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Senator Johne Binkley

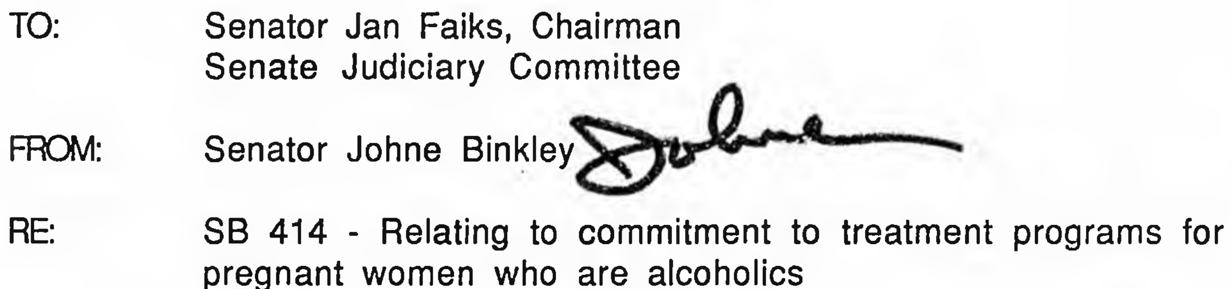
Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

MEMORANDUM March 8, 1990

TO: Senator Jan Faiks, Chairman
Senate Judiciary Committee

FROM: Senator Johne Binkley



RE: SB 414 - Relating to commitment to treatment programs for pregnant women who are alcoholics

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This is to request a hearing in your committee of SB 414 at the earliest possible time. SB 414 is one of a package of bills which target the problems of Fetal Alcohol Syndrome. It would provide for petition for commitment to a treatment center of an alcoholic pregnant person whose continued use of alcohol will likely harm the fetus. It is, by far, the bill which is receiving the most public interest, and I would appreciate your consideration of a teleconferenced statewide public hearing.

I have included with this request a copy of research recently completed by Legislative Research Agency which explores both sides of the policy and legal questions surrounding non-voluntary commitment of pregnant persons. There is no obvious right or wrong as we consider the rights of the mother and the rights of the child under our laws, but the consequences for the child of continued alcoholic drinking during the critical months of his or her development are staggering. A child born with Fetal Alcohol Syndrome has been damaged for life, with enormous medical problems, irreversable educational consequences, and social and daily living skills far below other children and adults. There are women in Alaska who have produced three, four, even as many as seven Fetal Alcohol Syndrome Child. In these instances it is time for society to intervene.

Alaska's alcohol commitment statutes are difficult under any circumstances, and would not be used to commit women who are casual or social drinkers. The commitment statutes provide a civil remedy, they would not put pregnant women in jail. SB 414 would provide an important tool where all other means of intervention had failed.

Also included with this memo is a copy of research which shows the costs to society of every FAS child born in Alaska. Estimating 29 FAS children born each year, we are

looking at an encumbered societal cost of nearly $40 million. If we add Fetal Alcohol Effect children that cost skyrockets to $104 million.

The problem is enormous. The arguments for and against involuntary commitment are persuasive, each in their own way. My sense, from the correspondence we've received in the office, is that the public would appreciate the opportunity to voice their concerns.

Thank you for your consideration of this request.

Bill would reduce birth of FAS babies

OPINION

by Sen. Johne Binkley
for the Tundra Times

JUNEAU — We can take an important step to reduce the number of Fetal Alcohol Syndrome babies born in Alaska if my bill providing for involuntary commitment of pregnant alcoholic women passes the Legislature. But one thing we *won't* be doing is putting drinking moms in jail.

It's understandable that people unfamiliar with this legislation might think the police will be prowling the bars, looking for pregnant women to haul off to jail if this bill passes. That's not true.

And even if an alcoholic woman did find herself in court under this law, she wouldn't be sent to jail. The judge would be able to order her to check into a residential alcohol treatment program.

Here's exactly what the bill — Senate Bill 414 — would do as it is currently written:

If a pregnant woman is showing signs of serious alcoholism, the bill allows the court to be petitioned to determine whether she needs professional help to avoid harming the baby she is carrying. And, while there is plenty of evidence to show that even a couple of drinks a day during pregnancy can cause some damage to the baby's health, this bill is aimed only at the hard core alcoholic, not the casual drinker.

The only peopole who could make a complaint in court against the woman would be her spouse, guardian, relative, a doctor or the administrator of a treatment facility. Because the bill also requires a doctor to file a certificate supporting the court petition, we've tried to protect against a situation where an angry husband or relative files an unjustified complaint.

The doctor must have examined the woman sometime within the two days prior to the petition being submitted to the court, or must have at least given her the opportunity to reject a physical examination.

If, after reviewing the evidence and the physician's certificate, the court decides that only intervention can prevent damage to the baby, the judge can then order the woman committed to a private or public facility for treatment of alcoholism.

The commitment period would be 30 days, with provisions for extension until the baby is born if the court is convinced during a second hearing that there is a need for continuing treatment.

As the treatment goes on, the patient would be provided reasonable opportunities to see the doctor of her choice.

And even if an alcoholic woman did find herself in court under this law, she wouldn't be sent to jail. The judge would be able to order her to check into a residential alcohol treatment program.

And, at any point during the treatment period, if the woman either is determined to be no longer alcoholic or she is no longer pregnant, she would be released.

Most mothers obviously want to take good care of their babies from the moment they find out they're pregnant, and they don't need or deserve anybody from the state telling them how to do it. But alcohol and drug addiction can override that natural protective instinct, and helping those mothers addicted to alcohol protect their babies is the aim of this bill.

Some would say we have no right to intervene in a pregnant woman's life. I'd point out that we already have laws on the books making it illegal to provide alcohol or drugs to children from the moment they are born. Shouldn't we provide that same protection — if only in the most serious cases of alcohol abuse by the mother — in the months before the child is born?

Others might argue that by the time a woman is obviously pregnant and her alcohol abuse is documented well enough to go to court, the fetus has already been damaged. That some damage already would have occurred probably is true, but medical research has documented the fact that the brain is developing through the whole term of the pregnancy.

So even if the mother didn't stop drinking until the latter stages of her pregnancy, the child would still have a chance of having fewer defects than if the alcohol abuse were allowed to continue right up until birth.

Finally, some opponents of this bill would argue that it would discourage women from seeking medical care during pregnancy, out of fear that the doctor might file a complaint to get her committed to an alcohol program. But again, this bill is aimed only at the most serious abusers, and we've found that many pregnant women who are seriously alcoholics don't get proper medical care during their pregnancy anyway.

Fetal Alcohol Syndrome saddles a child with lifelong defects that are directly attributable to the mother's behavior. And since most these mothers have no financial resources, they create expensive financial problems we end up paying for. It costs an average of $1140,000 just to get a newborn FAS child through the period of intensive care it requires at birth and $1.4 *million* to care for it over a lifetime.

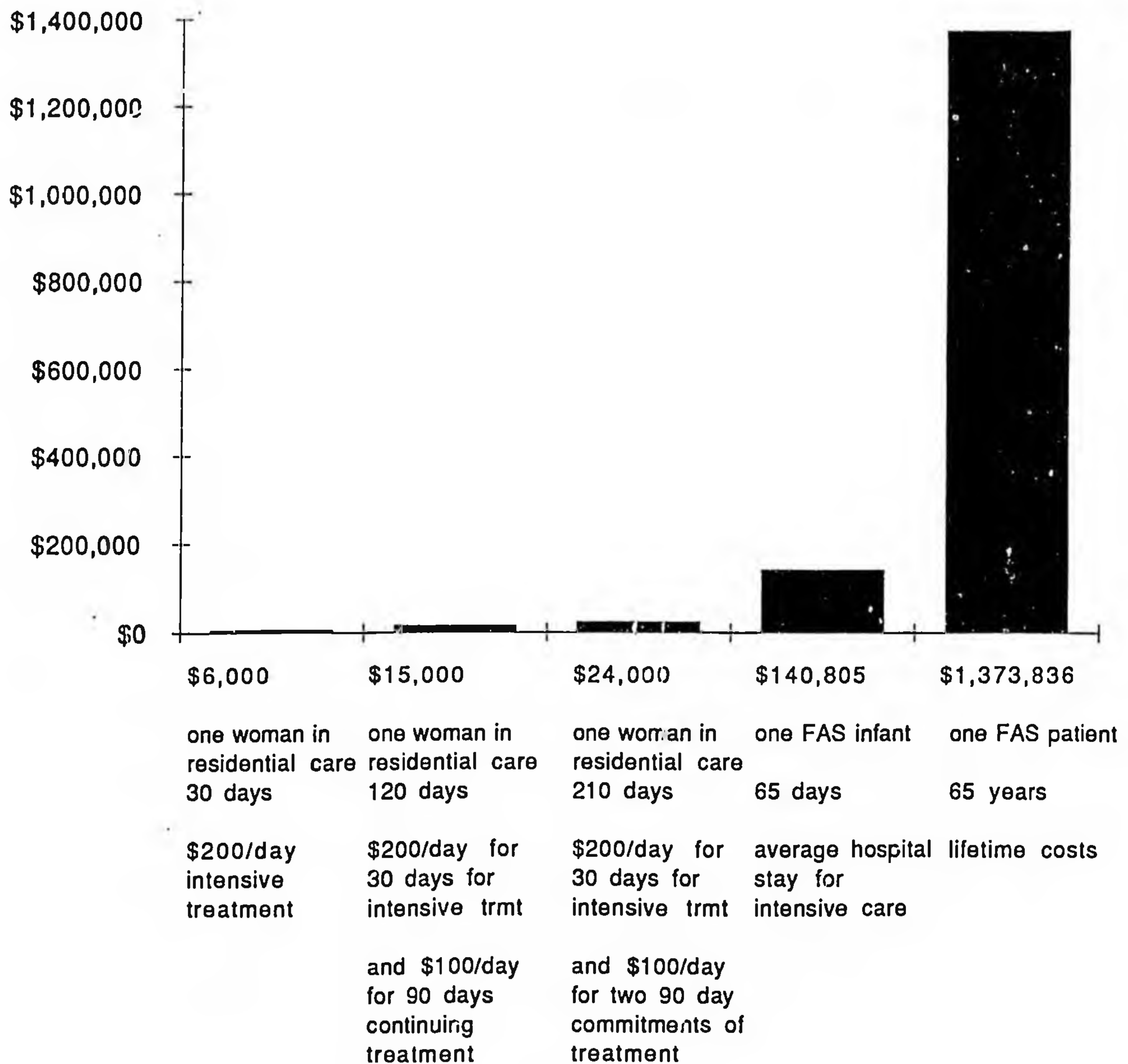
When I filed this bill, I thought a lot about a woman in Southcentral Alaska who has had seven FAS babies. All of those children are in foster families now, and the last we heard, this woman is pregnant again.

If we had had this law on the books, we might have been able to save not only her first FAS baby from some degree of damage, but the other six as well. Being committed to a treatment program might have brought an end to her alcohol abuse for good, and those other six babies could have been born healthy.

I don't claim to have written the perfect bill in this or any other case, but it will be debated and people surely will offer changes as it makes it way through the Legislature's committee process. An important part of that process is public input, and if you've got ideas on this subject, I encourage you to contact us.

Right now there are about 30 FAS babies being born every year in Alaska. This bill won't save them all, but it would at least give us the hope of saving some of them.

Costs of Treatment as Compared with Costs of FAS



Alaska State Legislature

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February 2, 1990

MEMORANDUM

TO: Representative Eileen MacLean

FROM: Maureen Weeks MW
Legislative Analyst

RE: **Nonvoluntary Treatment for Pregnant Women Who Habitually Use Alcohol;**
School Curricula
Research Request 90.137

You asked this agency what legal or policy issues are raised by two proposals: (1) to mandate treatment for women who habitually use alcohol during and after pregnancy; and (2) to implement a school curriculum on Fetal Alcohol Syndrome. This memorandum addresses these questions at some length. The summary below provides an overview of the major points of discussion. A table of contents can be found on page 4. The bibliography and list of personal communications are at the end.

SUMMARY

Number and Cost of Drug and Alcohol-Affected Newborns

A state study shows that in six months of 1989, in Anchorage and Fairbanks alone, physicians reported 111 newborns whose mothers had used alcohol during pregnancy or used drugs a few days or hours before delivery. At this rate, physicians in these two cities *this year alone* will report 222 children damaged by drugs or alcohol. At least two Anchorage cocaine babies are HIV positive.

Experts say this is only a fraction of babies exposed to drugs or alcohol during pregnancy. Many of these infants are not reported to the state. There are several reasons for this. First, toxicology tests on Alaska newborns are not routine. Second, some Alaska physicians are reluctant to report. Third, blood tests at birth do not show the larger number of babies whose mothers used drugs or alcohol at any other time earlier in their pregnancy.

Even before severely affected babies leave the hospital, the costs of care are enormous. The bill for a 16-month-old FAS baby boy who lives in the intensive

care unit at Providence Hospital is $1.4 million, so far. One study says the lifetime cost of Fetal Alcohol Syndrome babies born in one year is $39.8 million.

Legal Questions

Policy makers considering mandated treatment for pregnant women who abuse drugs or alcohol must juggle two basic rights: the pregnant woman's right to control her own body and the child's right to be born healthy. In most cases, the rights are compatible because most pregnant women want to provide the fetus with a safe place to grow. But some cannot or will not. Often, these women are addicted. When they abuse drugs or alcohol, does society -- a judge, a lawmaker, a physician, a relative -- have an obligation or a right to protect the fetus from harm? Ethicists and philosophers debate this question vainly, while lawyers write persuasive articles on both sides. Meanwhile, judges and legislators are left to seek a reasonable answer.

Policy Questions

Most state statutes do not address the problem of babies damaged by drugs and alcohol. Alaska, for example, does not require drug or alcohol tests for newborns. It does not require physicians to report newborns who test positive. Alaska child abuse and neglect laws do not include the fetus. No law tells Alaska physicians to test pregnant women if they believe she might be using drugs or alcohol. And officials say that if all substance-abusing pregnant women were identified and ordered into treatment, there would not be enough beds for them.

Some states are attempting to find a solution that respects the pregnant woman's privacy and protects the fetus. Minnesota has taken the lead with a two-month-old law that requires physicians to test and report substance-abusing pregnant women. When they get a report, state officials are required to offer the woman treatment and prenatal care. If she refuses or fails the treatment, the state must put the woman in nonvoluntary treatment. A state official says the law has already been used in several Minnesota counties.

