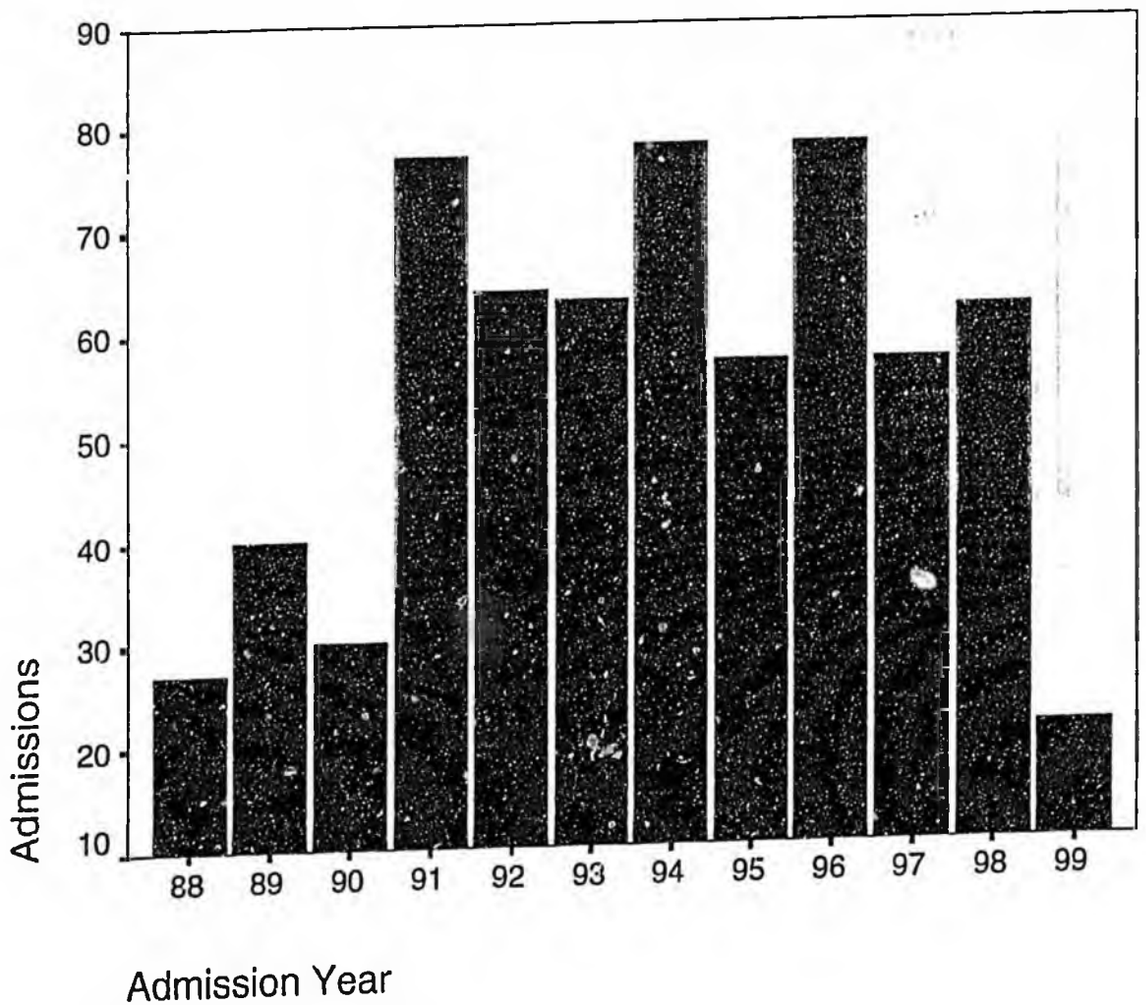
Inhalant Abuse: Average Age at Admission - Alaska
MIS 1988-1999



Inhalant Abuse: Frequency of Admissions - Alaska
MIS 1988-1999



Inhalant Abuse: Total Admissions Per Year - Alaska
MIS 1998-1999



Causes and Consequences of Inhalant Use

The question of what is a cause and what is an effect is a major problem when looking at substance use behavior and it becomes more of a problem with inhalant use. A couple of examples will illustrate this. Inhalant usersare known to have poor academic performance (Liu & Maxwell 1995; Frank et al. 1988). Does this poor performance lead to frustration, problems in school and then the use of inhalants? Or, does inhalant use interfere with cognitive functioning and thus poor school performance? Another major question has to do with neurological damage. It is commonly held that inhalant users incur such damage. However, there are few, if any, studies which address the question of whether some, or all, of this damage may have occurred prior to the use of inhalants. It is possible that neurologic damage prior to the use of inhalants may lead to adjustment problems within the family, or at school, thus priming the individual for future inhalant use.

