

Carolyn Edmonds, *Board of Health Chair*

BOH Members:

Richard Conlin
Dow Constantine
George W. Counts
Jan Drago
Carolyn Edmonds
Ava Frisinger
Larry Gossett
David Hutchinson
David Irons
Kathy Lambert
Frank T. Manning
Bud Nicola
Margaret Pageler
Alonzo Plough

BOH Staff:

Maggie Moran

**KING COUNTY BOARD OF HEALTH
MEETING PROCEEDINGS**

**October 20, 2000
9:30 AM to 12:00 PM
King County Council Chambers**

Roll call

- Greg Nickels
- Kent Pullen
- Richard Conlin
- David Irons
- Karen VanDusen
- Larry Gossett
- Joseph Pizzorno
- David Hutchinson
- Dan Sherman
- Alvin Thompson
- Nick Licata
- Alonzo Plough

Call to order

Chair Greg Nickels called the meeting to order at 9:51 AM.

Announcement of Alternates

Chair Nickels acknowledged that no alternates were present. Councilmember Pageler and Councilmember Miller were unable to attend and unable to find alternates.

Adoption of the September 15, 2000 Minutes

The Board approved the minutes of the September 15, 2000 meeting.

General Public Comments

Richard Jackman expressed his preference to address the Board following Dr. Spitters' presentation on HIV surveillance.

2001 Board of Health Meeting Schedule

Chair Nickels reminded the Board to reserve Board of Health meetings for 2001.

Chair's Report

Update on Violent Video Games

Chair Nickels reminded the Board that in March of 2000, the Board approved Resolution 00-302, which recommended elimination of violent video games from publicly owned or operated facilities in King County. The Board distributed that motion to jurisdictions within King County and to national associations, cities, counties, and others. On June 1, 1999, President Clinton requested that the Federal Trade Commission and the Department of Justice conduct a survey on whether violent entertainment materials being advertised and promoted to children and teenagers may lead to more aggressive and violent behavior in children. Enclosed in the Board materials is a report that was prepared by the Federal Trade Commission entitled, "Marketing Violent Entertainment for Children: A Review of Self Regulation and Industry Practices in the Motion Picture, Music Recording and Electronic Game Industries," presented to the United States Senate's Committee on Commerce, Science and Transportation on September 13, 2000.

Chair Nickels introduced Pam Eakes, Founder and President of Mothers Against Violence in America (MAVIA). Ms. Eakes stated that she was not surprised regarding the findings of the report; marketing dollars and research dollars are spent targeting young people. In fact, the report indicates that even nine-year-olds were in marketing focus groups for over 17-year-olds.

Mothers Against Violence in America has been working in the past year and a half with the Interactive Digital Software Association, of which Nintendo and Microsoft are two members. The ESRB rating system for video games expended dollars toward getting parents to have information about video game ratings, as well as a thirty second commercial by Tiger Woods that was very clever and informative. Other entertainment industries have had more standards for a longer period of time. There is a separate rating system for video games located in public places and arcade systems. In fact, the arcade video game ratings are more complicated to understand. Parents frequently do not receive information on the rating of video games located in arcades and public places. Ms. Eakes stated that there is still more work to do by the FTC, but she is proud of the efforts to protect kids from exposure to video games in public places that are not age appropriate.

Ms. Eakes reported working with Representative Marylou Dickerson and the Washington Department of Health, preparing for a press conference on October 26th to announce the publication of "What Games Do Your Children Play? Become a Video Smart Parent," which is available at MAVIA's web site, www.mavia.org.

In response to Chair Nickels' question whether Ms. Eakes has seen any kind of reaction from the video game industry that indicates they are hearing this message, Ms. Eakes stated that the industry seemed shocked and dismayed that a nine-year-old was actually in a focus group to discuss the advertising and marketing plans for an over 17 age appropriate video game. K-Mart, and other retailers, have indicated that they will not sell video games to kids that are age inappropriate.

In response to Chair Nickels' request for guidance on what to tell a parent in his neighborhood about children playing games in a neighborhood video arcade, Ms. Eakes stated that

parents have to recognize their power as consumers. For instance, one of the MAVIA members on Bainbridge Island did not feel a video game was appropriate for children at a local pizza restaurant. The MAVIA member informed the restaurant owner, who removed the video game. Ms. Eakes believes that consumers have a lot of power that they are not leveraging as much as they should.

Boardmember Pizzorno commented that he plays video games with his kids and subscribes to two of the most widely circulated video game magazines. Boardmember Pizzorno described an appalling ad for a driving game, which awards points for running into pedestrians and killing them. Boardmember Pizzorno advocated rating magazines, not just games, by restricting the market share unless video manufacturers publish more responsible ads.

Boardmember Conlin questioned how to establish boundaries for auto racing video games that are suitable for children under thirteen years of age. Boardmember Conlin expressed concern that motor vehicle accidents among teens is a problem in our society and it is necessary for children to understand the difference between fantasy and reality. Boardmember Conlin suggested encouraging the industry to develop video games that are similar to competitive, interactive, and challenging board games.

Criminalization of Mental Illness

Chair Nickels reminded the Board that Boardmember Thompson requested looking at some of the policy issues and education regarding treatment of the mentally ill in our society. Chair Nickels introduced Jackie MacLean, Assistant Manager of King County's Mental Health, Chemical Abuse And Dependency Services Division.