If a baby is born drugged in Oklahoma, state officials may take custody of the baby and require the mother (and the father) to complete treatment before they return the baby to the home. Some states require physicians to test newborns if they suspect the infant has been affected by drugs or alcohol and then require physicians to report positive test results. Some states allow authorities to take custody of children who are born with drugs in their blood. One means to do so is to redefine certain parts of child abuse or neglect statutes to include the fetus.

Policy Options

Some Alaska experts recommend requiring pregnant women to get treatment if they will not do it on their own. When an Alaska woman has committed a jailable offense, a judge may opt to use the threat of jail to convince the woman to enter a treatment program. State officials want to require physicians to report addicted newborns, but some physicians object on the grounds that the state should first make its position clear by passing a law to include the fetus in child abuse or neglect statutes. The National Conference of State Legislatures recommends identifying children born with drug or alcohol problems so they can be placed in the proper protective, health or rehabilitative channels. Dr. Ira Chasnoff, a nationally recognized expert on substance-abusing pregnant women, recommends treatment and parenting education. Finally, some say it is wrong to force women into treatment unless all-out efforts have been made to educate the public about the damage drugs and alcohol can do to the fetus. These advocates say policy makers should first make available effective treatment for pregnant women and change the conditions which breed abuse of drugs and alcohol.

Implementing a Fetal Alcohol Syndrome Curriculum

The question of legal and policy issues concerning implementing a curriculum to teach about Fetal Alcohol Syndrome in the schools is treated very briefly. In general, state experts on law and education see no difficulty in encouraging local school districts to teach this subject. Education officials, however, are traditionally hesitant to mandate curricula. For the first time in its history, the State Board of Education on January 30 passed a resolution to support mandating comprehensive health education in the school curriculum, including a segment on Fetal Alcohol Syndrome.

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BACKGROUND

Incidence of Babies Born with Alcohol and Drugs in their System

State officials say that in one six-month period, Anchorage physicians reported 65 newborns testing positive for cocaine and one positive for another drug. In the same six month period, Anchorage physicians identified and reported 33 babies or toddlers with symptoms of Fetal Alcohol Syndrome or Fetal Alcohol Effects. Two Anchorage cocaine babies are HIV positive but the number may be higher because it can take up to a year and a half after birth for a baby to test positive (Staciokas). In the six month period, Fairbanks physicians reported eight newborns positive for cocaine, two for marijuana and one for amphetamines. One baby was identified as affected by alcohol (Caskey, pers. com.). At this rate, physicians in Anchorage and Fairbanks could be expected to report 222 drug or alcohol damaged children a year.

Experts say this is only a fraction of infants who ingested drugs or alcohol before they were born.[1] The majority are not reported for several reasons:

- State law does not require toxicology tests on newborns who show signs of distress caused by drugs or alcohol;

- Once an infant is tested, state law does not require physicians to report positive tests and the state claims many do not. A state report says, "Many in the medical community are reluctant to report such births to DFYS (Division of Family and Youth Services)," adding that, "[I]t is not common to report (alcohol) births even when they are recognized" (Staciokas, p. 1); and

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[1] Alaska Department of Health and Social Service officials say the department is preparing to test all Alaska newborns for cocaine in a six-month "blind" study (Livey, pers. com.).

- Positive toxicology tests at birth cover only infants whose mothers used cocaine or other drugs within days or hours of delivery.[2] In addition, Fetal Alcohol Syndrome is sometimes difficult to identify at birth. Thus, tests and observations at birth do not include the larger number of infants whose mothers used drugs or alcohol at any other time during their pregnancy. Studies show that moderate doses of alcohol, as early as the first months of pregnancy, can impair a child intellectually, while even one hit of cocaine can do permanent damage to a fetus.

No one has counted the total number of babies born with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE) in Alaska. One survey shows that between 1981 and 1988 the incidence of FAS among Alaska Natives was 4.2 per 1,000 births -- twice the national average (Berner, p. 2 and Hild, pers. com.). No similar data exists for non-Native births. In the absence of a definitive count, a study by the Alaska Senate Advisory Council estimates that at least 29 Alaska babies are born annually with FAS (Research Request No. 89-100015, p. 1). Alaska experts believe about ten times more babies are born annually with FAE than with FAS (Hild, pers. com.).

Effects of Alcohol on the Fetus

When a pregnant woman drinks alcohol, her fetus, which also ingests the alcohol, may be damaged. If the damage is severe, it can include mental retardation and physical abnormalities such as cleft palate, curvature of the spine and heart and kidney defects. Less severe effects include hyperactivity, learning disabilities and short attention span.

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[2] Cocaine takes 48 hours to clear the pregnant woman's system but up to five days to clear the fetal system (Hild, pers. com.).

It is unclear how much alcohol can cause this damage. Fetal Alcohol Syndrome children always have chronically alcoholic mothers. But recent research by Ann Streissguth, a member of the team which originally identified Fetal Alcohol Syndrome, indicates that pregnant women who are "social drinkers" also risk harming their babies. Research published in 1989 shows that a woman who consumes more than one-and-a-half ounces of alcohol a day (approximately three drinks) has a three times greater chance of producing a child with a subnormal IQ (Streissguth et al, 1989, p. 7). An earlier study found that children of mothers who were "moderate drinkers" (averaging one drink a day during mid-pregnancy) had significantly shorter attention spans and more periods of inattention than children of infrequent or nondrinkers (S. Landesman-Dwyer et al, 1988, p. 187-193). Finally, in two other studies, researchers at the National Institute of Health and at the University of Washington found that one drink a day may substantially increase the risk of producing a low birthweight child (Mills, et al, 1984; Little, 1977). Dr. Streissguth and her associates caution that "safe" drinking levels for pregnant women have not been established.

The symptoms of alcohol damage to a fetus are divided into two sets. The more severe set is Fetal Alcohol Syndrome, a leading cause of mental retardation in the U.S. FAS children are characterized by premature birth, low birthweight, a characteristic facial appearance, central nervous system problems and malfunction of major organs such as their heart and kidneys. At birth, they may appear tremulous, jittery and irritable and they may have difficulty sucking and show abnormal sleep patterns.[4] Less severe, but more prevalent, is Fetal Alcohol Effects (FAE), which can also affect the intellect and cause hyperactivity as well as speech and hearing problems. Symptoms may not be

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[4] These are similar to the effects on newborns of prenatal exposure of cocaine: tremors, irritability, poor feeding, abnormal sleep patterns, prematurity and low birthweight (MacGregor, et al, p. 690; Doberczak et al, p. 356). Boston University School of Medicine pediatricians report the effects of marijuana on newborns include low birthweight, an abnormal startle reflex, tremors and an inability to shut out stimuli (Brody, p. 1).

- Among the policy questions: Would pregnant women abort or go "underground" to avoid mandated treatment? Is appropriate alcohol treatment available? Who is to report alcohol use and who is to mandate that the woman be treated?

The conflict between a woman's right to drink alcohol and the fetus's right to be free from damaging substances is a recent one. United States researchers did not identify alcohol as a hazard to the fetus until 1973 when Seattle physicians reported in the medical journal *Lancet* that children of chronically alcoholic mothers were abnormally small, had facial deformities, suffered from heart defects and were slower to develop (Jones et al, 1973).[5]

In the last 20 years, medical research has turned up a growing number of other hazards to a developing fetus, including environmental toxins, prescription drugs, illegal drugs and even nicotine. Research demonstrates that these may cause permanent handicaps and dangerously premature birth.

Although the perceived danger of prenatal exposure to drugs and alcohol is recent, two studies show that the effects of this exposure may be extensive.

- A 1989 study in Pinellas County, Florida found that, among women making their first visit for prenatal care, more than one in six tested positive for alcohol, marijuana, cocaine and/or opiates. The women were patients in public health clinics and the offices of private physicians. Dr. Ira Chasnoff, director of the National Association of Perinatal Addiction Research and Education (NAPARE),

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[5] Child abuse is another example of a recently perceived phenomenon. Although child abuse was identified in the late 19th Century, it wasn't until 1962 that Dr. C. Henry Kempe published an article in the Journal of the American Medical Association identifying the battered child syndrome (Kempe, et al, JAMA, Vol. 181, p. 17, 1962). Since that time, all states have written laws prohibiting child abuse and neglect.

evident until a child reaches school age. Both FAS and FAE may be difficult to identify at birth.

Data indicate that the drinking habits of fathers can also affect the fetus. A University of Michigan study shows that babies born to fathers who drank regularly during the month before conception were an average of 137 grams (4.83 ounces) lighter than those who were born to fathers who were occasional drinkers. Regular drinkers were defined as men who consumed about two standard-sized mixed drinks a day or had at least one binge before conception (Little and Sing, p. 1). Experiments with animals at Boston University School of Medicine show that alcohol consumption by male mice before mating can adversely and permanently affect the normal development of their offspring (Friedler, p. 129).

MANDATING TREATMENT FOR WOMEN WHO HABITUALLY USE ALCOHOL DURING PREGNANCY

Introduction

Most pregnant women make conscientious efforts to give the fetus a safe, healthy place to prepare for birth. Some do not or cannot. Among these are women whose consumption of alcohol threatens to injure the fetus.

Policy makers confronting the issue of alcoholic pregnant women find themselves juggling three notions fundamental to the structure of our political and social system: the right to life, the right to privacy and the expectation that society protects those who cannot protect themselves. This raises important legal and policy questions which are described, but not answered, in this memorandum.

- Among the legal issues: Does the child have the right to a healthy start in life? Does the mother have the right to be free of intrusion into her private life? Can a pregnant woman be compelled to live according to the dictates of a physician, a judge or society?

says the county's demographics may qualify the study as a microcosm of prenatal substance abuse in other U.S. communities (Sherman 1989, p. 28).[6]

- A 1988 survey of 36 hospitals nationwide showed that in one of every nine births, babies were born with an illegal drug in their system or their mothers admitted some type of illegal drug use during pregnancy, most commonly cocaine. The study did not include alcohol (P. Shaw, pers. com.).

Meanwhile, physicians have developed the technology to save damaged or premature infants who a generation ago would have died. In the 1950s, only two percent of babies born in the sixth to seventh month of pregnancy survived delivery and almost all were physically handicapped. In the 1970s, only one in five survived. Today, 40 to 50 percent survive and of these about one-third suffer major physical handicaps such as blindness, deafness, cerebral palsy and mental retardation (Orentlicher, p. 23).

Rapidly evolving medical technology and increased exposure to toxic substances create a conundrum for public policy makers, physicians and state officials. Does society have a responsibility to protect a fetus, which by its nature, is incapable of protecting itself? Is it ever possible to protect the fetus without riding roughshod over the pregnant woman's constitutional right to privacy, to control her own person and to freedom from all restraint or interference of others? The legal and policy issues raised by these questions are briefly discussed below.

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[6] Dr. Chasnoff will be in Anchorage May 3 and 4 to speak on cocaine and poly-drug use during pregnancy. His visit is sponsored by the Municipality of Anchorage, the Child Advocacy Network, Providence Hospital, the Indian Health Service and the Governor's Office.

Legal Issues

The rights of the fetus and the pregnant woman are brought into conflict by their unique relationship. Numerous courts have enunciated the child's right to begin life "unhampered and unimpaired by damage negligently caused to body or mind."[7] They have also upheld the right to privacy, the right to control one's own person, "the right of complete immunity: to be let alone."[8] The opposing rights are described below.

A: The Child's Right to a Healthy Start in Life

A New Jersey Supreme Court in 1960 was the first to write that a child has a right to a healthy start in life.[9] In a case involving a child born with deformed feet and legs after an automobile accident while he was in the uterus, the court wrote:[10]

> "There is no question that conception sets in motion biological processes which if undisturbed will produce what every one will concede to be a person in being. If in the meanwhile those processes can be disrupted resulting in harm to the child when born, it is immaterial whether before birth the child is considered a

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[7] *Sylvia v. Gobeille*, 220 A.2d, 222, Rhode Island, 1966.

[8] *Union Pacific Railway v. Botsford*, 141 U.S. Law. Ed. 734, 1891.

[9] Some commentators say this language does not establish a literal right to be born healthy. "To claim that *Smith* stands for the proposition that everyone owes a duty to a fetus to ensure that it is born 'with a sound mind and body' is to stretch the holding beyond recognition," according to Laurence J. Nelson, a California lawyer and ethicist.

[10] *Smith v. Brennan*, 157 A.2d 497, New Jersey, 1960.

> person in being. And regardless of analogies to other areas of the law, justice requires that the principle be recognized that a child has a legal right to begin life with a sound mind and body."

Other courts have quoted from this decision.[11] One court, however, recognized no such right in a case involving wrongful life, saying the matter is a "mystery more properly to be left to the philosophers and the theologians".[12]

Those who argue for the right to a healthy start in life say that recent research demonstrates an increasing number of ways the acts or omissions of a pregnant woman can harm her potential child. For example, smoking may cause a baby to be born underweight and at risk for severe handicaps; prescribed medicines may cause physical anomalies; and exposure to certain hazards at work -- such as anesthetic gases, and the chemicals used to manufacture rubber, plastics, paints, cellophane, pesticides, nylons, gasoline, adhesives and bullets -- may damage a fetus.

Once parents are aware of pregnancy, these advocates say, they should be held to a "reasonably prudent expecting parents standard" to provide and care for the child. Parents have a duty to act reasonably toward their children, these proponents say, and a parent's right to autonomy should be limited when it conflicts with the child's right to be protected so it can be born whole (Simon, p. 90). To those who argue that protecting the fetus interferes with the woman's control over her own body and actions, they respond that people addicted to drugs or alcohol do not have control over their use of these substances.

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[11] See, for example, *Grodin v. Grodin*, 301 N.W.2d 870, Michigan, 1981; *Womack v. Buchhorn*, 187 N.W.2d 222, Michigan, 1971; and *In Re Ruiz*, 500 N.E.2d 935, Ohio, 1986.

[12] *Becker V. Schwartz*, 386 N.E.2d 807, New York, 1978.

Noting that the right not to be wrongfully harmed by others is "perhaps a person's most basic right," Harvard fellow Deborah Mathieu writes that there may be times when a pregnant women's liberty justifiably may be limited to prevent harm to her future child, whether or not the woman is the cause of the harm. She warns that many factors (extent of harm, risk of harm, and chance and cost of avoiding it) must be considered before intervention is justified (Mathieu, p. 31). Dr. Mathieu notes several examples in which the U.S. Supreme Court has allowed intrusions: drawing blood for a blood alcohol test, compulsory smallpox vaccination and compulsory sterilization in which the court held that the principle of compulsory vaccination "is broad enough to cover cutting the Fallopian tubes."[13] Therefore, she argues, the strong presumption in favor of the pregnant woman's bodily integrity must sometimes be overridden by the child's right not to be harmed (p. 45).