While the search for specific, temporal "cause and effect" relationships may be useful at some point, it may be better to consider the characteristics of inhalant users as interactive. For example, a child from a dysfunctional family may be prone to inhalant use, but it also is likely that the use of inhalants only increases that family dysfunction. Resolution of the problem involves addressing both the family issues and the inhalant use. Appendix A lists the various interactive causes, correlates and consequences of inhalant use that have been identified.

ORIGINS OF SUBSTANCE USE

Introduction. These are the eight prime factors behind substance abuse (Lettieri 1989): (1) personality deficiency; (2) disruptive environment; (3) adaptive difficulties; (4) peer pressure; (5) stages of use; (6) self-rejecting, self-derogating attitudes; (7) ego deficits and impaired coping strategies; and (8) stress and tension reduction.

There are several conditions that increase susceptibility to inhalant abuse (Oetting et al. 1988): age; gender; ethnicity; community factors; family features; deviance; school adjustment; social adjustment; education problems; emotional problems; and, most importantly, peer influence. Although many factors can affect youth susceptibility to inhalant use, researchers stress that the peer group is almost always one of them. Best friends or fellow gang members form a drug-using peer cluster in which they share their beliefs and ideas, support the rationale for drug use, and decide who will use, how much, and when. There may also be a cultural model for the use of drugs which are inhaled (Dworkin & Stephens 1980; Trotter et al. in press); for example, the well-knit bonds in inhalant-using Mexican and Brazilian street children may be due more to cultural rather than peer factors.

The occurrence of learning disorders are disproportionately high among inhalant-abusing youth (Barratt 1990). The relatively low verbal IQ's of inhalant-using youth can be worsened by families that are typically unstable or unavailable to help children learn to overcome their reading and talking difficulties (Barratt1990). As a result, these youth do not adjust well to school, are more deviant, and thus are more likely to drop out and use inhalants.

Family. One of the more frequent research findings is that inhalant users suffer from serious family dysfunction. They are more likely to come from broken homes, from families with alcohol and/or drug problems, and from families that are marked by conflict and discord. Nearly every study that evaluated family structure found that inhalant users were more likely to come from homes where the primary family was not intact (Albaugh & Albaugh 1979; Berriel-Gonzalez et al. 1978; Carlini-Cotrim & Carlini 1988; Crites & Schuckit 1979; Guitierrez et al. 1978; Jacobs & Ghodse 1988; Leal et al. 1978; Massengale et al. 1963; Nurcombe et al. 1970; Schottstaedt & Bjork 1977; Zur & Yule 1990). In the few

reports where there were no differences in intact family structure between inhalant users and others, the users were relatively young and both users and non-users were from groups with serious socioeconomic problems.

Inhalant users are more likely to come from broken homes, from families with alcohol and/or drug problems, and from families that are marked by conflict and discord.

Family problems also show up in other ways. A number of studies indicate that families of inhalant users may be marked by discord, aggression and/or hostility (Berriel-Gonzalez et al. 1978; Comstock 1978; Crites & Schuckit 1979; DeBarona & Simpson 1984; Gilbert 1983; Korman et al. 1980; Matthews & Korman 1981; Fredlund 1994). When family drug or alcohol use was assessed, the families of inhalant users were more likely to be substance-involved (Albaugh & Albaugh 1979; Bachrach & Sandler 1985; Berriel- Gonzales et al. 1978; Carlini-Cotrim & Carlini 1988; Crites & Schuckit 1979; Guitierrez et al. 1978; Smart et al. 1972; Smith, Joe & Simpson 1991; Stybel et al. 1976). Inhalant users with drug-using families had used more types of drugs, perceived their friends as having a more favorable attitude toward drug use, had experienced more poverty, and were more likely to have disrupted families as well as parents who had been arrested (Bachrach and Sandler 1985).

Opportunity. Although inhalant users almost uniformly experience family problems such as alcoholism, drug use, and broken families, all of which should negatively influence socioeconomic status (SES), studies do not show large and consistent differences in SES. The lack of consistent findings in this area may be because measures of SES tend to be somewhat unreliable. It is more likely, however, that the difficulty lies in study comparisons: really low SES groups may be underrepresented in population surveys or in school-based surveys, and therefore these studies may miss the groups lowest in SES and, possibly, highest in inhalant use. Inhalant users themselves often show problems with employment (Berriel-Gonzalez et al. 1978; Comstock 1978; Korman et al. 1980; Fredlund 1994).