Ms. MacLean stated that the issue of protecting civil public safety and the balance of people's civil rights is a difficult subject. Ms. MacLean introduced the panelists: Amnon Shoenfeld, Coordinator of the King County Crisis and Commitment Service, which provides 24 hour per day service to people in King County and evaluates them under the Involuntary Treatment Act; Dr. Sharon Farmer, a psychiatrist and Medical Director of King County's Mental Health Division; and Eleanor Owen, Executive Director for Washington Advocates for the Mentally Ill.

Mr. Shoenfeld described the commitment law (RCW 71.05) passed in 1973 and enacted in 1974. The intent of the legislation was to put an end to indefinite and inappropriate commitments, provide short term evaluation and treatment, safeguard individual rights, provide continuity of care, promote and encourage community-based care, and protect public safety. Prior to the passage of this law, individuals could be involuntarily committed indefinitely without any judicial review. There are stories of abuse of that system; people initially hospitalized without good reason and then kept for many years without adequate safeguards for their rights.

The Involuntary Treatment Act established standards for initially detaining people and ensuring legal safeguards every step of the way. Each county was authorized to designate mental health professionals (thus the name County Designated Mental Health Professionals, or CDMHPs) to perform the initial evaluation as to whether an individual met the grounds for involuntary commitment. The CDMHP has the authority to evaluate a person and to place him/her on an involuntary hold or detention for a period of up to 72 hours. During that 72

hours, the person is evaluated again at the hospital, or an evaluation and treatment facility, to determine whether to petition for additional treatment. If additional treatment is petitioned, the individual is represented by legal counsel at a court hearing. At that Superior Court hearing, the individual can present his/her case and why s/he does not need to be hospitalized. It is up to a judge, or court commissioner, to decide whether or not the person can be committed for an additional 14 days, committed to a less restrictive alternative for up to 90 days, or be released. If the person is held for 14 days, there is another judicial hearing that must take place before the end of that 14 days. At that point, a person can be committed for 90 days. At the end of 90 days, there is a court hearing to determine whether the person can be detained longer. Thereafter, every 180 days, there needs to be a court review. Very rarely in Washington is anyone held beyond 180 days.

The Involuntary Treatment Act outlines four different standards for danger of physical harm: danger to self; others; property; and grave disability, which means that the individual's health or safety is in danger because basic needs are not being met. These standards have been upheld Washington State Supreme Court and by the United States Supreme Court. The courts have found that involuntary commitment is a significant infringement on an individual's liberty.

Over the years, there have been significant changes in the Involuntary Treatment Act. In 1979, the criteria for commitment were expanded. Prior to 1979, somebody could do significant property damage, but could not be committed unless another individual was endangered in the process. Dangerousness was added in 1979, as was another standard for grave disability, which allowed earlier intervention. There still needed to be some evidence that there would be dangerousness, but information could be presented to the court that somebody was deteriorating rapidly, and unless that individual received involuntary treatment care, there was a likelihood of serious harm in the future.

In 1982, the Washington State Supreme Court issued an opinion entitled, *In re Harris*. Justice Utter wrote the opinion, which defined the standards for non-emergency detention. Justice Utter found that a person's rights needed to be protected earlier in the process, even though there were subsequent judicial hearings. In order for a CDMHP to even take someone into 72 hours of custody, a court had to decide whether there was an imminent likelihood of harm. For instance, if someone presented an imminent danger, s/he could be taken into immediate custody. However, if there was not an imminent danger, then there must be a judicial order for involuntary commitment. That process takes approximately three times as long as it would to do an emergency detention. King County is the only county in the state that is actually doing non-emergency detentions, because public defenders challenge the CDMHPs who do not follow the court order process. Approximately twelve percent of all of the CDMHPs' detentions are non-emergency detentions; all of the detentions from the King County Jail are non-emergency detentions.

In 1989, Senate Bill 5400 was passed, placing more responsibility on the counties or regional support networks for the care of mentally ill individuals. Counties then decided to take more responsibility every step of the way. More effort was placed into providing local, less restrictive alternatives for individuals. Individuals with mental illness would be cared for and receive necessary services, so they would not wind up in the involuntary treatment system, or in the jails. Involuntary detentions had been rising: in 1974 there were 587 involuntary commitments in King County; in 1979, there were 1,300; and by the mid-1980's, there were well over 2,000 involuntary detentions. Since the regional support network was set up and King County took more responsibility for these individuals, involuntary commitments have leveled off and gone down.

In 1991, the Harper decision addressed involuntary medications. Although someone may be involuntarily committed, that does not mean that the individual can be forced to take medications or accept the treatment that is being offered, unless certain conditions are met. Individuals can be medicated on a short term basis, but on a long term basis. There needs to be a court review of that decision. Medications can have side effects and the court recognized that individuals had a right not to take medications.

In 1995, the Becca Bill was passed, which affected involuntary commitment, as well as the Involuntary Treatment Act for youths aged 13 to 17 and allowed parents to have more authority in that process. The first Becca Bill was ruled unconstitutional and the second Becca Bill was vetoed by the Governor. In 1998, the third Becca Bill was enacted. However, there are no hospitals in the state of Washington that are willing to accept children under this statute; hospitals are not required to accept youths and fear lawsuits. When laws are passed, there must be a system in place that will allow the laws to actually have some efficacy.

In 1998, Senate Bill 6214 was passed after a King County task force was appointed following the tragic murder of a King County firefighter. The task force, which was led by Executive Sims, was initiated in order to review all the involuntary treatment provisions, as well as the competency provisions. The goal was to evaluate the whole system in which individuals in the jail would be referred for involuntary commitment and look at the communication among courts, jails, and the involuntary treatment system. This law expanded the conditions under which an individual could be committed, as well as the kind of things that CDMHPs and the courts needed to look at in considering whether an individual could be involuntarily committed. Municipal and district courts had expanded authority to send someone to Western State Hospital for competency evaluation and treatment.