Some argue for restricting an addicted pregnant woman's use of drugs or alcohol. Advocates of this position say that using alcohol is a privilege, not a right, and they note that using illicit drugs is a crime. They say that distributing illegal drugs and alcohol to a fetus is a more serious crime than simply using illegal drugs oneself (M. Shaw, p. 104). They note that were a woman to give alcohol or drugs to a child the day <u>after</u> its birth, rather than the day <u>before</u>, she would risk criminal sanctions (Balisy, p. 1223). An Alaska case illustrates this argument. A Fairbanks woman in 1989 was sentenced to six months in jail after her two-week-old baby drank formula with cocaine in it and died. The mother was 7-1/2 months pregnant when she was sentenced and had used cocaine during both pregnancies. She had a third child who tested positive for the drug. Besides the jail time, she was ordered to spend six months to 1-1/2 years in a drug treatment program (Associated Press, August 28, 1989).

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[13] Drawing blood: *Schmerber v. California*, 16 U.S. Law. Ed. 2d 908, 1966 and *Breithaupt v. Abram*, 353 U.S. Law. Ed. 448, 1957. Compulsory sterilization: *Buck v. Bell*, 274 U.S. Law. Ed. 1000, 1927. Compulsory smallpox vaccination, *Jacobson v. Massachusetts*, 197 U.S. Law. Ed. 643, 1905.

These advocates say that officials may justifiably restrict a pregnant woman's use of alcohol, tobacco and licit and illicit drugs to keep her from passing drugs through her body to the fetus. Patricia King of the Georgetown University Law Center wrote in 1979 that it would "certainly be justifiable" to compel an addicted pregnant woman to undergo treatment (King, p. 1684). John Robertson of the University of Texas Law School says that once a woman decides to have a child -- that is, she does not have an abortion -- she has a "duty" to assure that the fetus is born as healthy as possible. "She no longer has the right to produce a dead or unhealthy baby" (Robertson, p. 352 and 360). Professor Robertson says a "mere ban" on certain activities during pregnancy, such as alcohol or drugs for the sake of the fetus, is no more intrusive on a woman's autonomy than regulating other activities, such as adding fluoride to the water or requiring vaccination (Robertson, p. 359-60).

B: <u>The Mother's Right to Privacy</u>

Those who weigh the competing constitutional rights and see the balance tip in favor of the woman, argue that vesting a fetus with rights creates an unacceptable intrusion into women's bodies and their personal lives. They say state interference pits woman against fetus, eroding bonding and encouraging women to avoid prenatal care (Note, p. 1012).

These advocates turn to the right of privacy, citing Justice Brandeis' often-quoted dissent that the "right to be left alone" is "the most comprehensive of rights and the right most valued by civilized man."[14] To this they add the

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[14] In his dissent in *Olmstead v. United States*, Justice Brandeis wrote: "The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature... They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things... They conferred, as against the Government, the right to be left alone -- the most comprehensive of rights and the right most valued by civilized men" (277 U.S. Law. Ed. 944, [1928]).

importance of control over one's own person, citing another Supreme Court opinion, "No right is held more sacred, or is more carefully guarded... than the right of every individual to the possession and control of his own person."[15]

In addition, these advocates note, the pregnant woman has the right to be free of sex discrimination: no man, they argue, would be forced to protect his sperm from alcohol damage that might harm a future child (Sherman 1989, p. 28). Pregnant women, they say, are singled out for intervention because of their unique status. They cite several examples in which the U.S. Supreme Court refused to force criminal suspects to submit to certain medical procedures. In one instance, the court held the state could not compel a suspect to have his stomach pumped for morphine capsules, saying such a process is "conduct which shocks the conscience."[16] In another, the court held that surgically removing a bullet from a robbery suspect's chest against his will for use as evidence against him is an "unreasonable" intrusion."[17] And in a third, the court allowed the state to take a blood test only if it could demonstrate that it was necessary to perform the test immediately or else the evidence would be lost.[18] This court added:

> "The integrity of an individual's person is a cherished value of our society. That we today hold that the Constitution does not forbid the States minor intrusions into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions."

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[15] Union Pacific Railway v. Botsford, 141 U.S. Law. Ed. 734, 1891.

[16] *Rochin v. California*, 96 U.S. Law. Ed. 183, 1952.

[17] *Winston v. Lee*, 84 U.S. Law. Ed. 2d, 662, 1985.

[18] *Schmerber v. California*, 16 Law. Ed. 2d, 908, 1966.

F -lly, a federal circuit court has held that mental patients committed against their will have the right to refuse treatment. The court cited the words of an Oklahoma state court, "[L]iberty includes the freedom to decide about one's own health. This principle need not give way to medical judgment."[19] Because of these basic rights, these advocates say, no pregnant woman who refuses treatment for the good of her fetus should be forced to submit to it.

Dawn Johnsen, writing in the *Yale Law Journal*, warns that granting rights to fetuses which conflict with a woman's autonomy reinforces the tradition of disadvantaging women on the basis of their sex. By subjecting women's decisions and actions during pregnancy to judicial review, the state questions women's abilities. At the same time, it seizes their rights to make decisions essential to their very personhood. This rationale is similar to that used in the past to exclude women from the paid labor force, Ms. Johnsen says. She warns that fetal rights could be used to restrict women's autonomy in ways far surpassing any regulation on the actions of competent adult men (Johnsen, p. 624-5).

Moreover, advocates of this view say, health care is a finite commodity, medical knowledge holds many lacunae and no law gives anyone -- including a fetus -- the right to be healthy (Nelson, p. 736; Mathieu, p. 27). These commentators note that virtually everything the pregnant woman does has some effect on the fetus. A woman could be held liable for fetal injuries from household accidents caused by her own negligence, they say. They list other behaviors for which she could be brought to account: using prescription, non-prescription or illegal drugs; eating improperly; smoking; exposing herself to infectious diseases such as syphilis or herpes; exposing herself to workplace hazards such as those found in dry cleaning establishments and service stations; and engaging in too much exercise (Johnsen, p. 606-7). A professor of law at the American University writes in a *Washington Post* editorial (Nov. 25, 1987):

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[19] *Rennie v. Klein*, 653 F.2d 836, 3d Cir., 1981.

> "What are we prepared to order next in the name of fetal health? Shall we arrest all pregnant women who smoke cigarettes? Drink liquor? Drink coffee? Shall we order hospital confinement, as has already been done at least twice, when a woman has been given medical advice and chooses not to follow it? Shall we shackle her to her hospital bed? Shall we compel a woman to submit to surgery to correct fetal defects? Shall the police hold her down while she is injected with anesthesia?"

A New York City judge, who denied a hospital's request to order a caesarean section on a 35-year-old indigent women who had borne ten children, says she also finds problems with restricting pregnant women. "It's absolutely clear that cigarettes and liquor are harmful to babies, that bad nutrition brings brain damage," Judge Margaret Taylor told a reporter. "So, do you prevent a woman from doing these things the minute she gets pregnant?" (Lewin, p. 1).

Commenting on forced medical treatment of pregnant women, bio-ethicist Lawrence J. Nelson of the University of California warns that infringing on a woman's rights by requiring certain behavior could lead to "unsavory" precedents for further invasion of a woman's privacy. This invasion could include court action against women who smoke cigarettes as well as court orders forcing women to undergo prenatal diagnostic procedures or fetal surgery, Dr. Nelson says. Paraphrasing John Stuart Mill, Dr. Nelson says it is far better to avoid compelling pregnant women to live as seems good to a particular physician, judge or even to the rest of us than to force them to sacrifice their wills and their bodies on the alter of someone else's notion of the good. He concedes that this may result in the birth of children who will suffer death or an avoidable injury or disease. "The price to fetuses and to society of honoring maternal refusals of treatment may seem high, but contrary policy would rob us of much more and leave us far poorer as human beings" (Nelson et al, p. 763).

The same view is held by George Annas, associate professor of law and medicine at Boston University (Annas, p. 45):

> "...[S]ome fetuses that might be salvaged may die or be born defective. This will be tragic, but it is likely to be rare. It is the price society pays for protecting the rights of all competent adults... The choice between fetal health and maternal liberty is laced with moral and ethical dilemmas."

C: Viability of the Fetus

The U.S. Supreme Court in *Roe v. Wade* found the state's compelling interest in the fetus's potential life begins with viability -- that is, when the fetus can survive outside the mother's body.[20] The court held (410 U.S. 113):

> "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications."[21]

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[20] When is a fetus viable? In 1973, when the Supreme Court wrote the *Roe* decision, it noted that viability was usually at the seventh month of pregnancy (28 weeks). Today, the earliest point at which a fetus can survive is 23-24 weeks, according to David Orentlicher, ethics and health policy counsel for the American Medical Association (Orentlicher, p. 23). If viability is defined as the age at which the fetus has any prospect of survival outside the womb, the age would be 23-24 weeks. If viability is defined as the point at which half of fetuses will survive, the age is 26 weeks, Orentlicher says.

[21] The fact that a child can survive outside the womb is no assurance that he or she will have a healthy life. Children born too soon have significantly increased risks of permanent injuries such as mental retardation, blindness, deafness and cerebral palsy.

Dr. Mathieu of Harvard hinges the burden of a woman's duty to the fetus on the concept of viability. She believes a woman's obligations to the fetus have two distinct levels:

- At the first level, the woman assumes an obligation to the future child by becoming pregnant. Since there is normally a high probability that a child will come into being, she owes this future person a duty of due care similar to the duty of due care she owes to any stranger: to refrain from causing harm, and, to some extent, to try to prevent or remove harm.

- The second level comes once she decides against abortion. Here, the pregnant woman assumes a higher level of obligation, placing herself in a special relationship with her future child that carries certain inherent obligations similar to those of any parent toward his or her child. Just as a parent's obligations to her child are stronger and more demanding than her obligations to other persons, so a pregnant woman's obligations at this stage to her future child may be stronger and more demanding than her obligations to others, Dr. Mathieu says.

Because of this, she says, "[T]here is good prima facie argument that the state may impose certain restrictions on a pregnant woman's behavior throughout her pregnancy. During the first few months of pregnancy, the restrictions would be relatively nonintrusive, but might increase in severity during the last few months."

At the higher level of duty -- after she forgoes abortion -- the woman may have to accept significant limitations on her freedom of action in order not to harm her child, Dr. Mathieu says. She adds that policy makers considering intervention should ask two questions: To what extent will the future <u>child</u> be

harmed by the mother's actions? And to what extent will the pregnant woman be harmed if her decision is overruled and her body is invaded? She concludes that intervention is justified in the case of pregnant women who are addicted to alcohol because alcohol can cause serious, permanent harm to a child (Mathieu, p. 51).

The director of the medical ethics program at the University of Wisconsin asks similar questions but comes to a different conclusion. Speaking at a conference on Prenatal Abuse of Licit and Illicit Drugs sponsored by the New York Academy of Sciences, Norman Fost said four conditions must exist before a mother is morally obliged to accept treatment:

- First, there must be high risk of serious permanent harm to the baby;

- Second, there must be low risk of serious permanent harm to the mother;

- Third, the recommended treatment must provide a clear benefit to the fetus; and

- Fourth, in order to remain consistent with the *Roe* decision, the fetus must be viable.

If all these conditions are met, a mother might legitimately be compelled to abstain from harmful behaviors, Dr. Fost says. But, he concludes, because the damage may already be done by the time the fetus is viable, there is no "clear benefit to the fetus" and society has no ethical stand from which to force a pregnant woman to abstain (Henig, p. 8).

One commentator says the decision to treat hangs on a "delicate balancing." John Myers writes in the *Duquesne Law Review* (p. 53):

> "When reliable scientific evidence clearly establishes that maternal conduct carries with it a very high probability of fetal death or serious disability, intervention may be appropriate... [A]s courts decide such cases, they will focus primarily on the likelihood and severity of fetal harm and the degree of invasion of protected maternal interests required to effectuate intervention."

Although he did not say it, Professor Myers could have added that legislators, too, will perform a similar "delicate balancing" when deciding whether to require treatment of substance-abusing pregnant women.

Professor Myers says that as the degree of state intervention becomes more intrusive on the woman's rights, the state must demonstrate an increasingly strong justification for interfering. He points out that it would be inconsistent to compel a woman to give birth (he means, making abortion illegal after viability) without protecting the soon-to-be-born child from injury which could follow it throughout life. There is no logical or legal reason to deny the state's interest in a newborn infant, he says. Similarly, there is no reason to deny the state's interest in a viable fetus which is completely unable to assert its own rights.

Finally, Professor Myers gives intervention a thumbs-up or thumbs-down judgment in three examples, one based on an actual case and two on hypothetical examples:

> <u>Example 1</u>. An alcoholic woman is 26 weeks pregnant (the fetus is approaching viability) and has given birth to one FAS child. Her physician fears that her drinking will damage her fetus. The physician cannot accurately predict the likelihood that this particular fetus will be damaged by alcohol, Mr. Myers says. This makes the probability and degree of fetal harm speculative. In addition, state intervention would be "highly invasive" (e.g., a constant watch, regular reporting or civil

commitment). Because of these factors, the state should not intervene, the professor says.

Example 2. A fetus has a growing hydrocephalic condition. Surgeons could stop the worsening condition with surgery that penetrates the woman's abdomen and the fetus's skull. The parents object to the medical intervention on religious grounds. Professor Myers says worsening harm is certain and this intervention would be justified.

Example 3. Because of placement of the placenta, physicians are "99 to 100 percent" certain an unborn child will die if delivered vaginally. Because of the certainty, Professor Myers says intervention is justified. (In this actual case, the court ordered the surgery but the mother did not return to the hospital, the placenta shifted and a healthy child was delivered vaginally. The case was *Jefferson v. Griffin Spalding County Hospital Authority*, 274 N.E.2d 457, Georgia, 1981.)

The American College of Obstetricians and Gynecologists in 1987 issued a policy statement that physicians were "almost never" justified in going to court to compel medical procedures for pregnant women. The statement read, "Obstetricians should refrain from performing procedures unwanted by the pregnant woman... The use of judicial authority to implement treatment regimens in order to protect the fetus violates the pregnant woman's autonomy." The statement was written by Dr. Kenneth J. Ryan of Brigham and Women's Hospital in Boston (Lewin, p. 1).

D: Child Protection Programs and Civil and Criminal Law

Generally, the law about fetal rights will develop in child protection programs, tort law and the criminal law. In most states, policy makers and the courts are silent on the subject of the rights and status of the fetus; this assumes that the rights of the pregnant woman have precedence over the rights of the fetus.

The examples given here are the exception and are provided for those contemplating how to deal with substance abuse during pregnancy.