School. Inhalant users also have serious problems in school. Inhalant users seem to disappear from school-based surveys beginning with the eighth grade (Beauvais 1990). Research results indicate that these students drop out. When compared with either non-users or with users of other drugs, inhalant users tend to have greater difficulty in school. They are more likely to have high absenteeism, to have been suspended, to drop out or have been expelled, and to have poor academic performance and lower grades (Altenkirch & Kindermann 1986; Bachrach & Sandler 1985; Beauvais et al. 1996; Carlini-Cotrim & Carlini 1988; Coulehan et al. 1983; Jacobs & Ghodse 1988; Matthews & Korman 1981; Reed & May 1984; Carlini-Cotrim & Carlini 1988; Coulehan et al. 1983; De Barona & Simpson 1984; Korman et al. 1980; Liu & Maxwell 1995; Matthews & Korman 1981; Wingert & Fifield 1985).

Deviance and Delinquency. As might be expected, since inhalant users have trouble adjusting to work and to school, they also have trouble adjusting to society in general. Even among other drug users, inhalant users stand out as deviant.

Inhalant users seem to be more likely to be involved with other drugs. Although there are those who

prefer inhalants, the studies that have looked at a range of drug use often find that inhalant users are heavily involved with other drugs as well (Jacobs & Ghodse 1988; Mata & Andrew 1988; Carlini-Cotrim & Carlini 1988; Compton et al. 1994; Dinwiddie et al. 1987; DeBarona & Simpson 1984; Ellison 1964; Shurtz et al. 1994; Sokol & Robinson 1963). This heavier involvement with drugs in general may help to explain some other findings. Among the inhalant users in a Texas youth program, chronic sniffers had been arrested an average of 9 times, 40 times more often than non-drug users, and twice as often as occasional sniffers (Stybel et al. 1976). In a study of Hispanic youth, two-thirds of the inhalant users who were patients in a treatment program had been arrested compared with only 3 percent of a control group (Berriel- Gonzalez et al. 1978). Among Hispanic youth in Texas drug prevention programs, inhalant users were more likely to have been stopped and questioned by the police, to have been arrested, and to be on probation (DeBarona & Simpson 1984).

INHALANT USE CORRELATES

In several ways the research on inhalant use is remarkable. First, early research, prior to 1975, and research completed since then are essentially consistent and lead to the same conclusions about inhalant users. Considering that drug use has changed radically over this time span, differences in findings over time might be expected. Instead, the recent research has only expanded on and amplified earlier conclusions. Second, the research is remarkably consistent; within a psychosocial area, the studies show high agreement. Third, the research results lead to similar conclusions regardless of age of the study population: inhalant users are found among the subjects who have the fewest social resources at any age and in any group. Fourth, results are consistent across cultures. Research results from four continents and, within the United States, from a number of different cultural contexts, are fundamentally in agreement.

The most general conclusion is that inhalant users are likely to be marginal in society. Inhalant use is highest in areas of poverty, prejudice, lack of opportunity, and dysfunctional family environment. Youth who are failing in school, showing lack of ability to meet the requirements of that environment, are also among those most susceptible to inhalant use. Inhalant users have friends who are also marginal; they are likely to be involved with inhalants, since most inhalant use is a group activity. Those who do move on to solitary use, however, are

> who do move on to solitary use, however, are probably the ones with the most problems. With all these social problems, it is not surprising to find that inhalant users are also likely to have problems with school authorities, to be involved in criminal behaviors, and to suffer from emotional distress.
>
> -- E. R. Oetting, Ph.D.

Inhalant users are also likely to get into trouble with the law earlier than users of other drugs. Among adolescent delinquents in London, on the average, the first arrest of inhalant users occurred about a year and a half before the first arrest of users of other drugs (Jacobs & Ghodse 1988). Inhalant using delinquents from a city in the southwestern United States, when compared with other delinquents, had been arrested almost 3 times as often, were arrested more often for the more serious crimes, and the age of first arrest was lower (Reed and May 1984).