In 1999, another Senate Bill was passed assuring greater continuity of care for mentally ill individuals who were leaving prisons and re-entering the community, and enabled CDMHPs to provide more services to ensure care.

Prior to seeking involuntary commitment, it is very important to ensure a full system of alternatives for commitment; allow people to stay in the community and function to the greatest degree. In King County, a number of programs have been initiated for mentally ill offenders and homeless mentally ill. The Host Program, currently administered by the Downtown Emergency Services Center, provides an array of services to homeless mentally ill individuals -finding them in the community and trying to engage them into treatment.

The Mentally Ill Offenders Community Transition Pilot Program is run by Seattle Mental Health and focuses on providing an array of services to mentally ill individuals being released from prison. The goal is to integrate these individuals into the community so they will not re-offend.

There are two mental health courts in King County; Seattle Municipal Court with Judge Levinson and the mental health District Court started by Judge Casey. These are specialized courts allowing incarcerated mentally ill to get into appropriate treatment. An individual's sentence is delayed as long as the individual is involved in treatment. This is a program in which public defenders and prosecutors work with case managers, probation officers, and judges to make sure that individuals with mental illness are treated fairly and given the opportunity to engage in appropriate treatment rather than serve time in the jail system.

The crisis triage unit is a program run at Harborview providing a 24 hour system to triage to sort mental health, drug abuse, alcoholism, or developmental disability and to focus services for specific needs. In 1999, over 7,000 individuals were served in this system.

Training for the Seattle Police Crisis Intervention Team began a few years ago to respond to mentally ill individuals in the community. The King County Mental Health Division has trained approximately 150 to 200 police officers. Eleanor Owen has assisted in training the officers, who are required to respond to individuals in a caring and humane way.

Dr. Sharon Farmer stated that a recent report was released by the Substance Abuse Mental Health Services Administration, part of the National Institutes of Health. This report discussed some of the nationwide public and private funding issues for the mental health system and the chemical dependency system. Combined funds for mental health and substance abuse represent a small portion of the health care dollar. From 1987 to 1997, it decreased significantly from 8.8 percent to 7.8 percent. There has been a significant push to get non-discriminatory health insurance coverage for people with mental illness, and now there is the same movement for people with chemical dependency problems. This refers to insurance of any kind, particularly private insurance, that will not limit mental health treatment any more than it limits other kinds of treatment. For example, an individual can go to a cardiologist for as many visits needed to treat the heart problem. In Dr. Farmer's experience, almost nobody has non-discriminatory health care insurance. People with mental illness and chemical dependency can lose their jobs, which results in losing insurance. Those individuals turn to publicly funded systems.

Another important feature from this report indicated that mental health and chemical dependency treatment relies more on the public dollar than other types of illnesses; reliance on the public dollar is increasing. In 1987, 55% of funding was public, not private insurance. It is now 58%. This is more so for chemical dependency services than it is for mental health services.

Both the mental health and the chemical dependency systems focus on persons whose income is at 200% of the federal poverty level or less. It is a little broader for children. There are services available for people in crisis, regardless of income level. There are many people who do not have insurance, particularly many of the working poor.

Limited dollars means prioritizing and the two systems have prioritized in different ways. Mental illness treatment focuses primarily on people who have Medicaid funding. Medicaid is a federal insurance program aimed at people who are disabled and low income. Half of the dollars are federal dollars, but to participate, the state has to match every federal dollar. If a state participates in Medicaid, it is obligated to provide the treatments that are entitlements, and treatment for mental illness is an entitlement. Limited dollars go primarily toward people who are on Medicaid. However, the chemical dependency system has different funding and different priorities.

There are additional ways to make dollars stretch. In the mental health system, there is a managed care model, where utilization of services is carefully reviewed so services are aimed toward people who need it most. In the chemical dependency system, there are other ways used to limit services. For example, people who qualify through the ADATSA system can get six months of treatment for every two year interval. For people who have both mental illness and chemical dependency, the research is very strong that the best way to offer treatment to those people is to address both problems simultaneously. If people qualify for one system, and not the other, it really is a major problem for the treatment providers who are able to attend to that person.

It is necessary to improve services for people with mental health and chemical dependency disorders. There should be more services for people with a history of violence. The mental health system can improve in identifying chemical dependency problems and treating them more aggressively. Similarly, the chemical dependency system can improve in identifying persons with mental illness and referring them for services where that is possible. Many community mental illness treatment providers have obtained certification and licensing to become chemical dependency treatment providers.

Another gap involves improvement in continuity of care and coordination of care across systems, particularly looking at some of the confidentiality restrictions. Obviously, it is preferable to have people consent to sharing of information about themselves, but that is not always possible, and it is important to be able to coordinate care within the limits of the confidentiality laws.

Most professionals and advocates who work with mentally ill people would like to see more of a movement toward need for treatment as the grounds for commitment as opposed to some of the dangerousness criteria that Mr. Shoenfeld discussed. There will never be involuntary commitment laws that will reach out and attract all the people who need treatment. Instead, there should be efforts toward fighting some of the stigma and building public awareness, so that people recognize these problems as illnesses and know that treatment can be effective. There must be treatment that is meaningful at the individual level, and makes sense in terms of that person's culture, beliefs, and values. That will attract people into treatment.