Child Protection

In most cases, pregnant women cannot be tested involuntarily for use of drugs or alcohol. But newborns exhibiting distress can be tested and some states require physicians to do so and report positive results. Some localities consider the presence of an illegal drug in an infant's blood evidence of child abuse and allow emergency custody of the child. An example is Nassau County, New York, which takes emergency custody for up to eight months of newborns testing positive for illegal drugs. Los Angeles County allows social workers to remove from the mother's care newborns who show positive drug tests. The County Chief Probation Officer, Barry J. Nidorf, says the county would rather rely on residential treatment than on emergency custody but "there is just a dearth of treatment programs" (Sherman 1988, p. 24).

Civil Law

In the civil law, the attitude toward the fetus has changed since Justice Oliver Wendell Holmes ruled that a fetus is part of its mother and cannot sue for prenatal injuries.[22] Sixty years after Justice Holmes wrote his decision, a United States District Court found that a child can recover for prenatal injuries if the fetus was viable when the injuries occurred. One by one, other courts agreed, until today this view is as well established as was the contrary rule in 1884, according to Roland F. Chase, who summarized prenatal injury in an *American Law Review* article (Chase, p. 1227).

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[22] *Dietrich v. Northampton*, 138 Mass 14, 1884.

Criminal Law

With increased use of alcohol and drugs among women, criminal law is feeling its way to the new area of fetal injury caused by acts of the pregnant woman. In most jurisdictions, mothers who abuse drugs or alcohol are not charged with a crime. The *National Law Journal* reports, however, that in 1989 at least ten women in five states (California, Florida, Illinois, Massachusetts and South Carolina) faced criminal prosecutions because they used cocaine, heroin or alcohol while pregnant. Only one was convicted. She was Jennifer Johnson of Florida, convicted of delivering cocaine to a minor through the umbilical cord and sentenced to one year in a rehabilitation program as well as 14 years probation during which she must report any pregnancies to authorities and receive approval for her prenatal care program. The case is being appealed (*State v. Johnson*, 89-890CFA, Cir. Ct. Seminole County.)

One celebrated case involves a pregnant woman jailed during her pregnancy. She was Brenda Vaughan, who tested positive for cocaine in a presentencing hearing after she was convicted of forging checks. Washington, D.C. Superior Court Judge Peter Wolf sentenced Ms. Vaughan to jail until her due date, saying at the sentencing hearing, "You've got a cocaine problem, and I'm not going to have this baby born addicted" (Moss, p. 20). Wolf later said he sentenced Ms. Vaughan to jail because there were no treatment programs available. He also said many of his colleagues told him they had similarly sentenced or incarcerated pregnant drug abusers (Jost, p. 88; Sherman 1988, p. 25).

A northern California district attorney, Michael Ramsey, says he is seeking jail terms for women who give birth but refuse medical care for substance abuse. He says the approach works. He says he has filed only one case, and that case was dropped when the woman agreed to treatment. Meanwhile, the number of newborns

testing positive for drugs in his county has fallen from up to ten a month to almost none, he says.[23]

E: Court Decisions Regarding the Fetus

Like judges across the nation, Alaska judges faced with pregnant women using illegal drugs have been in a quandary. On the one hand, they are urged by prison officials not to imprison expectant mothers because of concern that jail personnel cannot care for them properly. On the other hand, a judge may order prison (if the crime is a jailable offense) because the woman is a danger to others, and because nurse practitioners at the jail can give the woman better care than she might get out of jail. Other judges may use the court's "persuasive powers" to talk reluctant substance-abusing pregnant women into voluntarily entering local treatment centers.

Nationwide, judges forced by circumstance into this frustrating arena have made hurried decisions in rushed hearings that began after a women went into labor. They have upheld laws they did not like after emergency hearings in hospital rooms or hurried conference telephone calls. A 1987 study published in the *New England Journal of Medicine* (May 7, 1987) shows 21 cases since 1981 in which hospitals had sought court orders to override the wishes of a pregnant woman. In all but three, judges granted the orders.

This section is limited to examples of rulings involving (1) pregnant women brought to the attention of the court for fear their actions or inactions might harm an unborn fetus and (2) infants born with drugs or alcohol in their systems. Among the cases:

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[23] Sources of information about these cases include: Gest, p. 50; Sherman, p. 28; Moss, p. 20; and Grace, p. F10.

Judicial Intervention Before the Child is Born

Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, New Jersey, 1964.

Despite evidence that she could hemorrhage so severely that she and her unborn child would die, Willimina Anderson refused blood transfusions in her 32nd week of pregnancy because they were against her religion. A trial court held that it could not intervene. The state supreme court heard the case immediately and ordered the blood transfusions, should they become necessary. The court wrote, "We are satisfied that the unborn child is entitled to the law's protection" (201 A.2d 537).

The Matter of Dittrick, Michigan, 1977.

Six weeks before a child was to be born, a Michigan probate court ordered social workers to take temporary custody of the fetus. The order was based on testimony that the parents had lost custody of an earlier child following allegations of continuing physical and sexual abuse and faced pending criminal charges. The court of appeals ruled that Michigan law gave courts no jurisdiction over an unborn child (MSA Sec. 27.3178(598.2). The legislature might want to consider appropriate amendments to the probate code, the court said, adding, "Indeed, the background of the present case has convinced us that such amendments would be desirable" (263 N.W.2d 37).

Case No. 79-JN83, Denver Juvenile Court, Colorado, 1979.

In this case, physicians decided on a caesarean section when the fetal heartbeat slowed during labor. The mother resisted, the hospital went to court and at a bedside hearing, hospital lawyers argued the state had a compelling interest to protect the unborn. They asked the judge to

declare the fetus a "dependent and neglected child." The judge granted the order and the mother told her lawyer afterward that she was grateful for the surgery. The judge, Jon Lawritson, now a lawyer in private practice, later told the *American Bar Association Journal*, "I didn't like being placed in the position I was placed in" (Jost, p. 86).

Matter of Steven S., Los Angeles County, 1980.

When a pregnant woman was certified to receive intensive psychiatric treatment for up to two weeks, the Los Angeles County went to juvenile court for an order to detain her during the final weeks of her pregnancy. The juvenile court found that the unborn fetus was a minor and detained the fetus (and the woman). It ordered the mother's release when the child was born. The order was overturned on appeal six weeks later, after the detention and pregnancy were both over. The appeals court found the unborn child was not a person under California law (126 Cal. App. 3d 29).

Jefferson v. Griffin Spalding County Hospital, Georgia, 1981.

Jessie Mae Jefferson, 39 weeks pregnant, objected to a physician-prescribed caesarean section on religious grounds. The county hospital went to court, saying the placenta had moved down near the cervix and there was a "99 to 100 percent certainty" that the unborn child would die if delivered vaginally. In an emergency hearing the same day, the superior court authorized the surgery if Ms. Jefferson came to the hospital for care. The court wrote, "The Court finds that the intrusion involved...is outweighed by the duty of the State to protect a living unborn human being from meeting his or her death before being given the opportunity to live." One day later, the state supreme court upheld the decision. The woman did not return to the hospital, the placenta shifted and a healthy baby was delivered (274 S.E.2d 457).

Taft v. Taft, Massachusetts, 1983.

Lawrence Taft went to court to force his pregnant wife to have a surgical procedure to suture her cervix and avoid miscarriage. Susan Taft refused on religious grounds and a probate judge ordered her to submit to the procedure. The appeals court found the wife could not be ordered to have surgery. The court ruled that the wife's constitutional rights were established on the record, while any interest the state might have in requiring a competent adult woman to submit to the surgery was not established (446 N.E.2d 395).

In re Jamaica Hospital, New York, 1985.

In this case, the court appointed a physician as the guardian of the unborn child. It ordered the physician to do all that was necessary to save the life of an 18-week-old fetus, including administering blood transfusions over the mother's objection (491 N.Y.S.2d 898).

Crouse Irving Memorial Hospital, Inc. v. Paddock, New York, 1985.

Here, the court ordered a pregnant woman to receive blood transfusions to protect the welfare of her fetus which was being delivered prematurely.

In re Madyun, Washington, D.C., 1987.

Ayesha Madyun, a 19-year-old woman, had been in labor two days when she arrived at the hospital; 18 hours later, her labor had not progressed and physicians decided on a caesarean section to avoid a fatal infection to the baby. When Ms. Madyun refused, the hospital won a court order authorizing surgery. Superior Court Judge Richard Levie wrote, "It is one thing for an adult to gamble with nature regarding his or her own life;

it is quite another when the gamble involves the life or death of an unborn infant" (Lewin, p. 1; 114 *Daily Washington Law Reporter* 2233).

In re A.C., Washington, D.C., 1987.

Angela Carder, a pregnant woman who had suffered from leukemia since she was 13, married when she had been in remission for three years. In her 25th week of pregnancy, she was diagnosed as terminally ill. Physicians disagreed about whether she would want surgery were she lucid. One believed she would not want to deliver a child that might have to suffer the pain of handicap; another believed she would have accepted a caesarean section. The trial court ordered surgery and afterwards, in a period of lucidity, Ms. Carder stated she would agree to the surgery although she might not survive it. But when another physician went to her for verification, the dying woman mouthed the words, "I don't want it done." While Ms. Carder lingered between life and death, the case was appealed and the appeals court allowed the surgery. In a later opinion filed five months after the mother and child died, the appeals court said the state's interest in protecting innocent third parties may override the individual's right to bodily integrity. It suggested that "a sort of quasi-official body" should balance the many factors, with the judiciary playing "an appropriate and limited reviewing role, rather than the primary adjudicator in a highly charged and short time frame" (533 A.2d 611).

The Case of Brenda Vaughan, Washington D.C., 1988.

Brenda Vaughan, a first-offender convicted of check forgery, tested positive for cocaine in a pre-sentencing drug test. The judge ordered her to jail until after she had given birth. "She's apparently an additive personality and I'll be darned if I'm going to have a baby born that way," he said (Jost, p. 88).

Judicial Intervention After the Child is Born

Reyes v. Superior Court of California, California, 1977.

A pregnant woman addicted to heroin was warned by health care workers that if she continued using the drug, her child was in danger. She ignored the advice and twin boys were born addicted and suffering from withdrawal. The mother was charged with two counts of felony child endangering. The California appeals court found that California statute did not cover the mother's conduct before the children were born and dismissed the case (75 Cal. App. 3d 214).

The Matter of Male R., New York, 1979.

A family court judge found that a child born with mild drug withdrawal symptoms to a mother who used barbiturates, cocaine and alcohol was a neglected child. The mother had refused to enroll and remain in treatment programs (422 N.Y.S.2d 819).

The Matter of Baby X, Michigan, 1980.

When a newborn baby showed symptoms of heroin withdrawal, a probate court judge appointed a guardian ad litem for the baby and found enough evidence of neglect to take temporary custody. The decision was affirmed by the circuit court, which found that withdrawal symptoms caused by prenatal maternal drug addiction may qualify the child as neglected. The court repeated language by earlier courts that a child has a "legal right to begin life with a sound mind and body" and said the way a mother treats a child before it is born is an indication of how she will treat it afterwards (293 N.W.2d 736).

The Matter of Danielle Smith, New York, 1985.

A New York family court held that an unborn child is a person and that a child born to an alcoholic mother was a neglected child. The mother, who consumed ten drinks a day three or four days a week, had not complied with earlier orders to get treatment. The infant, born prematurely, was small, jittery, irritable and had facial anomalies; physicians noted a "small possibility that the child might have fetal alcohol syndrome." Based on the medical reports, the court held there was sufficient proof to establish imminent danger of physical impairment to the unborn child (492 N.Y.S.2d 335).

In re Ruiz, Ohio, 1986.

The court of common pleas determined that Nora Ruiz, a mother who used heroin intravenously within two weeks of the birth of her child, exposed the child to substantial risk before its birth and abused the child. The child was born early and small for his gestational age; he was irritable, jittery, trembly and had trouble taking food; his urine test was positive for cocaine and heroin. Agreeing with earlier courts that the child has a "right to begin life with a sound mind and body", the Ohio court held that a viable fetus is a child under the state's child abuse statute (R.C. Sec. 2151.031). Relying on *Roe v. Wade*, the court said the state has an interest from the point of viability in the child's care, protection and physical and mental development (500 N.E.2d 939).

F: <u>Legal Issues in Alaska</u>

Child Protection

In Alaska, child protection services begin when the child is born. Use of drugs or alcohol during pregnancy is not considered child abuse. Once the child is

born, state law does not require physicians to report a newborn with drugs or alcohol in its system.

When a physician report is made, however, child protection workers assess the home situation and, if the baby appears to be in danger, go to court to remove the baby from the mother's care, according to Martha Holmberg, social services field administrator. How long the child lives away from its mother depends on the individual situation, Ms. Holmberg says.

Alaska physicians do not generally report alcohol in a baby's system, according to Ms. Holmberg. They are more likely to report a child born with cocaine, she says. Similarly, the department is less likely to intervene if the substance used is alcohol, Ms. Holmberg says. She contends that an alcoholic mother is less dangerous to the child than a mother addicted to cocaine. She also contends that a baby affected by alcohol is less difficult to care for -- and less at risk for further abuse -- than a baby affected by cocaine. The cocaine baby is at "double risk," she says.

Civil and Criminal Law

The extent and nature of fetal rights in civil law and of the fetus as a protected entity in criminal law remain largely unexplored. There has been little or no civil litigation on fetal rights versus parental rights in Alaska. As for criminal law, the Criminal Division of the state Department of Law interprets Alaska statutes to give no protection to an unborn fetus at any stage unless there is injury to the mother (Otto, pers. com.).

G: Summary

The child's right to a healthy start in life collides with its mother's right to be left alone. Frequently, the repercussions come when the pregnant woman

uses drugs and alcohol which others believe will harm her fetus. The situation is pervasive: in a survey, 15 percent of pregnant Florida women tested positive for drugs or alcohol at their first prenatal visit. The dilemma is intensified because physicians are winning difficult medical victories to save younger and younger infants -- some of them already permanently damaged by the acts of their own mothers. Against this backdrop, policy makers search for workable answers to philosophical, ethical and legal questions about the fetus.

Policy Issues

The U.S. Supreme Court articulated in *Roe v. Wade* the state's "important and legitimate interest in protecting the potentiality of human life" (410 U.S. 162). One obvious interest is financial. A child damaged by prenatal substance abuse is likely to require expensive state services. There are other good reasons, apart from the value of human life itself, to attempt to protect the physical and mental health of a fetus. Among them is the loss of a contributing member of society.

Some commentators find it inconsistent that a state makes no move to protect an unborn child from the drugs or alcohol taken by a pregnant woman, but is willing to seek custody minutes after that same child is born already damaged for life by harmful substances (Parness and Pritchard, p. 294). The difficulty is that whatever the state does to protect the fetus, it must necessarily do to the mother.