Psychological Characteristics. The picture thus far is that inhalant users are a group with serious social and societal problems. Early studies suggested that inhalant users might suffer from greater emotional distress. Case studies, for example, suggested that inhalant users might be anxious and depressed (Weise et al. 1973). Inhalant users have higher scores on the Taylor Manifest Anxiety Scale, have been treated more often for emotional problems, and are more alienated (Fejer & Smart 1973; Smart et al. 1972). More adolescent delinquents who used inhalants are depressed than adolescent non-inhalant users who used other drugs (Jacobs & Ghodse 1988). There is some evidence that inhalant users are lower in self-esteem. One study found lower self esteem and satisfaction with social relationships (De Barona & Simpson 1984). Another found inhalant users were lower in variables that would logically relate to self-esteem (Annis et al. 1971).

Inhalant users do seem to suffer from greater emotional distress, and there are hints that some inhalant users may indeed have serious personality disorders (Dinwiddie et al. 1991; Swadi 1996). A long-standing pattern of drug use alone, particularly when accompanied by other deviant behaviors such as with inhalant users, could lead to a diagnosis of personality disorder or antisocial personality disorder. An adolescent reaction to the family problems that are often associated with inhalant use (broken families, family hostility, and aggression) could easily lead to a diagnosis of adjustment disorder in an adolescent, another diagnosis that has been applied to inhalant users in some studies. The signs of emotional distress and the behaviors of inhalant users could equally be simply an outcome of the social and family problems and social environment of the inhalant user, and not a result of personal psychopathology.

Peer Drug Involvement. One stereotype of the heavy inhalant user is that of the social isolate or "loner." Research reports, however, are highly consistent in describing most inhalant use as a group activity. In an early report on inhalant-using youth in Texas, about three-fourths of inhalant use occurred with other youth (Stybel et al. 1976). Among London delinquents, 75 percent of users inhaled with friends (Jacobs & Ghodse 1988). Among adolescent users in Northern Ireland, nearly 80 percent inhaled with friends (Lockart & Lennox 1983). More than 80 percent of Brazilian "street kids" used with their friends (Carlini-Cotrim & Carlini 1988). Among Native-American children in a boarding school, sniffing was typically done in a group (Schottstaedt & Bjork 1977). Among poor Hispanic youth, 90 percent used with their friends (Guitierrez et al. 1978).

The kinds of friends that inhalant users have may be an important factor in their inhalant use. Inhalant users may have a narrower group of friends, with higher deviance among them. While family sanctions against inhalant use tend to be high, even in the families of inhalant-using youth, sanctions against inhalant use by peers are much lower (Bachrach & Sandler 1985; Beauvais et al. 1985). Chronic inhalant users in Texas spent more time with their friends and their friends were more deviant (DeBarona & Simpson 1984). Friends of inhalant users may use more drugs (Mata & Andrew 1988), and the friends of inhalant users are also likely to be using inhalants (Bachrach & Sandler 1985; Oetting et al. 1988; Stephens et al. 1978).

In general, more than three-fourths of inhalant use is probably with friends. This leaves a considerable gap, however, showing that a significant amount of inhalant use does occur when the user is alone. From general experience of those working with inhalant users, solitary users seem likely to be more disturbed and have more problems. Only one study compared those who use alone with those who do not, and it indicated that there was more psychopathology in those who used alone (Guitierrez et al. 1978).

In general, more than three-fourths of inhalant use is probably with friends.

Adult patterns of use are less well documented. From the descriptions available, adult use is probably more social than that of adolescents. The milieu of use is typically that of a stereotypic "skid row". Groups of adults will share resources, share inhalants and engage in prolonged binges lasting several days. These bouts are usually marked by sexual promiscuity, poor nutritional intake and the danger of exposure. Alcohol will be used and shared when available. Fredlund (1994) found among adult Kickapoos poverty, low educational attainment, cultural distinctiveness and cultural isolation, as well as physical health and safety problems for these adults and their children.

Culture. The location of "hot spots" of inhalant abuse in Hispanic barrios and on Native American reservations suggests the possibility of cultural influences. Studies that show differences in drug use rate related to ethnicity usually assume that the problems are occurring because youth are caught between two cultures (Gilbert 1983; Guitierrez et al. 1978; Nurcombe et al. 1970). There are, however, almost no actual studies of the cultural identification of minority youth and how that relates to inhalant use. When such studies are conducted, they should carefully control for socioeconomic status. Many studies have not done so and wrongly conclude that certain cultural beliefs and values lead to substance abuse when the real cause is actually socioeconomic.