Eleanor Owen, founder and former president of the Washington Advocates for the Mentally Ill, currently serves as the Executive Director. Ms. Owen stated that Public Health and the county and state mental health systems should be more integrated. Family advocates recognize the role of government to step in as a parent when the individual is not capable of caring for himself or recognizing what s/he needs. This is almost never taken into consideration. The trend toward punishing individuals by putting them in the most restrictive environments (jails and prisons), as opposed to treatment facilities, can be reversed by much more intervention in the schools.

Ms. Owen has been actively involved in both helping to get the police training started, as well as a program at Monroe. Some Monroe inmates are young people who have destroyed their lives by taking actions without any real recognition of the consequences. One of the men stated he would like to go back to Seattle area schools and talk to the kids about what it is really like to be in prison. Those consequences are not shown on TV.

Some persons with mental illness have written advance directives for those times when they are off medications and not thinking in their own best interests. Most of the people who are stabilized in the community mental health programs can be rehabilitated, learn skills, obtain jobs, and regain dignity. According to Ms. Owen, "the Department of Health must be less invisible?be out there doing more preventable work and participating in legislation?I think it's shameful that the courts are making medical decisions. I think medical decisions need to be made by trained medical providers."

Boardmember Pizzorno asked how the mentally ill have been abused, who defends the mentally ill, and what is the rationale for the insurance industry to limit the number of times a person can be seen by a mental health professional?

Mr. Shoenfeld explained that every individual served with a petition for involuntary detention by a County Designated Mental Health Professional is given a statement of rights, including the right to have an attorney immediately appointed to the individual. The job of the public defender is to meet the needs of the client. It is important to know that legal standards must be met. Approximately 30% of the individuals subject to initial detention are not held beyond the 72 hours. Some cases are voluntarily dismissed by the prosecutor, because there is insufficient evidence.

Mr. Shoenfeld used the example of the late Frances Farmer to illustrate abuse. This person would not have qualified for commitment under current commitment laws. Was she mentally ill? It is hard to tell. She was certainly high strung. But was she dangerous? Certainly not. She disagreed with her mother. She did not do what her mother wanted. She was placed in the hospital. She was kept there for long periods of time, subjected to shock treatment, and all sorts of things that happened to her without legal protections. There are many, many examples of people who have spent 20 or 30 years in the state hospitals with no recourse.

Ms. Owen stated that the same abuses are occurring to very needy people in prison. With all the civil rights protections, there are currently more people in the most restrictive environment as opposed to the 1964 law which said individuals are entitled to be treated in the least restrictive environment.

According to Dr. Farmer, she has never heard an insurance company offer an explanation for limited benefits. However, she speculates that this is a business decision that insurance companies make when putting together benefits packages for employers. There is tremendous pressure on businesses to fund health insurance for their employees. Dr. Farmer suspects that when limited benefits for mental illness and chemical dependency are proposed, that people who do not have mental illness do not object, because if people do not have mental illness they do not believe that they will need mental health benefits. People with mental illness do not want to say they need mental health benefits because of stigma.

Boardmember Conlin recalled that when the Mental Health Act was first passed, there was a commitment on the part of the federal government to expand community mental health services in order to replace institutionalization. It is Boardmember Conlin's impression that there has been a significant reversal of the federal commitment regarding community mental health.

Dr. Farmer responded that although she does not have any numbers regarding the federal commitment, some of the thinking was naïve and did not appreciate what people would face outside of institutions, such as housing, meals, physical care, medications, and supervision. A lot of funding stayed with the hospitals and was not invested in developing community services.

Boardmember Sherman stated that he has been a member of Washington Advocates for the Mentally Ill for many years and is a psychiatrist in private practice. Boardmember Sherman raised the recent incident involving Mr. Walker and questioned whether that particular situation represented a failure of the mental health system or was it simply an inevitable consequence of the uncertainties of life and the indefinite nature of the commitment issue? If there is a failure, where can services be improved?

Without knowing factual information, Mr. Shoenfeld cannot comment on specific issues. According to Mr. Shoenfeld, "we don't have all the resources we would like to have. We can't always provide all the services we would like to provide. There are some individuals who

choose not to be in our services, and unless they meet the criteria for the law and they come to our attention, we can't intervene. So there are a whole lot of variables that affect whether or not we can do the job we'd like to do."

Mr. Shoenfeld further described the problem of homeless mentally ill individuals and inadequate supply of low-income housing. A lot of individuals are forced onto the streets, but that does not mean those individuals should be locked up.

Dr. Farmer explained her quality improvement activity of annually obtaining the King County Medical Examiner's suicide list to determine which of those individuals were in treatment in the mental health system. The most surprising conclusion is that the vast majority of those people are not in King County's mental health system.

Boardmember VanDusen questioned what right a parent or spouse may have in seeking mental health treatment for a family member who does not need public assistance and does not want treatment. Dr. Farmer responded that there is nothing in the law that would require an adult wanting a spouse, or another adult family member, to get mental health treatment. A parent has full authority to have a child under the age of thirteen be in treatment, whether the child wants it or not. Once an individual reaches the age of eighteen, the only way to force treatment is under the Involuntary Treatment Act.

King County's Mental Health Division contracts with West Seattle Psychiatric Hospital for involuntary commitment. Harborview Hospital also provides involuntary commitment. Northwest Hospital has a geriatric involuntary commitment unit. Children are admitted to Fairfax. Approximately 99% of individuals involuntarily committed for short-term (14 days) are detained in King County. Individuals committed for 90 days or more are sent to Western State Hospital.