A: Cost of Fetal Alcohol Syndrome

A report by the Senate Advisory Council estimates that the lifetime cost of one FAS birth in Alaska is $1.4 million. The lifetime cost the FAS babies born each year in Alaska is $39.8 million. These cost estimates are selected medical and

social costs only. They do not include costs of welfare, the justice system, mild physical problems, learning disabilities or the loss of a useful member of society, nor do they include the education and social service costs of victims of FAE (Research Request 89-100015, p. 1).

Providence Hospital officials report costs of $1.4 million for a 16-month old child born with FAS who has been abandoned to the hospital by his mother. He is his mother's third FAS baby. Weighing today what other babies weigh when they are born, the little boy reaches out to touch other babies in the intensive care ward. He cries, but his wails are rendered soundless by a tracheotomy tube dangling from his throat 24 hours a day. A hospital official describes the situation as "awful." Janet Oates, of the hospital's administrative council, says visiting Soviet physicians seem "moved and astonished" that hospital staff take the time to care for this baby.

A 1990 report by the Department of Health and Social Services Division of Family and Youth Services estimates actual cost to the state over 18 months for one addicted infant at $5,600. Costs for one substance-abusing parent are $12,000 over 18 months. These are costs for services not eligible for Medicaid reimbursement. They do not include costs of welfare, the justice system, mild physical problems, emergency medical problems, learning disabilities or loss of a useful member of society.

For children, costs include clothing ("in our experience, children of substance-abusing parents seldom, if ever, have adequate clothing or infant supplies," the memorandum says.) They also include costs of foster care and day care while the parents take treatment. This care also guarantees the child is seen by competent adults alert to the possibility of abuse or neglect, the report says. For adults, costs include urine tests, transportation (most clients do not have transportation, the report says), court evaluations, drug and alcohol treatment and other therapy and parent training.

B: Is Treatment Available for the Pregnant Woman?

Currently, no Alaska residential treatment beds are specifically reserved for pregnant substance abusers. This will change when a federally funded residential treatment center for 15-20 substance-abusing pregnant women opens this year in Anchorage. Requests for proposal for the $520,412 center have been distributed, according to Vicki Hild of the Alaska Native Health Board. The center will be limited to Native pregnant women and their children unless the state provides funds for pregnant women of other races. The state Department of Health and Social Services has reserved $200,000 in the FY 91 governor's budget for residential treatment for pregnant women. The money will be distributed through grants, according to Matt Felix of the State Office of Drug and Alcohol Abuse.

Ms. Hild says that, faced with publicity about pregnant substance abusers, some Alaska co-educational treatment facilities have recently begun accepting pregnant women, but none have programs designed specifically for these women. Ms. Hild and others believe that women are more likely to succeed in drug and alcohol treatment if they are in a woman-only program. Ms. Hild says the confrontational technique effective for males does not work for women, especially for Native women. She adds that men have played negative roles in the lives of many female substance abusers, making it difficult for women to progress in co-educational therapy programs.

Dr. Wendy Chavkin, associate professor at Columbia University School of Public Health and Department of Obstetrics, says that, nationally, treatment is not available for motivated pregnant women. She surveyed 78 drug treatment program in New York City to learn that 54 percent excluded pregnant women, 67 percent excluded pregnant women on Medicaid and 87 percent excluded pregnant women on Medicaid who are addicted to crack. Health advocates say Dr. Chavkin's survey, the first survey of drug treatment available to pregnant women, is limited in scope but accurately portrays what is happening around the country. Janet

Chandler of Northwestern Memorial Hospital's Perinatal Center for Chemical Dependence in Chicago, says addiction treatment programs discriminate against pregnant women. "Most centers worry about the liability, so as soon as they discover a woman is pregnant, they refuse her or throw her out of the program" (Brody, p. 1).

C: Current Alaska Law

No Alaska law mandates treatment for addicted pregnant women. One statute, AS 47.37.190(a), allows the involuntary commitment of alcoholics. It is restricted to people who are considered alcoholic.[24] The statute allows commitment by a superior court judge if the person is likely to inflict physical harm on others or is incapacitated by alcohol.

In practice, alcoholic Alaskans are rarely committed for treatment under this statute, according to Assistant Attorney General Elizabeth Shaw. In Juneau, for example, only two attempts have been made in the ten years Ms. Shaw has represented the state Department of Health and Social Services. Both attempts failed. Ms. Shaw says she is not aware of attempts in other jurisdictions. She cites two reasons why the statute is infrequently used and even less frequently successful:

- The first is lack of resources. Ms. Shaw says the 500 treatment beds in Alaska are not adequate for the number of alcoholics of any sex or age. In 1989, women filled 29 percent of treatment slots statewide (Mundell, pers. com.). Statistics do not show how many of these women were pregnant.

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[24] Alcoholic is defined in AS. 47.37.270 as "a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that the person's health is substantially impaired or endangered, or the person's social or economic function is substantially disrupted."

- The second problem is time, according to Ms. Shaw. Once the involuntary commitment case is on the court docket, the state or municipality must obtain confidential documents, protected by strict federal confidentiality laws. Moreover, most defendants exercise their right to a jury trial, which can cause further delay. Shaw says that by the time the case gets to trial, the defendant can sober up enough to convince a jury that he or she will voluntarily obtain treatment.

D: Practical Pros and Cons of Mandating Treatment

Experts believe that most substance-abusing pregnant women want to stop using drugs and alcohol. They want their babies to be healthy and are more open to help during pregnancy than they will be at any other time in their lives. In the first of two comprehensive articles on substance-abusing pregnant women, the *National Law Journal* says experts agree that legal disputes could be avoided if society would focus its resources on positive methods of encouraging maternal health (Sherman 1988, p. 25). They recommend spending money to help pregnant women overcome their addiction. This is money well spent, they say, because the alternative is to spend even more on medical care, education and foster care for damaged children.

However, the proposal to require treatment for pregnant women who use alcohol poses some practical problems in addition to questions about the woman's right to privacy and the child's right to a healthy start in life. Among them:

How much? How much alcohol does the woman have to use before treatment becomes mandatory? Are other licit and illicit drugs included? What about nicotine, caffeine, poor nutrition, exercise, sexual intercourse or hazards encountered at work?

Who reports? Alaska's involuntary commitment statute, AS. 47.37.190, allows relatives, a certifying physician or a treatment facility administrator to make a petition to commit. If physicians are required to report, how does that affect patient-client confidentiality? Does it affect the physician's liability? Would women avoid prenatal care to avoid detection? Would the requirement erode the physician's practice?

Does the woman have access to treatment? Residential treatment facilities are in urban areas. It would be difficult for a pregnant woman to leave her rural home for months of treatment in a far-away facility. The problem would be compounded if she had children. (Ms. Hild of the Alaska Native Health Board says the federally funded 15-20 bed residential treatment center for pregnant women set to open this year in Anchorage will reserve beds for children.)

Would the woman go "underground" or seek an abortion? The threat of mandatory treatment might make some women stop drinking. But others might attempt to obtain an abortion to avoid the ordeal. Or, they might go "underground" for fear of being reported for drinking.

Will the physician recognize substance abuse? Some women are loath to tell their physician that they use drugs. New mothers told state social workers taking a preliminary survey that they used drugs during their pregnancies, adding, "I didn't tell my doctor, but I'll tell you" (VandeCastle, pers. com.).

Dr. Ira Chasnoff, who heads a national organization researching perinatal dependency and is director of the Perinatal Center for Chemical Dependence at Northwestern Memorial Hospital in Chicago, cautions that many physicians need training on how to conduct a thorough drug history on every patient, particularly every pregnant patient. Dr. Chasnoff told a

conference on Prenatal Abuse of Licit and Illicit Drugs in September 1988, "If an obstetrician asks about drugs at all, he'll say something like, 'You don't do drugs, do you?' There's a science to getting an honest answer about drug use, and that's not the way to do it" (Henig, p. 8). In recognition of this problem, the Boston University School of Medicine has designed a Fetal Alcohol Education Program to demonstrate how to take a drinking history (Weiner, Rosett and Mason, p. 34).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) complains that some physicians appear reluctant to inform their patients that the safest choice is to avoid drinking during pregnancy (Funkhouser and Denniston, p. 57.) In an article published in *Alcohol Health and Research World*, NIAAA staff say physicians do not advise women of the risks associated with drinking alcohol for several reasons. First, they fear that once confronted with her drinking problem, the woman may not return for treatment. Second, the physician may not be aware of community referral services. And third, some physicians are concerned that they could stigmatize the patient by suggesting she is alcoholic. Similarly, two professors of psychiatry at the Boston University School of Medicine and one at Harvard Medical School say physician intervention with women who abuse alcohol is "minimal." They say physicians feel they lack the time needed to deal with problem drinking and they feel the woman won't tell them the truth (Weiner, Rosett and Mason, p. 35).

Some physicians do not recognize the harm done by alcohol or cocaine. According to state officials, new mothers report that local physicians have told them (erroneously) that they can safely breast feed while using cocaine. Some physicians may not be aware of studies showing that a fetus can be damaged by moderate drinking. In addition, those who received their training before FAS was identified in 1973, may not be convinced that alcohol can harm the fetus. As recently as 12 years ago, a physician who identified himself as a Harvard Medical School graduate objected in

Treatment for Substance-Abusing Pregnant Women: Once it receives a report that a pregnant woman is using a controlled substance, the **Minnesota** welfare agency may offer the woman treatment for chemical dependency and prenatal care (Minn. Stat. 626.5561.2).

The agency may also seek emergency admission to a treatment facility under the civil commitment law. If the pregnant woman refuses or fails treatment, the agency is required to seek nonvoluntary admission. Allison Wolf, counsel for the Minnesota State Senate, says commitment is "short term -- up to 72 hours." After 72 hours the case is reviewed to determine whether the woman should stay in treatment. However, Joan Monahan, Social Service Program Advisor for the State of Minnesota, says counties have already used the two-month-old nonvoluntary admission law. She predicts it will be used frequently.

Beginning January 1, 1990, **Illinois** is developing a model program to care for and treat addicted pregnant women and addicted mothers. The program includes individual prenatal care under the supervision of a physician and temporary residential shelter for pregnant women and mothers and their children. The health department is to report on the program's progress at the end of each year (P.A. 86-877).

The **Connecticut** legislature in 1989 voted down a bill which would have required child protective workers to work with any pregnant woman whose behavior endangers the fetus (Wilson-Coker, pers. com.).

The Children's Act of the **Yukon Territory, Canada**, allows provincial officials to go to court if they believe that a fetus is subject to "serious risk" of FAS or "other congenital injury" because the pregnant woman is using addictive or intoxicating substances. The officials may ask for a court order requiring the woman to participate in "reasonable supervision or counselling" (Statutes of the Yukon Territory, Children's Act, Vol. 2, Section 134(1).)

After the Baby is Born

Required Testing of Newborns: In Minnesota, a physician must test a newborn infant if there is evidence that the child was exposed to a controlled substance (Minn. Stat. 626.5562.2). The same is true in Illinois, which passed legislation this year including under child abuse or neglect newborns with any trace of a controlled substance (HB304 and HB2262).

Required Reporting of Positive Toxicology Tests: Oklahoma requires physicians and other health care professionals to report any birth of "a child who appears to be a child born in a condition of dependence on a controlled dangerous substance." Knowing and willful failure to report is a misdemeanor (Oklahoma Statutes 21.846). In Minnesota, positive test results must be confirmed by another test and reported. Physicians are immune from liability arising from administration of the test (Minnesota Statutes 626.5562). Positive test results must also be reported under a new Illinois statute (HB304 and HB2262).

Emergency Custody of Newborns. At least four states have amended their statutes to allow authorities to investigate and possibly take custody of children who are born with drugs in their blood.

- In Oklahoma, newborns must be dependent on a controlled substance before the case can be investigated and the child removed from the home (Ok. Stat. 10.1101 and 1115.1; 21.846).

- If there is substantial proof that a new mother has been using a controlled substance or if a baby tests positive at birth, Florida physicians must report to the child abuse registry. Child protection investigators may remove the child from the home (415.503-504). Although state law lists only controlled substances,

health department policy includes alcohol, according to Shirley Smith of the department.

- Indiana law allows officials to investigate if there is evidence of FAS or evidence of physical or psychological injuries because the mother was addicted to drugs or alcohol; the child must also need care or rehabilitation (IC 31-6-4-3.1).

- California in 1989 set up a pilot program in four counties allowing officials to put newborns with drugs or alcohol in their blood into foster care with specially trained and recruited families (SB1173 amending Children, Ch. 1365). Statewide, no policies address reporting and placement of these newborns, according to Sharon Miller of the California Family and Children's Services Policy Bureau. Ruth Range of the California Disabilities Prevention Program says that if the state took automatic custody of drugged newborns, "there would be no place to put them."

  Connecticut, passed a bill in 1989 (SB1069) funding treatment for newborns of low-income, substance-abusing women. No Connecticut child goes into the program if the only reason for referral is a positive toxicology test, according to Pat Wilson-Coker, statewide director of Children's Protective Services. The mother must also ask the state to help treat her child.

Some localities also take custody of a baby born with drugs in its system. For example:

- In Nassau County, New York, the Department of Social Services allows emergency custody of up to eight months for any newborn who tests positive for an illegal drug. County officials say positive tests are evidence of drug abuse.

- In **Los Angeles County**, the Department of Children's Services requires physicians to report all positive toxicology tests on newborns (Miller, pers. com.). On average, 200 drug-exposed babies are born a month in Los Angeles County. About 120 of them have been placed in group nurseries at a cost of up to $2,500 a month per child. Others go to special foster homes (Greene, p. 34).

Parents Must Get Treatment: An Oklahoma law allows state officials to require treatment for a drug dependent mother of a newborn who tests positive and has been removed from the home. Under the plan, the mother must complete treatment before the child is returned to the home. The child's father, stepparent or other adult in the home who is drug dependent may also be required to complete a treatment program before the child can go home. Testing for parents may be required monthly for one year, after treatment is completed. Positive drug tests are reported to the district attorney (Ok. stat. 10.1101; 10.1115.1; 21.846).

Neglect: **New Jersey** defines child neglect to include the fetus (Sec. 30 4C-11). **Minnesota** includes prenatal exposure to a controlled substance in its definition of neglect. Neglect may be shown by withdrawal symptoms in the child, by a positive toxicology test and by developmental delays during the child's first year (121.883.2). **Oklahoma** defines as "deprived" a child born in a condition of dependence on a controlled dangerous substance, and whose parents fail to provide special care and treatment (10.1101). **Indiana** defines a child in need of services to include a child whose mother was addicted to alcohol or a controlled substance during pregnancy, and who needs care, treatment or rehabilitation (31-6-4-5). **Florida** defines as abused or neglected a child who is born physically dependent on a controlled substance, adding that no parents of such a newborn shall be subject to criminal investigation solely on the basis of the infant's drug dependency (415.503).