The most serious levels of inhalant use may occur in specific drug-oriented subcultures. Perhaps the most extreme example of a subculture is reported in a study of Mexico City "street kids" who essentially severed all ties with their families and formed their own subculture, probably to replace the family (Leal et al. 1978). Another example is among the adult members of the Kickapoo people living in Eagle Pass, Texas (Fredlund 1994).

REASONS FOR USE

When inhalant users are asked why they use, some common themes are noted: (1) desired euphoric effects ("it feels good"); (2) easy availability; (3) low expense; (4) possession is not clearly illegal (avoidance of legal hassles); (5) convenient packaging; (6) gives fast and multiple highs (which is particularly attractive to young children who want quick gratification); (7) adolescent expression or rebellion; (8) easier to hide from or explain to parents than alcohol or marijuana; (9) alleviates stress;

and (10) peers approve of or insist on use, which enhances peer respect because use is "cool."

Discerning the link between awareness and behaviors is a complex problem, and is com- pounded by the drug user's frequent inability to fully recognize or verbalize motives for drug use.

BEHAVIORAL CUES

Many behavioral cues present in a drug-use setting can trigger continued drug use. These cues are important indicators for treatment and prevention regimens. The following are among the most common: time of day; day of week; a certain person; smell; taste; a particular street, neighborhood, house or building; an emotional feeling (anger, loneliness, depression, sadness, boredom, hurt feelings); a social gathering or a group of people; a memory (good or bad); success or failure (some take drugs to celebrate, others to forget); alcohol and other drug use (use of one drug may disinhibit the user and thus encourage other or continued drug use).

ADOLESCENT REBELLION

The root problem of inhalant abuse may have more to do with normal stages of adolescent development and adolescent rebellion than with inhalants per se. Youth may like inhalants because they shock, confuse and disturb their parents (Gregory 1986). These youth could merely be acting out their normal stages of adolescent rebellion, a period in which youth test the boundaries of autonomy and independence versus dependence. Inhalant use may also be a way to get parental attention. In this regard, inhalant abuse may be more a problem of adolescence than of drug abuse (Duncan 1986).

MORTALITY

Although toxic drug effects can and do directly cause death, deaths among inhalant users are also indirectly related to use. Death appears in at least five ways: (1) asphyxia (solvent gases can significantly limit available oxygen in the air, causing asphyxiation); (2) suffocation (typically seen with inhalant users who use bags); (3) choking on vomitus; (4) careless and dangerous behaviors in potentially dangerous settings (e.g. explosions & fire); and (5) sudden sniffing death syndrome most often from cardiac arrest (Tenenbein 1990).

In a San Antonio study of inhalant deaths, the most prevalent mode of death was suicide (28 percent) (Garriott 1990). A large majority of inhalant suicides hung themselves (91 percent) in contrast to the relatively low use of this method of suicide by non-inhalant users (18 percent). In addition, the study found that only a small percentage of the inhalant-user deaths (18 percent) were due to inhalant-induced cardiac arrhythmias. Overall, 77 percent of deaths of inhalant users were by violent modes (suicide, homicide and accident), rather than as direct consequences of drug toxicities.

Another study (Maxwell 1994) found persons who died of inhalants in Texas in 1990- 1993 were male (94 percent), Anglo (90 percent), and average age was 26. Close to half of the deaths each year involved freon and the occupations of decedents included air conditioning technicians, engineering technicians and pipefitters.

INHALANT USE/VIOLENT DEATH

The Bexar County Medical Examiner's Office has investigated all cases of death related to inhalant abuse occurring during a recent 6-year period in Bexar County, Texas. Thirty-nine cases had inhalant chemicals detected by screening of blood or other suitable specimens, and were initially identified by circumstances suggesting inhalant abuse, external physical signs at autopsy, or by toxicological screening of high risk deaths. Although few deaths were found to be directly due to inhalant toxicity, a striking correlation was made relating inhalants with violent death. The most prevalent manner of death was suicide (28 percent of cases) fol- lowed by accident (26 percent), homicide (23 percent), and inhalant-induced death (18 percent). By far, the most predominant inhalant agents used were compouonds containing toluene (32 cases, representing 82 percent), although toluene was considered the cause of death in only one instance. The mean toluene concentration in blood in 32 cases was 3.78 mg/L. All other inhalants (trichloroethane/trichloroethylene, nitrous oxide, gasoline and freon 12) were detected in only seven of the cases. The high rate of suicide and violent death in these inhalant abusers while under the influence of the chemicals is suggestive of neurotoxicity.