According to Mr. Shoenfeld, lawyers have access to their mentally ill clients' medical records. Mr. Shoenfeld further stated that public defenders are ethically responsible for representing what their clients want, not necessarily what their clients need. There is a rotating list of commissioners who preside over mental illness court at Harborview Hospital. Depending upon the rotation, the same commissioner may not hear the case of someone recently released. However, the commissioner may consider the mentally ill individual's history in order to determine the individual's treatment.

Boardmember Gossett asked Mr. Shoenfeld to comment on Dr. Farmer's suggestion that involuntary commitment laws be expanded to encompass a need for treatment rather than a dangerousness standard. Mr. Shoenfeld responded that a number of advocates for the mentally ill would like the state to intervene in those cases in which a mentally ill person needs treatment, but does not voluntarily accept treatment. However, there are Constitutional issues regarding deprivation of liberty. More should be done to encourage people to get voluntary care. According to Mr. Shoenfeld, studies indicate that individuals who have been involuntarily committed are less likely to seek voluntary care. A person forced to accept treatment tends to mistrust the involuntary system and the voluntary system.

Boardmember Gossett requested Dr. Farmer and Mr. Shoenfeld identify the main reasons that so many mentally ill individuals are being incarcerated across the nation. Mr. Shoenfeld reported that the explosion of drug abuse and alcoholism is a significant problem for many mentally ill individuals. Dr. Farmer agreed and added other epidemiological factors such as young adults being more likely to commit crimes, homelessness, etc.

In response to Boardmember Hutchinson's question whether drug or alcohol abusers have some mental health problems, Dr. Farmer stated that least 25% of drug/alcohol users have mental health illness. Approximately 40% to 50% of individuals in the mental health system have chemical dependency problems. A lot of mental health providers are becoming dual certified as chemical dependency specialists in order to offer comprehensive services to mentally ill chemically addicted individuals.

Boardmember Thompson expressed a concern to find a solution for lowering the threshold for involuntary commitment, yet recognizing a similar commitment to civil rights. Standards have changed for mental illness as they have for many illnesses, so it is appropriate and timely to increase access to mental health treatment. There ought to be greater emphasis on rehabilitation.

Boardmember Thompson commented on insurance companies not paying for mental health, because mental illnesses were sometimes poorly described and there were not always good standards for proper treatment.

According to Boardmember Thompson, lawyers representing mentally ill individuals should look at what is best for the client. Boardmember Thompson suggested continual training for police officers regarding firing weapons and commented on the recent shooting of Mr. Walker. Boardmember Thompson stated that firefighters go into burning buildings at great threat to their lives, whereas, police officers are able to shoot individuals who threaten police officers' safety.

According to Boardmember Thompson, outcomes are not good with respect to non-incarcerated mentally ill individuals. Boardmember Thompson encouraged a future panel presentation discussing outcomes.

Chair Nickels thanked the panelists and Boardmember Thompson for compelling insight into the mental health system. Chair Nickels indicated the Board intends to continue discussion regarding criminalization of mental illness from a public safety perspective.

Director of Health's Report

Dr. Alonzo Plough, Public Health - Seattle & King County, reminded the Board of its previous deliberations about how to approach some of the underlying changes in the AIDS epidemic and the need for earlier monitoring of asymptomatic HIV disease. Representatives from the State Health Department have been invited to provide an update on the evaluation of HIV reporting. Dr. Plough introduced Dr. Chris Spitters, Marie Courogen, and Jack Jordan, from the Infectious Disease Reproductive Health Division of the Washington Department of Health.

HIV Reporting Evaluation

Dr. Spitters explained the chronology of events leading to the adoption of regulations making asymptomatic HIV infection reportable. In 1997, the Governor's Advisory Council on HIV and AIDS sponsored forums taking place across the State to get input about the merits and risks of pursuing such a program. Approximately one year later, the State Board of Health directed the State Department of Health to draft revisions to the Notifiable Conditions rules that would include reporting of asymptomatic HIV infection. The State Board of Health further directed the Department to revise proposed rules which included name-based reporting to a code system. The local health jurisdiction would receive case reports by name, but before

forwarding those to the Department of Health, would convert the name to a code that could not be subsequently traced back to any individual. In July of 1999, those revisions were adopted by the State Board of Health and became effective September 1, 1999. Part of those revisions included a section assigning the State Health Officer the duty to report back to the State Board of Health within 12 months and to give information about four areas of the reporting system. First was the ability of the system to meet the Centers for Disease Control (CDC) performance criteria for HIV surveillance. One concern was whether changing the name to a code at 90 days would impact the ability to function effectively as a surveillance system, because funding for HIV prevention control efforts would be linked to surveillance efforts for HIV. Secondly, it was important to evaluate the costs of the reporting system, both to local health jurisdictions and the State Health Department. Third, it was necessary to evaluate the reporting system's effect on disease control and prevention activities. Finally, it was important to address the concern about whether or not HIV reporting would have any impact upon counseling and testing behaviors among high risk individuals.

Marie Courogen described evaluating each of the four criteria. The first parameter evaluated completeness of reporting. The State did not meet the criteria of greater than equal to 85% completeness, which is the CDC standard. The State had a 61% completeness rate, which is not surprising given that surveillance has only occurred over one year. It is anticipated that the percentage will increase over time. The State's completeness for AIDS case reporting is over 90%.