Study: Oregon legislators in 1989 passed a bill (SB448) requiring the Department of Human Resources to study the problem of substance- abusing pregnant and postpartum women and their infants. The study will focus on prevention, education and treatment. It will identify the size and nature of the problem and develop strategies for providing services.

Hotline: Illinois's Child Abuse and Neglect Hotline takes reports of newborn babies who are victims of substance abuse. Hotline employees also answer questions about Illinois law regarding newborns and controlled substances (Tel. No. 217/785-4010).

F: <u>What Experts Suggest</u>

Require Non-voluntary Treatment for Substance-Abusing Pregnant Women

Vicki Hild of the Alaska Native Health Board, and a recognized expert on substance-abusing pregnant women in Alaska, recommends involuntary commitment when the addicted pregnant woman is "out of control" and won't go to treatment on her own. She prefers involuntary treatment to jail.

But some officials wonder how to make women get mandatory treatment. New York City Judge Margaret Taylor asks, "If a woman says a month before her baby is due that she won't have a C-section, do you put her in jail or chain her to a hospital bed until it's time to deliver the baby?" (Lewin, p. 1).

Alaska judges may combine treatment with jail. Judge Rodger W. Pegues of Juneau considers prison the least worst place for a pregnant woman who is using drugs, who has committed a jailable offense and who refuses to enter in-patient treatment. The judge says that prison offers the woman medical care and better conditions than she might have at home, while at the same time denying her access to drugs or alcohol. He strongly recommends substance abuse treatment

during the jail sentence and will release the offender to the third-party custody of a treatment facility if the offender opts for that. He reports that in the cases he has handled this way, the women have chosen treatment (pers. com.).

A Florida state official says her state's laws put mothers in jail rather than into treatment programs and she finds this "appalling." She says, "The idea was to scare people into getting treatment. But these women don't use drugs because they want to. They use them because they are addicted. It was the 'good ol' boy image of 'kick them in the rear'," says Shirley Smith of the Substance Abused Newborns section of the state Department of Health and Rehabilitative Services.

Mitchell J. Wiet, a lawyer for Northwestern Memorial Hospital's Perinatal Center for Chemical Dependence in Chicago, recommends nonvoluntary treatment for women who refuse or fail treatment. Mr. Wiet says the U.S. Supreme Court has laid the groundwork several times. First, the court articulated the state's "important and legitimate" interest in the potentiality of human life.[25] Second, it spoke of the state's "unquestionably...strong and legitimate interest in encouraging normal childbirth" and its "direct interest in protecting the fetus."[26] Third, it discused the state's "legitimate governmental objective of protecting potential life."[27]

In addition, Mr. Wiet argues that the courts already require parents or third parties to protect children from prenatal injury. For example (Wiet, p. 155):

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[25] *Roe v. Wade*, 410 U.S. 133, 1973.

[26] *Mauer v. Roe*, 432 U.S. 464, 1977.

[27] *Harris v. McRae*, 478 U.S. 297, 1980.

- Every jurisdiction in the U.S. now permits a live-born child to sue a third person for injuries to the child before birth. [Appellate courts either have ruled to permit the lawsuit or the topic has not come before them. A survey of cases in the *American Law Review* (40 ALR3d 1222 and Supplement) shows no Alaska rulings.]

- Some case law allows a live-born child to recover damages for prenatal injury caused by a parent [two examples: *Grodin v. Grodin* allowed a child to sue the mother for taking Tetracycline during pregnancy, causing the child to have badly discolored teeth (301 N.W.3d 869 Mich. App, 1980); *Stallman v. Youngquist*, in which a child was allowed to sue the mother for prenatal injuries from a motor vehicle (152 Ill. App. 3d 683, 1987)].

- Court decisions give a state *parens patriae* powers which allow it to require medical care for minors against the parents' wishes. [An example is *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, (377 U.S. 985, 1964) in which the court held that "an unborn child is entitled to the law's protection" and ordered a pregnant woman to have a blood transfusion contrary to her religious conviction.]

- Approximately half the states, including Alaska, have set aside the doctrine of parent-child tort immunity. This means parents have a duty to avoid injury to the child and the child has a right to be free of injury caused by a parent. In Alaska, the supreme court in 1967 held that a minor child could sue her mother for injuries allegedly sustained as a result of the mother's negligent driving (*Hebel v. Hebel*, 435 P.2d 8).

These court decisions support the concept that the state can require an addicted expectant mother to be treated, even if she doesn't want to be, Wiet says,

especially after the fetus is viable. The high risk of serious injury to the fetus, including death, is well documented in the literature and should outweigh the effects of restricting the mother's personal liberty, Wiet says (p. 155).

Educate and Fund Before Mandating Treatment

Some observers say it is wrong to impose the harsh sanctions of the criminal law, to require testing, to take custody of children or to force pregnant women into treatment without first making all-out education and funding efforts.

It would be far better, these advocates say, to expand efforts to educate women and their partners about the dangers of drug and alcohol use during pregnancy. In addition, it would be better to make certain that all pregnant women, including drug and alcohol abusers, have access to frequent and high quality prenatal care. This approach encourages pregnant women to go to the doctor and it helps create bonding between the woman and the fetus by emphasizing prenatal care. Moreover, the state should first provide adequate and effective treatment aimed at pregnant women. In addition, the state should first try to change conditions which breed abuse of drugs and alcohol. This increased emphasis on funding and education would represent a social commitment to benefiting women, not controlling them, they say (Note, p. 1011-12).

Reacting to reports that courts compel pregnant women to undergo medical procedures in order to protect the fetus, the editors of the *New England Journal of Medicine* write:

> "The best chance we have to protect fetuses is through enhancing the status of all women by fostering reasonable pay for the work they do, providing equal employment opportunities and adequate day care, providing a reasonable social safety net and ensuring all pregnant women access to high-quality prenatal services."

Identify Infants Born with Drugs or Alcohol in Their Systems

The National Conference of State Legislatures (NCSL) recommends that states adopt legislation to identify infants born with FAS or substance abuse problems for appropriate child protective, health or rehabilitative services. The NCSL did not suggest specific ways to identify these children. Although it would not reach all children affected by drugs or alcohol, one method is to require testing of newborns and pregnant women when there is reason to suspect drug or alcohol abuse (see Minnesota Statutes 626.5562). State Department of Health and Social Service officials say they are taking steps to test all Alaska newborns for cocaine (Livey, pers. com.).

Require Physicians to Report Newborns with Drugs/Alcohol in Their Systems

Officials at the Alaska Department of Health and Social Services favor requiring physicians to report if a child is born addicted to a drug or alcohol, according to Russ Webb of the Division of Family and Youth Services. State officials reason that children damaged before birth by drugs or alcohol are at risk for abuse and neglect because they are more difficult to care for than other children. The department says Alaska physicians do not report all cases, despite requests to do so (Webb, pers. com.).

Providence Hospital physicians use their own judgment about which cases to report, based on knowledge of the family situation (Wolf, pers. com.). A Providence Hospital ethics committee has written guidelines for drug testing of newborns but the guidelines are not established protocol. Some physician groups do not agree with them, fearing that reporting infringes on the privacy rights of the mother, according to Janet Oates of the hospital's administrative

council.[28] Hospital administrators say they believe it is the state's role to provide physicians with clear direction about whether or not newborns with signs of drug or alcohol injury fall into the category of abused and/or neglected children (Oates, pers. com.).

Providence Hospital guidelines state that if a newborn shows certain signs, the newborn's physician "should consider" ordering a toxicology urine screen for the baby. Nursing staff are to alert the physician if the signs are observed. If urine tests are positive for any known non-prescribed drug, the nursery staff "will immediately notify" the primary physician and the hospital social work department. Physicians will tell the family of the positive results. "The physician should inform (the family) of the Child Protective Service referral... The hospital social worker will...make the report to DFYS, coordinate services with DFYS and communicate with medical and nursing staff on the disposition decision" *(Providence Hospital Guidelines*, August 16, 1989).

A drug-screening policy at Humana Hospital in Anchorage states that any newborn with any of the tell-tale signs "will be considered" for a toxicology urine screen. It adds that a drug screen test and a urine screen test "will be ordered" by the physician. Language concerning referral to child protective services is similar to that in the Providence Hospital policy (Humana Hospital, *Policy No. 101.45*).

Physicians at the Alaska Native Medical Center recommend follow up through the state Division of Family and Youth Services for all newborns who test positive for cocaine (Alaska Native Medical Center, Feb. 23, 1989).

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[28] Janet Oates, a member of the hospital administrative council, did not want to release copies of the guidelines because they have not been accepted by all physicians. The copies used for this memorandum were provided by the state Department of Health and Social Services. The guidelines have not been finalized.

Among the criteria for testing at the hospitals are: a newborn's unconsolable irritability, difficulty feeding, prematurity, withdrawal symptoms, low Apgar scores, malformations of the genito-urinary system, seizures or tremors and small head.

Draft Laws Recognizing a Pregnant Woman's Obligations to Her Future Child

Deborah Mathieu of Harvard says requiring a pregnant woman to give up certain activities during pregnancy is not materially different from other accepted limits on a person's behaviors, such as compulsory vaccination. She says it should not be difficult to draft laws that make a pregnant woman's obligations to her future child clear and not unduly burdensome. Policy makers contemplating these laws should consider five factors, she says (Mathieu, p. 50-4):

a) The magnitude of harm: To what extent will the future child be harmed by his mother's actions? To what extent will the pregnant woman be harmed if her decision is overruled and her body is invaded? She concludes that the right to the woman's bodily integrity is so important that the only justifiable interventions would be those that prevent major harm to the child and cause only minor harm to the woman.

b) A balance of the interests involved: The woman's interests include that of bodily integrity, of making decisions for her children, of not being pregnant and of not rearing a child. The child's interests include not suffering or being disabled. Dr. Mathieu concludes that early in the pregnancy, the woman's interests dominate. Later in the pregnancy, however, the interests of the future child are "at least as compelling as are hers."

c) The probability that harm will occur: There must be ample evidence of a high probability of serious harm to the child if the state does not intervene, and only minor harm to the woman if it does intervene.

d) The probability that harm can be avoided or removed: It only makes sense to intervene if there is significant probability that the harm can be prevented or ameliorated. Policy makers must consider whether the contemplated intervention is reliable and effective.

e) The proportion of harm: If intervention creates more harm than it cures, the point of intervention would be defeated. For this reason, the harms prevented or removed should be substantial when compared to the degree of invasion. Secondly, the intervention should be the least intrusive available.

Treat the Pregnant Woman for Drug or Alcohol Abuse

Dr. Ira Chasnoff recommends drug and alcohol treatment for the substance-abusing pregnant woman, combined with parenting education. He says intervening to provide specialized, comprehensive treatment for addicted pregnant women has been shown to cut the average hospitalization period for affected infants from a four-to-six-week stay to a stay of only two or three days. This represents a savings of $27,000 per child, he said (testimony before U.S. House of Representatives, May 21, 1986). The savings would be greater in Alaska, where in 1989, one day in the Providence Hospital Level III nursery averaged $2,400. Other national experts in alcohol abuse during pregnancy report that 60 to 80 percent of heavy drinkers who enter treatment programs reduce their consumption before the third trimester of pregnancy (Weiner, Rossett and Mason, p. 70).

Require Parents of Drugged Newborns to Complete Treatment

Alaska judges and prosecutors strongly support treatment for substance abusers (see, for example, "Legislators Drafting Bill for Treatment of Inmates," Associated Press, *Anchorage Times*, January 25). One judge says he has convinced "more than one" reluctant substance-abusing pregnant woman to take treatment.

G: <u>Summary</u>

Legislators and judges who want to write a coherent body of law about substance abuse that is constitutional and protects both the woman and the fetus are in a dilemma. This is because whatever is done for the fetus must necessarily be done to the pregnant woman.

Some other states have begun to attack the problem. At least one is requiring testing and reporting of pregnant women and newborns when physicians suspect drug or alcohol abuse. At least one allows the state to require successful treatment before the drug-damaged infant can be allowed back in the family home. Some have redefined child neglect to include an unborn child or a fetus. Some are allowing the state to take custody when a child shows evidence of drugs or alcohol in its system. Meanwhile, experts suggest systematically identifying babies born with drugs or alcohol in their systems, requiring physicians to report these births, and treating women for their drug or alcohol problem before the baby is born.

IMPLEMENTING A SCHOOL CURRICULUM ON FETAL ALCOHOL SYNDROME

Legal Questions

Assistant Attorney General Gary Amandola says there are no legal problems with requiring FAS curriculums in Alaska school districts.

Policy Questions

The state Department of Education sees no problem with encouraging local school districts to initiate a curriculum. However, the department has significant concerns about mandating a specific curriculum, according to Mary Hakala, the department's legislative liaison.

In a "first time ever" move, however, the state Board of Education on January 30 voted to support a mandatory comprehensive health curriculum in Alaska schools. FAS would be one component of that curriculum, according to Ms. Hakala.

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Economic Impact of Fetal Alcohol Syndrome in Alaska

February 1989

by

Maureen Weeks
Senate Advisory Council

for

Senator Johne Binkley

Alaska State Legislature

Senate Advisory Council

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MEMORANDUM

TO: Senator Johne Binkley
Alaska State Senate

FROM: Maureen Weeks MW
Senate Advisory Council

DATE: February 17, 1989

SUBJECT: Economic impact of Fetal Alcohol Syndrome; IR # 89-100015

An estimated 29 babies with Fetal Alcohol Syndrome (FAS) are born in Alaska annually; of these 26 survive the first year. Two to 15 times this many babies are born with a lesser set of symptoms known as Fetal Alcohol Effects (FAE). Babies exposed to alcohol before birth may be too small when they are born. Just ten years ago almost all low birthweight babies died at birth. Today, increasingly expensive medical technology saves the lives of four out of five but cannot correct many defects already caused by alcohol. Fifty-eight percent of both FAS and FAE patients have IQ's below 70 (classified as Developmentally Disabled). Conservatively estimated, the lifetime cost per Alaska FAS birth is $1.4 million. Lifetime cost for Alaska FAS babies born each year is $39.8 million.

These are selected medical and social costs only; they do not include, among other things, costs of welfare, the justice system, mild physical problems, mild learning disabilities or loss of a useful member of society.[1]

A table of costs associated with FAS and FAE follows page 18 of this report.