-- James C. Garriott, Ph.D., D-ABFT

Classifying the Inhalant User & Abuser Table of Contents Effects of Inhalant Use

EFFECTS OF INHALANT USE

The reports from most inhalant users indicate that the perceived ffects mimic the intoxication produced by alcohol. The initial effects are lightheadedness, tingling sensations, agitation and a sense of euphoric exhilaration. Further, there is a sense of well-being and power. From these perceptions, one would think that inhalants are stimulants, but prolonged use, as with alcohol, demonstrates that the primary action is one of a physiological depressant. Later effects include dizziness, blurred vision, poor judgment, loss of contact with reality, slurred speech, unsteady gait and, with a sufficient dose and duration, loss of consciousness. There are some reports that heavy doses of inhalants will also produce hallucinations, both visual and auditory. Several hours after use, lethargy and headache are common.

Neuropsychological problems. From the perceived and observed effects noted above it is clear that there is some level of impairment due to inhalants in the short term. Additional evidence for this comes from studies of neuropsychological studies of inhalant users. (Neuropsychological functioning refers to such things as intelligence, memory, problem solving, and visual, auditory and tactile perception). For instance, Korman et al. (1981) found that inhalant users performed more poorly on a number of neuropsychological tests including IQ measures and various measures of perception. It should be noted that these studies did not control for length of abstinence from inhalants, nor for problems that may have existed before inhalants were used. In a general review of this issue, Chadwick and Anderson (1989) concluded that, while most studies do show neuropsychological deficits in inhalant users, it is difficult to tell how extensive these are, or how long-lasting they are due to the many methodological problems already discussed.

Neurological problems. For a number of reasons, there is a modest degree of uncertainty as to the nature of the physical effects of inhalants. First, the high degree of variability and the combinations of chemicals in commercial and industrial compounds makes it very difficult to determine a direct effect from any particular chemical. Second, the degree of physical impairment is related to the dose and duration of use, factors which are difficult to ascertain from users. Third, there is the important question of the degree to which physical damage will be reversed upon cessation of use. Fourth, it is difficult to sort out problems that may have been in existence prior to the onset of inhalant use. Finally, many studies do not make a distinction between acute and chronic effects. For example, many neurological studies take place while inhalers are intoxicated and draw the conclusion that the effects found will be permanent. It should be recognized that inhalants are lipophilic which means they are deposited in fat tissues in the body and leach out into the bloodstream over an extended period of time. Tests for chronic effects should take place after an extended period of abstinence. Despite these problems, there are some commonly agreed upon physiological effects from the use of inhalants.

Tests for brain damage suffer from many of the same methodological problems listed above. Rosenberg and Sharp (1990), Ron (1986) and Dinwiddie (1994) reviewed the existing studies and came to essentially these conclusions: While a number of studies have revealed brain abnormalities (e.g. through CAT and MRI imaging), it is not clear whether these were preexisting conditions, they existed in all inhalant users and whether these problems will reverse over time. A very recent and comprehensive review of all of the evidence, including that from animal studies, leads one to the conclusion that some lasting damage does accrue but it is difficult to detect except in chronic, high dose users. (Sharp & Rosenberg, in press).

These conclusions raise a major question -- does the use of volatile solvents result in the level of brain damage that is commonly held among research and treatment professionals? What we know so far would indicate that the level of injury is not as severe as some think.

For a number of reasons, inhalant use does constitute a dangerous behavior and this danger should not be minimized:

1. **Current methods of assessment may not be sensitive enough to detect injury that may persist over time. Some studies have shown that among chronic, heavy users there is an actual loss of neural tissue (e.g. Fornazzari, 1983) so there is some reason to suspect that some neural loss is occurring among most heavy users.**

2. **Death can and does occur among inhalant users, (Garriot 1990; Cunningham et al. 1987; Bass, 1970; Maxwell 1994; Tenenbein 1990), some from first time use. The causes of death have already been discussed but bear repeating; asphyxia (commonly from plastic bags over the head), cardiac arrhythmias and failure, violence (both homicide and suicide), and accidents such as explosions, fires and head injury from passing out.**

3. **There are some inhalants that are known to cause permanent damage (e.g. compounds containing hexanes produce irreversible peripheral nervous system damage and other compounds cause hearing loss). It is difficult for the user to know whether the compound they are using contains the chemicals leading to these problems.**

Non-neurologic effects. In addition to the dangers already discussed, there are other medical problems that have been detected among solvent abusers; some of these involve acute crises that require immediate medical attention. Linden (1990) has reviewed the medical literature which indicated that there are heart, liver, kidney, blood and lung complications that accompany moderate to heavy use of inhalants (not all inhalants cause all of these problems). For the most part, once the immediate medical crisis had been managed, these problems tended to resolve with time.