The second performance standard of timeliness is important to evaluate, because the system must be efficient. The CDC standard is that within six months of diagnosis, greater than equal to 66% of cases need to be reported. The State has met that criteria in 93% of the cases reported.

The third performance standard involves duplicates, which need to be evaluated to establish the accuracy of the system. It is important to identify people who have been previously reported to avoid over-reporting. The CDC standard is a less than 5% duplication rate and the State had a 3% rate.

The State spent a lot of time evaluating security and confidentiality, as well as working with local health jurisdictions. The CDC standards were adopted and the State developed and implemented a protocol for investigating confidentiality breaches.

The State looked at the cost of HIV surveillance above and beyond what is normally incurred for AIDS surveillance. The State reviewed estimates that were provided in the economic analysis at the time the rule was adopted. Additionally, local health jurisdictions provided information about additional costs associated with implementing the system. The State incurred \$154,000. Public Health - Seattle & King County incurred \$202,000. Other combined local health jurisdictions incurred \$90,000. Even though these places incurred additional costs related to HIV surveillance, there were no new State or local dollars allocated for the implementation or evaluation. Public Health - Seattle & King County received some federal money, a little over \$100,000, to conduct evaluation activities including the HIT survey. Although there was no additional money received to implement HIV surveillance, there were no reports indicating the reporting system diverted prevention or care resources.

The State evaluated the effect on disease control activities and looked at partner notification services. Recently diagnosed HIV cases, when compared to recently diagnosed AIDS cases, showed a higher proportion of the HIV cases were in women. A higher proportion of HIV cases compared to AIDS cases were under the age of 30. There may be a shift in the

risk profile and demographics of these HIV cases as the proportion of newly diagnosed cases increases over time. In addition, AIDS case reporting increased 21%. When the State implemented HIV surveillance, a box was added on the case report providing information about how partner notification would be conducted. The person completing the HIV case report has a choice of either checking "Yes," s/he will take care of partner notification, or the other box is, "Yes, I need some assistance from the local health jurisdiction to do partner notification." A database was created to follow up on some of the case reports. Two-thirds of the providers indicated they would assume responsibility for partner notification and one-third of the providers either requested local health jurisdiction assistance or left that section of the case report blank. Of those 222 that either asked for assistance or left it blank, all of those required some local health jurisdiction follow-up. Approximately three-quarters of those 222 providers did not meet their local health jurisdiction criteria for follow-up, because the cases were more than one year old. Most local health jurisdictions prioritize partner notification among people recently diagnosed. In addition to collecting that information, 15 providers were interviewed, all of whom stated they sought assistance from their local health jurisdictions regarding partner notification. The State also conducted a survey of representatives from all of the AIDS network regions to get a sense about what was going on with partner notification. Some respondents indicated that there was an increase in partner notification associated with the surveillance, but others did not see that same increase.

The State evaluated the impact of HIV testing of high risk individuals and looked at different data sources - publicly funded counseling and testing, private labs, and home testing. The State reviewed data from the Oregon Health Department thinking that perhaps people who did not want to get tested in Washington State would be going to Oregon where mandatory HIV reporting is not in effect. The State also looked at some preliminary data from the HIV testing survey, performed a couple of surveys on the availability of anonymous testing, and sought input from a community advisory group.

Ms. Courogen introduced a graph illustrating tests and number of positives done at publicly funded sites. The blue bars represent the number of tests done in each half year and the red line represents the number of positive tests. There have been downward trends in both of those parameters over time. This graph shows the number of confidential tests and the number of anonymous tests done over the same time period in publicly funded sites. The number of confidential tests remain stable and there is a slight decrease in the number of anonymous tests performed. This graph shows the number of men who have sex with men, including men who have sex with men and inject drugs, and injection drug users who tested. Those trends did not show a lot of difference.

In summary, there were steadily declining trends in the number of tests done and the number of test positives since 1992. There was no real change in the trend following implementation of HIV reporting. The anonymous versus confidential ratio remained stable and the demographic composition, which profiled the testing population, remained relatively stable. Approximately 25% of HIV tests were actually done in publicly funded sites. Private labs were reviewed to see if there were any changes in those trends. There are four labs that primarily process HIV tests and the State was able to obtain data from two of those labs, Smith Kline and Path, which are responsible for over half of the HIV tests processed. The total number of tests processed increased over the reporting period and the proportion testing positive remained stable.

There were some declines in home testing and the testing of Washington residents in Oregon remained stable since the implementation period. Approximately 100 to 150 Washington residents tested in Oregon per year; the number did not change over the implementation period, and there were low positive rates in both populations.

The State interviewed 129 individuals among high risk populations in the Seattle - King County area. Most individuals interviewed had not heard about any changes in policies regarding HIV testing or reporting in the past two years. Ten percent of the people who delayed testing indicated that fear about reporting was one of the reasons for the delay, but it was the main reason for only one individual, and that is consistent with results from the HIT survey in other cities that have performed this study.

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The State met with an advisory group three times. This group was comprised of people from HIV advocacy, prevention and care specialists, epidemiologists, and public health officials. The group evaluated counseling and testing data, as well as trends in the HIV data and were in agreement that the data does not show changing trends over time and the HIV data does not indicate any major shifts in the epidemic. The advisory group also suggested that more resources and time are needed for data collection and analyses.