I. BACKGROUND.

Fetal Alcohol Syndrome (FAS) is caused when the alcohol which a pregnant woman drinks damages the brain and body of the fetus as it develops. Until 1973, alcohol was not suspected as toxic to an unborn baby. Respected medical authorities told pregnant women that the placenta protected their fetuses from harmful substances. Today we know these authorities were wrong. Babies who are exposed to alcohol before they are born can be irreversibly harmed for the rest of their lives.

The damage done by alcohol has profound implications for the victim and society. The harmful effects of alcohol on the fetus last a lifetime. A common problem is mental retardation. The average IQ of FAS patients is 66. Almost every child

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[1] Harwood and Napolitano estimate direct average lifetime costs at $405,000 per person and indirect costs at $191,000, in 1980 dollars. Adjustment for inflation and cost of living differences (3 percent per year and 30 percent) yields direct costs of $528,000 and indirect costs of $249,000, for a total of $1,010,000/person, Alaska 1989. Total costs for 29 Alaska FAS births would be $29,290,000. (A 30 percent increase is conservative; the Bureau of Labor Statistics reports that medical services increased by 83.5 percent in Anchorage between 1980 and 1988.) It should be noted that some costs in the Harwood study are much less than Alaska costs. For example, intensive care hospitalization is estimated nationwide at $2,500 per infant v. $120,000/year per infant in Alaska; institutionalization is estimated at $25,000/year nationwide v. $109,000 in Alaska.

or adult with FAS needs lifelong care, supervision or support from family and society. Those most severely affected may spend their lives in institutions. Some suffer physical anomalies such as heart problems, cleft palate, kidney problems, blindness and deafness.

Few, if any, families can pay the enormous costs of supporting an FAS child or adult. Babies born with FAS may need intensive hospital care at birth at an average cost of $2,400 <u>a day</u>. One in eight children born with FAS have cleft palates, requiring surgeries costing up to $75,000 and long term speech therapy twice or three times a week at $96 an hour. Fifty-eight percent of patients with FAS have IQ's below 70 and as such are classified as developmentally disabled. Cost of special education for a severely retarded child is $20,000 a year. Average annual cost for each FAS patient in an institution is $109,000.

Two national studies of the economic impact of Fetal Alcohol Syndrome have been published since the syndrome was discovered in 1973. Harwood and Napolitano in 1985 found the U.S. spends up to $108.8 million a year on FAS births; Abel and Sokol in 1986 found annual costs of $321 million a year. This report adapts the more conservative Harwood and Napolitano study to Alaska.

II. INCIDENCE OF FAS AND FAE

An estimated 29 Alaska babies are born a year with FAS. Experts believe between two and 15 times that many FAE babies are born annually.

A diagnosis of FAS requires signs in three areas:

(1) Pre and/or post natal growth retardation (weight, length, and/or head circumference below the tenth percentile).

(2) Central nervous system problems (neurological abnormality, developmental delay, or intellectual impairment.

(3) Characteristic facial features (including small eyes, crossed eyes, short nose, or abnormalities of the mouth such as cleft palate).

FAS may be difficult to identify, especially among newborns. The identifying facial features may not be easily recognized and mental retardation may not be identified until years after birth.

U.S. researchers speculate that some racial groups, such as certain American Indian tribes, may be at greater risk for FAS than the population as a whole. A 1982-83 study of Indians on 26 reservations in New Mexico, Colorado, Utah and Arizona showed a wide variation in prevalence of FAS among cultural groups. For example, among Navajo Indians, the incidence was 1.4 FAS cases per 1,000 births; among Pueblo Indians it was 2 per 1,000 births and among Plains Indians it was 9.8 per 1,000 births.

Dr. James Berner of the Native Health Service, and Vicki Hild, FAS Coordinator for the Alaska Native Health Board, report statewide incidence of FAS between

1981 and 1988 at 4.2 per 1,000 live births. At an average of 2,700 deliveries annually, this would be about 12 FAS Native births a year.

The estimate comes from an Alaska Area Native Health Service survey of Alaska Native children born between 1981 and 1988. The study shows that the highest recorded FAS rate among any population in the world is in the Copper River area of Alaska: 250 FAS cases per 1,000 births (or one in every four births). Estimated incidence among Alaska Natives in other areas:

Sitka region:	2.1 FAS cases per 1,000 births
Bethel region:	3.5 FAS cases per 1,000 births
Anchorage:	3.8 FAS cases per 1,000 births
Nome region:	4.0 FAS cases per 1,000 births
Tanana Chiefs:	5.9 FAS cases per 1,000 births

It would be a mistake to ignore FAS among non-Native Alaskans. Data shows, for example, that one non-Native woman in Southcentral Alaska has produced seven children with FAS. No one has studied the incidence of FAS among non-Native Alaskans. Indeed, relatively few studies of the incidence of FAS among the general population have been done in the U.S. The literature commonly estimates overall FAS prevalence at from 1 to 3 cases per 1,000 live births (see <u>Sixth Special Report to the U.S. Congress on Alcohol and Health</u>, January 1987). Estimates in U.S. cities show:

Cleveland (1973-79)	.4 FAS cases per 1,000
Cleveland (1979-82)	3.0 FAS cases per 1,000
Seattle (1978)	1.3 FAS cases per 1,000
Boston (1977)	3.1 FAS cases per 1,000
Boston (1983)	2.1 FAS cases per 1,000

Estimates from Europe include:

Sweden (1979)	1.6 FAS cases per 1,000 births
	1.4 cases per 1,000 births
France (1977-79)	1.3 cases per 1,000 births
	2.9 cases per 1,000 births.

Abel and Sokol added together all FAS births reported worldwide in text or by personal communication and found a worldwide incidence of 1.9 FAS cases per 1,000 live births. Rates were higher in North America (2.2 cases per 1,000 live births) than in Europe and other countries (1.8 cases per 1,000 live births). They believe site, economic class and culture affect the reported FAS rate. Hild and Berner place national incidence at 1.7 per 1,000 live births. This study will use that conservative estimate. At an average of 10,000 deliveries annually, this would be about 17 non-Native babies born with FAS in Alaska a year. Added to the estimated 12 Native births, this brings the total Alaska FAS births per year to 29 babies. Of these, 26 babies survive their first year. See Table 1.

In the 16 years since U.S. doctors recognized that alcohol harms the fetus, researchers have concentrated on the more serious illness, FAS. However, patients with FAE have an average IQ of 73 and researchers now believe that in addition to lowered IQ, FAE causes hyperactivity, learning disorders, speech and hearing problems, perceptual problems and short attention span, among other problems. In some cases, these signs may not become evident until the child has trouble in school. Educators faced with a "difficult" child may not associate school problems with prenatal exposure to alcohol.

Researchers disagree on the incidence of FAE. Ann Streissguth of the University of Washington Medical School, an associate of the U.S. discoverers of FAS, estimates that FAE occurs twice as often as FAS. The National Institute on

Table 1

Incidence of FAS births in Alaska, 1988

Native births:	
Deliveries (a)	2,736
Incidence of FAS births (b)	4.2/1000
Number of FAS births (2736 x .0042 = 11.5)	12
Non-Native births:	
Deliveries (a)	10,163
Incidence of FAS births (b)	1.7/1000
Number of FAS births (10163 x .0017 = 17.3)	17
Total FAS births:	29
First-year survivors:	
Neonatal mortality rate, Alaska: (c)	5.1%
Neonatal survivors:	28
Postneonatal mortality rate: (c)	5.9%
FAS first-year survivors	26

(a) Alaska Vital Statistics 1985, Department of Health and Social Services, Juneau, 1988.

(b) J.E. Berner, "Update: Incidence of Fetal Alcohol Syndrome (FAS) In Alaska Natives", February 3, 1989.

(c) Alaska Vital Statistics 1985, p. 7.

Alcohol Abuse and Alcoholism reports a ten times increase and Sokol estimates much as a 15 times increase. Hild believes the incidence of FAE in Alaska is ten times that of FAS, or higher. In an effort to be conservative, this report will use the lowest estimate (twice FAS). At this rate, 58 Alaska FAE babies are born a year.

Table 2 shows the number of FAE births per year at each estimate.

Table 2

Incidence of FAE, Alaska 1985 (a)

Estimate of times increase over FAS	Number of FAE born/year (FAS = 29/yr)
2	58
10	290
15	435

(a) Three estimates of the frequency of FAE are quoted in the literature:

* 2 times FAS: Ann P. Streissguth, Ph.d, of the University of Washington Medical School. (Manual on Indian Adolescents and Adults with Fetal Alcohol Syndrome, July, 1986, p. 4)

* 10 times FAS: National Clearinghouse for Alcohol Information at Rockville Maryland. (Fact Sheet, December 1985). V. Hild, FAS coordinator for the Alaska Native Health Board, estimates the FAE incidence in Alaska exceeds 10 times that of FAS.

* 15 times FAS: R.J. Sokol. ("Alcohol Abuse During Pregnancy: An Epidemiologic Study", Alcoholism: Clinical and Experimental Research, April 1980, p. 135-145.

B. Medical costs associated with FAS and FAE.

FAS patients commonly require medical care for cleft palate, heart defects, kidney defects, visual and hearing defects, dental problems and skeletal and postural problems. When estimates of the prevalence of these anomalies are available, this report relies on Abel and Sokol, Harwood and Napolitano and Hild for accurate statistics. Unfortunately, the prevalence for the majority of physical problems has not been established and these costs are not be included in this report. Table 6 shows costs of selected physical disorders. Hospital costs are explained below.

Alcohol can lower birthweight even in babies who do not have FAS. Ruth Little reports that when a pregnant woman drinks one ounce of alcohol a day, birthweight can fall by 160 grams. Alcohol also lowers birthweight in the majority of FAS births. Low birthweight babies are at risk to need intensive care. Just ten years ago almost all low birthweight babies died at birth. Today, newborn intensive care saves the lives of four out of five. This intense early care is increasingly expensive and cannot correct the lifelong and expensive defects already caused by prenatal exposure to alcohol. In some cases, the desperate effort to save a too-small baby's life adds to the irreversible burden of harm the child will carry with it for the rest of its life.

Abel and Sokol report that 79.8 percent of FAS babies are low birthweight (see Table 3). Of 29 Alaska babies born annually with FAS, 23 babies would be low birthweight. Alaska vital statistics records show that 4.6 percent of babies are born low birthweight despite their prenatal care. Thus, one Alaska baby would be low birthweight despite the best prenatal care, leaving 22 Alaska babies whose low birthweight is due to FAS. Abel and Sokol report that 74.3 percent of FAS low birthweight babies are moderately low birthweight, weighing between 1500 and 2500 grams. At this rate, 16 Alaska FAS babies would be

moderately low birthweight. The rest (six babies) are very low birthweight, weighing less than 1500 grams.

The National Institute of Medicine reports that 32.8 percent of moderately low birthweight babies need intensive care (see Table 4). Of the 16 moderately low birthweight Alaska babies, five would need intensive care. All of the very low birthweight babies (six babies) would need intensive care. The total number of FAS low birthweight babies needing intensive care is 11 per year. This estimate is corroborated by Dr. Jack Jacob, Providence Hospital neonatologist, who reports between ten and 15 FAS infants are treated in the intensive care unit each year.

Providence Hospital records show that in 1987, the average length of stay in intensive care for an FAS baby was 27 days and in 1988, it was 65 days.[2] Average FAS hospital costs in 1987-88 were $99,740 per FAS child; average neonatal physician fees for FAS infants were $11,065. These costs include all hospital costs except transport, other physicians and anesthesiology. Total average cost of intensive care for one FAS baby is $110,805 per year. For 11 low birthweight babies, it is $1,218,855 per year.

The Institute of Medicine estimates that 19 percent of all moderately low birthweight babies and 38.3 percent of very low birthweight babies must be rehospitalized during their first year. Streissguth of the University of Washington reports that it is "usual" for FAS babies to be rehospitalized for pneumonia and problems such as hip dysplasia; applying statistics for all low birthweight babies to FAS births may result in conservative estimates.

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[2] To compare, average length of stay for all low birthweight babies in the intensive care unit at Providence was 19.7 days in 1987 and 23.7 days in 1988.

Using the Institute of Medicine averages for all low birthweight babies, one FAS moderately low birthweight baby would be rehospitalized for 12.5 days and two very low birthweight babies would be rehospitalized for 16.2 days. Hospitalization for children not in intensive care was about $900 a day at Providence Hospital in Anchorage in 1988. Rehospitalization for one baby for 12.5 days is $11,250 and for two babies at 16.2 days it is $29,160. Total cost of rehospitalization for low birthweight FAS babies: $40,410. This does not include physicians, surgery, special procedures or transportation. See Table 5.

Table 3

Low birthweight of FAS births,
Alaska 1985

Alaska Low Birthweight Births (under 2500 grams) due to FAS.	
FAS births which are Low Birthweight:	
Total FAS births:	29
% FAS births which are under 2500 grams (a)	79.8%
LBW babies in 29 FAS births: (29 x .798 = 22.9)	23
Low Birthweight births not due to FAS:	
% Alaska LBW births under 2500 grams not due to FAS (b)	4.6%
4.6% x 23 = 1 LBW birth not due to FAS	
LBW births due to FAS: (23 x .046 = 1.1)	22
Weight distribution of Alaska FAS Low Birthweight births:	
1500-2500 grams (MLBW):	
% FAS births between 1500-2500 grams (a)	74.3%
FAS MLBW babies: (22 x .743 = 16.4)	16
Under 1500 grams (VLBW):	
All other LBW babies are VLBW (under 1500 grams)	6

(a) Abel and Sokol, "Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies", Elsvier Scientific Publishers, Ireland, August, 1986, p. 58.

(b) If FAS were eliminated from Alaska, 4.6 percent of all births would still be low birthweight. Although they would still need treatment, the costs of their treatment should not be attributed to FAS. This number is the solution to the following equation: 4.8% x 12,900 births = 79.8% x 24.6 FAS births + p x 12,869 non-FAS births, where 4.8% is low birthweight rate in Alaska; 12,900 is number of Alaska births in 1985; 79.8% is U.S. LBW rate for FAS births; 24.6 is FAS births in Alaska in 1985. Formula devised by J.W. Senner, Oregon State Health Division, "Revised Annual National Cost Estimates" (Portland), p. 2.

Table 4

Costs of intensive care hospitalization for FAS LBW babies
Alaska 1985

Moderately LBW (1500-2500 grams) Intensive Care hospitalization:	
% MLBW babies requiring intensive care (a)	32.8%
MLBW FAS babies requiring intensive care (16 x .328 = 5.4)	5
Very LBW (under 1500 grams) Intensive Care hospitalization:	
% VLBW babies requiring intensive care (a)	100%
VLBW FAS babies requiring intensive care	6
Total	11 babies
Hospital cost for 11 babies at $99,740 (b)	$1,097,140
Physician cost for 11 babies at $11,065 (b)	$ 121,715

(a) The Institute of Medicine reports that 32.8% of LBW infants and 100% of VLBW infants require newborn intensive care. Preventing Low Birthweight, Institute of Medicine, (Washington, D.C.), 1985. This may be an underestimate for FAS babies who show a longer average length of stay in intensive care, an indication that they may be sicker than other low birthweight babies. Providence Hospital reports the following average lengths of stay in the newborn intensive care unit in 1987 and 1988.