PSYCHOLOGICAL AND SOCIAL EFFECTS

As with the use of any other drug, the use of inhalants is not without its effects on an individual's psychological and social functioning. It has been shown that inhalant users often have a number of other psychological problems (Dinwiddie et al. 1987 Oetting et al. 1988; Swadi 1996) and the continued use of inhalants will only exacerbate those conditions. In particular, the cognitive confusion caused by inhalants will only interfere with any therapeutic interventions or attempts to maintain a competent lifestyle.

Problems in family, work and school adjustment are also hallmarks of inhalant users.

Once again, amelioration of these problems is extremely difficult for an individual whose intellectual capacity is compromised by the use of inhalants. Furthermore, existing problems are only extended by inhalant use. Families will be more rejecting of youth who are using inhalants, and schools will be reluctant to provide educational and supportive services. Continued inhalant use into later adolescence is seen as an aberration even among peers leading to rejection in this important developmental arena. Inhalant using youth are marginal in many ways and the time used in obtaining, using and experiencing the effects of inhalants only serve to move them further away from normal socializing influences. Inhalants have not been shown to be addicting in the sense of exhibiting tolerance and withdrawal, yet the powerful psychological dependence that users report make it extremely difficult to stop use and engage in normal developmental tasks.

SIGNS AND SYMPTOMS

Signs and Symptoms Most Frequently Reported in Long-term, Heavy Users of Toluene-Containing Solvents

Short-term memory loss
Emotional instability
Cognitive impairment
Slurred and "scanning" speech
Wide-based ataxic gait
Staggering or stumbling
Nystagmus
Ocular flutter
Tremor
Optic neuropathy
Unilateral or bilateral hearing loss
Loss of sense of smell
Diffuse slowing of the EEG
Abnormal or absent brainstem auditory-evoked response
Diffuse cerebral, cerebellar, and brainstem atrophy
Enlarged ventricles and widening of cortical sulci, especially in the frontal or temporal cortex

-- *Gordon T. Pryor, Ph.D.*

RESEARCH NEEDS IN STUDYING INHALANT EFFECTS

Given the complexity of inhalant abuse, interdisciplinary research is necessary to effectively study the observed toxic effects of inhalants on humans. Contributing disciplines could include chemistry, pharmacology, medicine, psychology, psychiatry, sociology, child development, social psychology and group influence, and quantitative test and measurement specialties. Listed below are some of the desirable data elements for comprehensive studies.

Type of Substance Used. Relevant chemical and pharmacological data on inhalants might include the

type of substance used; the specific formulation; the nature and degree of its impurities; the volatility, potency, and resultant metabolites; the dose response curve; and the effects when used alone as compared to when used in combination with other chemicals.

Mode of Administration. Helpful sociological data would include the mode of administration (cloth, aerosol, bagging or huffing, heated volatile) and whether it was by mouth, nose, gastrointestinal routes, or skin absorption.

Drug Interactions. It is essential to know if other drugs are used consecutively or at the same time with the solvent; what interaction effects may have occurred such as adaptivity, synergism, antagonism, or independence; and whether observed effects were complicated by withdrawal or tolerance. Data on the user's drug history are also essential.

Developmental Issues. It is important to know the user's position in the drug dependence cycle (for example, whether (s)he is a novice or chronic user). Information on adolescent rebellion could help explain the user's

systematic or unpredictable use of solvents as well as the types of negative effects (social-behavioral and/or toxicological).

Dose. The amount of inhalant used may relate to mode of administration, potency of the solvent or its volatility, developmental factors, and social psychological factors such as duration of individual exposures and shared use among peers.

Reversibility of Damage. There is a common perception that inhalant users incur immediate and substantial brain damage. This perception leaves many practitioners, particularly in the treatment area, with the sense that there is little that can be done for these people. Accurate measurement of the extent and type functioning that can be recovered would be of great benefit to both those treating inhalant users and the users themselves.

Style of Use. Social psychological data could distinguish between episodic or continuous use, ascertain the dose and duration of exposure per drug-taking occasion, pinpoint the time lapsed between exposures, and determine whether the solvent is used alone, shared with peers, or combined with other substances.