Mr. Jordan concluded that there is no evidence indicating implementation of HIV surveillance has had a negative impact upon the ability to collect case reports, maintain a database that does not contain duplicate counting, or negatively impact high risk persons seeking HIV testing. The reporting system does meet most of the CDC performance criteria, but it will take some time to get completeness up to standards, because there are probably 5,000 to 8,000 people in the state who are in some degree of care and who have not yet been reported. There has been insufficient time to yield substantial disease control effects through partner notification or for use of this data for planning. There are other factors that are dominant in determining access to testing and partner notification. Those include pre-existing trends, for instance, the declines that have been going on for almost a decade in HIV testing, participation of both providers and patients in seeking public health-based partner notification efforts, and resources for counseling, testing, and partner notification.

The surveillance systems are not intended to provide comprehensive insight into access to services. In reality, this system provides information about individuals who are in care and who are getting reported either by their provider or by having a lab test done that indicates HIV infection. The surveillance systems do not provide information regarding the quality of medical services being rendered, nor information about individuals who are not being tested. Nation-wide, it is estimated that approximately one-quarter to one-third of HIV infected individuals do not know their status. Additional resources, outside of a surveillance system, are required to do public health-based research to outline characteristics of individuals who are not getting tested or care, as well as to ensure the quality of care that is provided to HIV infected individuals.

In response to Boardmember Pizzorno's question whether partner notification follow-up occurred, Mr. Jordan explained that the State has no legal leverage to enforce partner notification follow-up. However, studies suggest that health care provider-based partner notification efforts tend to be less successful in identifying and notifying exposed persons than the Public Health Department-based partner notification efforts.

Boardmember VanDusen commented that if partner notification is not being accomplished, it may contribute to the increase in the number of HIV reports among women and young people. Boardmember VanDusen expressed concern that the HIV increase among youths may demonstrate that young people may not believe that AIDS is a disease that can kill. The Public Health Department should convey a message of education and prevention.

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Mr. Jackman encouraged the Board to pay particular attention to the preliminary data from the HIT study that is being done in King County, which shows that 10% of people questioned indicated that HIV names reporting is one of the reasons the individuals are deterred from testing. The State has dismissed this information. Mr. Jackman reiterated the question, "does HIV names reporting deter people who should get tested?"

According to Mr. Jackman, the State has already documented two relatively minor security breaches in the reporting system. Mr. Jackman further commented that there are probably a lot of other breaches that were not discovered, because the State only sees the breaches on the State level. There are probably a lot of things going on at local health jurisdictions that the State would have no way of knowing.

According to Mr. Jackman, the State has found that most local health jurisdictions are not meeting CDC's security standards and Mr. Jackman found an appalling casualness in the State's report about data security. There is a new report from the Institutes of Medicine for the CDC that determine the passive HIV reporting, whether names-based or unique identifier-based, does not provide the data needed to try to stop the HIV/AIDS epidemic in this country. They propose an active nationwide system of anonymous seroprevalence studies, just what Resist the List has been talking about for quite a long time. Mr. Jackman quoted from a report from Harvey Fineberg, Provost of Harvard University, Co-Chair of the Committee of HIV Prevention Strategies in the U.S., "While HIV case reporting provides us with more information about HIV prevalence than it does AIDS case reporting, it is an incomplete data source for determining HIV incidents. That is, the number of new HIV infections. Without accurate information regarding where the epidemic is headed, we cannot effectively direct prevention interventions to individuals or communities who are greatest risk of prevention."

Dr. Alonzo Plough, Public Health - Seattle & King County, reminded the Board of its previous deliberations about how to approach some of the underlying changes in the AIDS epidemic and the need for earlier monitoring of asymptomatic HIV disease. Representatives from the State Health Department have been invited to provide an update on the evaluation of HIV reporting. Dr. Plough introduced Dr. Chris Spitters, Marie Courogen, and Jack Jordan, from the Infectious Disease Reproductive Health Division of the Washington Department of Health.

HIV Reporting Evaluation

Dr. Spitters explained the chronology of events leading to the adoption of regulations making asymptomatic HIV infection reportable. In 1997, the Governor's Advisory Council on HIV and AIDS sponsored forums taking place across the State to get input about the merits and risks of pursuing such a program. Approximately one year later, the State Board of Health directed the State Department of Health to draft revisions to the Notifiable Conditions rules that would include reporting of asymptomatic HIV infection. The State Board of Health further directed the Department to revise proposed rules which included name-based reporting to a code system. The local health jurisdiction would receive case reports by name, but before forwarding those to the Department of Health, would convert the name to a code that could not be subsequently traced back to any individual. In July of 1999, those revisions were adopted by the State Board of Health and became effective September 1, 1999. Part of those revisions included a section assigning the State Health Officer the duty to report back to the State Board of Health within 12 months and to give information about four areas of the reporting system. First was the ability of the system to meet the Centers for Disease Control (CDC) performance criteria for HIV surveillance. One concern was whether changing the name to a code at 90 days would impact the ability to function effectively as a surveillance system, because funding for HIV prevention control efforts would be linked to surveillance efforts for HIV. Secondly, it was important to evaluate the costs of the reporting system, both to local health jurisdictions and the State Health Department. Third, it was necessary to evaluate the reporting system's effect on disease control and prevention activities. Finally, it was important to address the concern about whether or not HIV reporting would have any impact upon counseling and testing behaviors among high risk individuals.

Marie Courogen described evaluating each of the four criteria. The first parameter evaluated completeness of reporting. The State did not meet the criteria of greater than equal to 85% completeness, which is the CDC standard. The State had a 61% completeness rate, which is not surprising given that surveillance has only occurred over one year. It is anticipated that the percentage will increase over time. The State's completeness for AIDS case reporting is over 90%.