Health Status. Medical data about the user's general health could help distinguish the observed effects of inhalants from the user's other medical conditions such as nutritional status, cognitive impairments, extant neurological damage, hepatitis, and other organ dysfunction.

Mental Health. A variety of psychological and psychiatric conditions can cloud relevant psychological test performance measurements, and distort the user's self-reported accounts of perceived inhalant effects.

Measurement Errors. Many measurement errors disrupt research of inhalant users, particularly those involving the source of subjects and the truthfulness of self-reports. Because inhalant use is a relatively rare phenomenon, locating appropriate test subjects is difficult. The setting from which subjects are taken can influence study results. For example, treatment clients are likely to be the most severe cases with multiple complications. The general inhalant user typically does not seek treatment, and those that do may not be typical of the user population. Subjects that are involved in the criminal justice system may be less likely to fully report their drug use or its effects for fear of further legal penalties. While subjects from school-based settings are useful, many inhalant users are often not in school. Similarly, data from household settings exclude the large number of homeless inhalant users.

Another concern is the truthfulness of the inhalant user's self-reports on use, as well as responses to a variety of interview questions. Self-reported data can be influenced by whether or not the subject is involved with the criminal justice system; by self-perceived stigma in reporting solvent use, and related deviant behavior; by cultural or peer-group taboos; or by the subject's accuracy in remembering his/her behaviors (due to inattention, memory loss, withdrawal effects, or other cognitive or neurological impairments).

Causes and Consequences of Inhalant Use Table of Contents Treatment of Inhalant Users

TREATMENT OF INHALANT USERS

Treatment of inhalant abusers must incorporate effective outreach, screening and diagnosis; involvement of the family in the therapy; consideration of environmental and behavioral influence; and appropriate selection of the treatment regimen (client/treatment matching)

PROBLEMS IN OUTREACH

The four basic problems in conducting outreach are as follows: (1) inhalant users do not typically seek treatment, thus only the most severe cases are observed in clinical settings; (2) inhalant users are often not in school, so school-based treatment and prevention/education may not reach many of the users; (3) home-based case-finding is ineffective for the homeless; and (4) involvement of the family in the treatment process is necessary. When treatment is focused solely on the youthful client, without family involvement, relapse is likely (WHO 1986).

The families of many inhalant users have been described as extremely chaotic and early assessment of family functioning is essential. It may well be determined that the family is not at a point where they are capable of making the needed therapeutic changes and alternative short or long-term foster placement of an adolescent should be considered (Jumper-Thurman & Beauvais 1992). It has also been observed that, once identified, inhalant users are reluctant to enter treatment and will often leave treatment in the early stages. Careful work must be done at this stage to insure continued compliance with treatment. Most clinicians who work with inhalant users recognize that users are very wary of professionals and physiologically are very sensitive to strong stimuli; thus strong, confrontive interactions should be avoided as users are brought into the early stages of treatment.

SCREENING AND DIAGNOSIS

Due to the wide range of problems encountered by inhalant use, a thorough assessment of all areas of physical, psychological and social functioning is necessary. While this is standard practice in most drug abuse treatment, it takes on added importance with inhalant users since the level of dysfunction in any one area may seriously impact another. A thorough physical exam should be performed to rule out acute system problems that may need attention before treatment for inhalant abuse can begin (Linden 1990). A careful history of length and intensity of inhalant use is useful in determining when and at what level treatment can begin (See "Detox" below). An inventory of family, peer, educational and occupational resources (or deficits) should be conducted early on since restructuring in all of these areas may constitute a major part of treatment (Jumper-Thurman & Beauvais 1992). Discharge and aftercare plans should begin with the assessment process and continue throughout the course of treatment. Where resources are available, a neurological examination at intake can be helpful in assessing level of neurologic injury and functioning.

Neurotoxic disorders due to inhalant use can be confused with other conditions, and mild cases of neurotoxic injury are very difficult to diagnose (Rosenberg 1990). Although diagnoses are difficult to make, individuals do develop a similar clinical picture when exposed to solvents at equivalent doses for equivalent durations of time (Rosenberg 1990). The use of MRI (magnetic resonance imaging) is a potent procedure to detect abnormalities in users (Rosenberg 1990). Current technology can detect abnormalities in brain structures, and continuing advances offer great promise for enhanced screening and diagnosis in the future.

DETOXIFICATION

Detoxification is typically seen as the time during which a drug or alcohol user is recovering from the acute effects of the substance they have been using. For most drugs this is usually less than a week. After