The second performance standard of timeliness is important to evaluate, because the system must be efficient. The CDC standard is that within six months of diagnosis, greater than equal to 66% of cases need to be reported. The State has met that criteria in 93% of the cases reported.

The third performance standard involves duplicates, which need to be evaluated to establish the accuracy of the system. It is important to identify people who have been previously reported to avoid over-reporting. The CDC standard is a less than 5% duplication rate and the State had a 3% rate.

The State spent a lot of time evaluating security and confidentiality, as well as working with local health jurisdictions. The CDC standards were adopted and the State developed and implemented a protocol for investigating confidentiality breaches.

The State looked at the cost of HIV surveillance above and beyond what is normally incurred for AIDS surveillance. The State reviewed estimates that were provided in the economic analysis at the time the rule was adopted. Additionally, local health jurisdictions provided information about additional costs associated with implementing the system. The State incurred \$154,000. Public Health - Seattle & King County incurred \$202,000. Other combined local health jurisdictions incurred \$90,000. Even though these places incurred additional costs related to HIV surveillance, there were no new State or local dollars allocated for the implementation or evaluation. Public Health - Seattle & King County received some federal money, a little over \$100,000, to conduct evaluation activities including the HIT survey. Although there was no additional money received to implement HIV surveillance, there were no reports indicating the reporting system diverted prevention or care resources.

The State evaluated the effect on disease control activities and looked at partner notification services. Recently diagnosed HIV cases, when compared to recently diagnosed AIDS cases, showed a higher proportion of the HIV cases were in women. A higher proportion of HIV cases compared to AIDS cases were under the age of 30. There may be a shift in the risk profile and demographics of these HIV cases as the proportion of newly diagnosed cases increases over time. In addition, AIDS case reporting increased 21%. When the State implemented HIV surveillance, a box was added on the case report providing information about how partner notification would be conducted. The person completing the HIV case report has a choice of either checking "Yes," s/he will take care of partner notification, or the other box is, "Yes, I need some assistance from the local health jurisdiction to do partner notification." A database was created to follow up on some of the case reports. Two-thirds of the providers indicated they would assume responsibility for partner notification and one-third of the providers either requested local health jurisdiction assistance or left that section of the case report blank. Of those 222 that either asked for assistance or left it blank, all of those required some local health jurisdiction follow-up. Approximately three-quarters of those 222 providers did not meet their local health jurisdiction criteria for follow-up, because the cases were more than one year old. Most local health jurisdictions prioritize partner notification among people recently diagnosed. In addition to collecting that information, 15 providers were interviewed, all of whom stated they sought assistance from their local health jurisdictions regarding partner notification. The State also conducted a survey of representatives from all of the AIDS network regions to get a sense about what was going on with partner notification. Some respondents indicated that there was an increase in partner notification associated with the surveillance, but others did not see that same increase.

The State evaluated the impact of HIV testing of high risk individuals and looked at different data sources - publicly funded counseling and testing, private labs, and home testing. The State reviewed data from the Oregon Health Department thinking that perhaps people who did not want to get tested in Washington State would be going to Oregon where mandatory HIV reporting is not in effect. The State also looked at some preliminary data from the HIV testing survey, performed a couple of surveys on the availability of anonymous testing, and sought input from a community advisory group.

Ms. Courogen introduced a graph illustrating tests and number of positives done at publicly funded sites. The blue bars represent the number of tests done in each half year and the red line represents the number of positive tests. There have been downward trends in both of those parameters over time. This graph shows the number of confidential tests and the

number of anonymous tests done over the same time period in publicly funded sites. The number of confidential tests remain stable and there is a slight decrease in the number of anonymous tests performed. This graph shows the number of men who have sex with men, including men who have sex with men and inject drugs, and injection drug users who tested. Those trends did not show a lot of difference.

In summary, there were steadily declining trends in the number of tests done and the number of test positives since 1992. There was no real change in the trend following implementation of HIV reporting. The anonymous versus confidential ratio remained stable and the demographic composition, which profiled the testing population, remained relatively stable. Approximately 25% of HIV tests were actually done in publicly funded sites. Private labs were reviewed to see if there were any changes in those trends. There are four labs that primarily process HIV tests and the State was able to obtain data from two of those labs, Smith Kline and Path, which are responsible for over half of the HIV tests processed. The total number of tests processed increased over the reporting period and the proportion testing positive remained stable.

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Presentation of the 2001 Budget for Public Health

Dr. Plough introduced Kathy Uhlorn, Manager, Administrative Services, Public Health - Seattle & King County, to briefly provide an overview of the 2001 budget for Public Health. Ms. Uhlorn indicated Public Health faced an \$8.5 million challenge in salaries due to class comp settlements and union agreements. The Department was also faced with a \$1.1 million current expense reduction, a Clark lawsuit settlement, and Board of Health potential fee reduction. There were \$1.1 million increases in two major accounts - pharmaceuticals and leases. Additionally, the Department had to correct revenues that were overstated in the 1999 budget.

Ms. Uhlorn introduced a chart indicating local and flexible funding, general fund, MVET, MCX, and the different levels between the 2000 and 2001 budget.

In response to Boardmember Pullen's question whether mercury dental fillings were being used in the Health Department's dental clinics, Ms. Uhlorn indicated that non-mercury amalgams are being used.

Dr. Plough reminded the Board that a more detailed discussion of the Health Department's 2001 budget would be presented at the next Board meeting.

Chair Nickels adjourned the meeting at 1:17 p.m.

KING COUNTY BOARD OF HEALTH

s/Greg Nickels/s