	1987	1988
Low Birthweight	19.7 days	23.7 days
FAS Low Birthweight	27 days	65 days

(b) Costs do not include transportation, other physician or anesthesiology fees. Neonatologist Dr. Jack Jacob estimates between 10 and 15 FAS infants a year enter the unit (Lisa Wolf, pers. comm.).

Table 5

Cost of first-year rehospitalization for FAS LBW babies
Alaska 1985

LBW rehospitalization:	
FAS MLBW babies in intensive care	5
Neonatal mortality rate (a)	5.1%
FAS MLBW babies who survive intensive care (5 x .051 = .25)	5
Percent LBW bal ;s rehospitalized (b)	19%
Number of LBW babies rehospitalized (5 x .19 = .95)	1
Cost of rehospitalization: 1 x $11,250 (c)	$11,250
VLBW rehospitalization:	
FAS VLBW babies in intensive care	6
Neonatal mortality rate (a)	5.9%
FAS VLBW babies who survive intensive care (6 x .059 = .35)	6 babies
Percent VLBW babies rehospitalized (b)	38.3%
Number of VLBW babies rehospitalized (6 x .383 = 2.3)	2
Cost of rehospitalization: 2 x $14,580 (c)	$29,160
Total cost of first-year rehospitalization:	$40,410

(a) Alaska 1985 Vital Statistics, Department of Health and Social Services, (Juneau), p. 7.

(b) The National Institute of Medicine reports that 19% of 2500-1500 gram babies are rehospitalized during the first year, as are 32.8% of babies under 1500 grams. Preventing Low Birthweight, National Institute of Medicine, (Washington, D.C.), 1985. This may be an under-estimate for FAS births. Streissguth reports that it is "usual" for FAS babies to be rehospitalized during the first few months of life for pneumonia, failure to thrive, hip dysplasia and other problems. A Manual on Indian Adolescents and Adults with Fetal Alcohol Syndrome, University of Washington Medical School, July 1, 1986.

(c) Providence Hospital charges for pediatric ıission, 1988: $900/day (MLBW average length of stay, 12.5 days; VLBW stay, .2 days).

C. <u>Costs associated with mental retardation</u>.

Streissguth in a [illegible] study of 61 FAS/FAE diagnosed patients between the ages of 12 and 40 shows that more than half (58 percent) of both FAS and FAE patients were developmentally disabled (IQ's below 70). Hild finds the 58 percent estimate likely in Alaska. This report will rely on that estimate. At this rate, 15 FAS first-year survivors and 34 FAE patients have IQ's below 70. (Note that computing the incidence of FAE at 10 times that of FAS, the percentage used by Alaska experts, there would be 336 developmentally disabled FAE patients born every year.) Social service costs for the average moderately to mildly retarded child are $25,000 a year (not including education). For adults, these costs are as high as $45,000 a year (including vocational rehabilitation). About five FAS children currently are part of the Alaska Youth Initiative program for severely troubled youth at an average cost of $90,000 a year each.

If 58 percent of FAS and FAE patients are developmentally disabled, an estimated 42 percent have minimal brain dysfunction. In this report, costs for this portion of patients are estimated at $4,000 each, the additional cost of special education for mildly disabled persons (above regular education operating costs). State officials caution that FAS/FAE patients with IQ's between 70 and 100 may actually be more expensive than those with lower IQ's because of added counselling, legal and corrections costs. This is not reflected in this report.

Streissguth's study of 61 FAS/FAE patients from the Southwest U.S., Seattle and Vancouver, B.C. showed the following patient characteristics:

(1) IQ's ranged from a score of 20 to 105. Average IQ of patients with FAS was 66 and of patients with FAE, 73. No patient with FAS showed

an IQ above 90. Streissguth concludes it is impossible to predict from a diagnosis alone how handicapped an individual patient with FAS/FAE will be as an adolescent or adult.

(2) 58 percent of both FAS and FAE patients had IQ's below 70, (generally classified as developmentally disabled).

(3) The average reading, spelling and arithmetic level of these patients (ages 12 to 40) was 4th grade, 3rd grade and 2nd grade, respectively.

(4) Average level of general adaptive functioning was 7 years 5 months. (Median age of those tested was 16 years 5 months.)

(5) There was no indication of general improvement in IQ, achievement or adaptive living scores as patients got older.

(6) None of the patients were able to live independently.

Vicki Hild of the Alaska Native Health Board has tabulated living situations for 118 Alaska Natives with FAS. She found that 20 percent had been adopted and 10 percent had died. The remaining children shuttled back and forth between their biological parents and state custody. It is state policy to keep children with their biological parents if possible; children move in and out of state custody as a parent's condition improves or worsens. Among biological parents of the 118 children in the Hild study, only three mothers appeared "reasonably" stable.

Hild cites as an example of "ping-ponging" custody, the case of one Alaska FAS child who had lived in seven foster homes by the time she was three.[3]

D. Costs not included in this estimate.

Medical researchers have not yet determined a reliable rate of incidence for the majority of physical defects common to FAS victims and these costs have not been included in this estimate. These physical anomalies include visual problems, kidney and genital tract problems, and dental and skeletal defects (more frequently found in adolescents and adults), including club foot and scoliosis and neurotube defects such as spina bifida. Also not included are on-going lifelong medical costs associated with the ill health of patients with these problems. (Despite their illnesses, however, FAS patients are expected to live a normal life span.) Transportation, anesthesiology and some physician costs for first-year hospitalization and costs of FAE babies with physical damage are also not included.

Many social costs are also not included in this estimate. FAS children and adults are at high risk for physical and sexual abuse. They may exhibit signs of depression; some may be suicidal; a few may become violent. As they grow into adulthood, some may exhibit increasingly inappropriate sexual behavior.

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[3] Streissguth believes stability is important to the well-being of FAS patients. "We usually find great improvement in emotional development and social functioning when children with both full and partial FAS have stable and supportive living arrangements. Improved behavior which often occurs, even in the absence of changes in IQ, should not be ignored simply because it is more difficult to measure and quantify." "Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol", Alcohol Health and Research World, Fall 1988, p. 10.

Many of the costs of welfare, child abuse, sexual abuse, psychiatric care, incarceration, stress on the care-giver and loss of a useful member of society are not included in this report. Hild has stated that "without early intervention, all FAS and most FAE patients will be on welfare." In addition, this report does not consider what may be the enormous, but still unrecognized, costs of learning disabilities suffered by children afflicted with FAE.

TABLE I

LIFETIME COST ESTIMATES OF SPECIFIC BIRTH DEFECTS IN FAS BIRTHS -- ALASKA

	Birth Defect	Annual Cost per Patient	Number of Times or Years	Lifetime Cost per Patient	Prevalence	Number Per Yr (% x 26)	Lifetime Cost: All Born 1988
	ANNUAL FAS BIRTHS (29 BIRTHS; 26 SURVIVORS)						
1	Neonatal Unit/Providence	99,740	1	99,740		11	1,097,140
2	Neonatal Physician	11,065	1	11,065		11	121,715
3	First Year Rehospitalization	13,470	1	13,470		3	40,410
4	Initial Audio Screening	100	1	100	52%	15	1,500
5	Audio Check-up	100	4	400	100%	26	10,400
6	Otitis Media Surgery	1,224	1	1,224	56%	15	18,360
7	Hearing Aid	1,260	14	17,640	33%	9	158,760
8	Hearing Aid Mold	50	65	3,250	33%	9	29,250
9	Heart Surgery	75,000	1	75,000	5%	1	75,000
10	Cleft Palate Surgery	65,000	1	65,000	12%	3	195,000
11	Infant Learning Program (HSS)	2,513	3	7,539	100%	26	196,014
12	H/C Child: phys defect (HSS)	8,700	18	156,600		7	1,096,200
	H/C Child: devel delay (HSS)	8,700	3	26,100	58%	15	391,500
13	Minimal Special Eductn (DOE)	4,000	15	60,000	42%	11	660,000
14	Child Mental Retardation (DOE)	20,000	15	300,000	58%	15	4,500,000
15	DD Child (HSS)	25,000	18	450,000	58%	15	6,750,000
16	Alaska Youth Initiative (HSS)	90,000	12	1,080,000		1/2	540,000
17	DD Adult Initial Training(HSS)	45,000	3	135,000	58%	15	2,025,000
18	DD Adult Supervised Work (HSS)	22,500	44	990,000	58%	15	14,850,000
19	Institution	109,000	65	7,085,000	3%	1	7,085,000
	Lifetime Costs for FAS Births: 1988						39,841,249
	Lifetime Costs per FAS Birth			1,373,836			
20	ANNUAL FAE BIRTHS AT TWICE FAS RATE (58)						
21	Infant Learning Program (HSS)	2,513	3	7,539	58%	34	256,326
22	DD Child (HSS)	25,000	18	450,000	58%	34	15,300,000
23	Child Mental Retardation (DOE)	20,000	15	300,000	58%	34	10,200,000
24	DD Adult Initial Training(HSS)	45,000	3	135,000	58%	34	4,590,000
25	DD Adult Supervised Work (HSS)	22,500	44	990,000	58%	34	33,660,000
	Lifetime Costs for FAE Births: 1988						64,006,326
	Total FAS/FAE Births						103,847,575

NOTES TO FAS COST TABLE

Numbers refer to line numbers on the table.

1. Neonatal Unit. Charges per FAS patient in the Providence Hospital Neonatal Intensive Care Unit were $68,910 in 1987 and $130,570 in 1988, for an average of $99,740. Average length of stay of FAS infants in the Neonatal Intensive Care Unit more than doubled between 1987 and 1988. It was 27 days in 1987 and 65 days in 1988 (v. 19.7 and 23.7 days for all low birthweight babies in the unit). Statistics provided by Lisa Wolf of Providence Hospital.

2. Neonatal Physician. Physician costs per FAS child were $6,130 in 1987 and $16,000 in 1988, for an average of $11,065. Estimates by Sharon Lee of Alaska Neonatal-Perinatal Associates.

3. First-year rehospitalization. Cost estimate is based on 1988 Providence Hospital pediatric charges of $900/day. The number of infants and average length of stay (12.5 days for moderately low birthweight infants and 16.2 days for very low birthweight babies) are from the National Institute of Medicine and are for all low birthweight infants. Applied to FAS births, these may be underestimates. Streissguth reports it is "usual" for FAS babies to be rehospitalized in the first few months of life.

4. Initial Audio Screening. The state audiologist, Communicative Disorders Program, Anchorage, reports all FAS children need a workup. This report estimates that 11 infants receive a workup in intensive care; the 15 remaining surviving infants are counted in this entry.

5. <u>Audio Check-up</u>. FAS children need three to four follow up checks. The $100 charge is from the Alaska Treatment Center in Anchorage; the check-up estimate is from the state audiologist.

6. <u>Otitis Media Surgery</u>. Estimate is from the Geneva Woods Ear Nose and Throat Associates. Source of 56% prevalence is Harwood and Napolitano. These costs do not include less severe ear problems common to 93 percent of FAS patients (Alaska Treatment Center). Twenty-nine percent of FAS patients have permanent hearing loss.

7. <u>Hearing Aid</u>. A hearing aid for a baby costs $1,260; it is replaced once every five years for life at this cost. Cost estimate from Alaska Treatment Center.

8. <u>Hearing Aid Mold</u>. A $50 ear mold must be replaced annually. Estimate from Alaska Treatment Center.

9. <u>Heart Surgery</u>. Up to 70 percent of FAS patients have heart problems (Streissguth reports the portion at 30-40 percent; Hild reports 70 percent). Harwood and Napolitano report 10 percent require heart surgery, but reduce the estimate to 5 percent to reflect cases actually having surgery. Cost estimates from Vicki Hild, Alaska Native Health Board FAS coordinator.

10. <u>Cleft Palate</u>. Costs include an average of four surgeries, dental and orthodontics work. They do not include long term speech therapy at $96/session twice or three times a week. Estimates from Vicki Hild. The 12% estimate is average of Abel and Sokol (11.5%) and Harwood and Napolitano (12.5%).

11. Infant Learning Program. Mary Diven of the state division of Maternal and Child Health reports these figures are "deceptively low", under estimating the true cost of rural service. Infant Learning Program costs as much as $6,000/year in some rural areas.

12. Handicapped Children's Program. Cost estimates include averages for children with heart problems, cleft palate and developmental delay. Children with physical problems can be on the program for 21 years; children with developmental delays may be on the program for as few as three years. Cost estimates by Kathy Robinson, Maternal and Child Health, Alaska Department of Education. This report estimates that one child per year has heart problems (a low estimate in view of the 30 to 70 percent with heart problems); three have cleft palates; and three more have other physical problems such as spina bifida, progressive scoliosis, or severe visual and hearing loss.

13. Minimal Special Education. Costs cover only $4,000/year for additional special education for learning disabled children, above normal operating and capital education costs (Tom Buckner, Department of Education). Christine Hagmeier of the Department of Health and Social Services cautions that patients with IQ's above 70 and below 100 "may well be more expensive than those with lower IQ's" because they an become involved in counselling, corrections and the law. These costs are not reflected in this report. The 42 percent prevalence estimate is from Streissguth.

14. Child Mental Retardation. Cost of special education for severely retarded children is $20,000 - $23,000/year, in addition to normal operating and capital education costs. Estimates from Tom Buckner, Department of Education.

15. Developmentally Disabled Child (HSS). Cost estimate by Christine Hagmeier of the Department of Health and Social Services. Costs can include foster care, in-home care, shared care, respite care, in-home training, advocacy and family support. Hagmeier reports that severely disabled children can cost between $35,000 and $85,000 with average cost of $55,000.

16. Alaska Youth Initiative. Cost estimate from John Van Den Berg, Department of Health and Social Services. This is a program for 52 severely troubled youths. The average age is 15.8 years; the average number of failed housing placements is 16. Currently five FAS youths are in the program. This report estimates children remain on the program an average of 12 years (based on Van Den Berg's report that "absolute minimum lifetime costs per child are $1 million".) It further assumes that one FAS child would enter this program every two years. Streissguth reports that aggressive behavior may be a problem for about 40% of the boys. Those from a less structured and protected environment may be "quick to anger when crossed and quick to strike out impulsively".

17. Developmentally Disabled Adult Initial Training. Costs include $25,000 residential care (example: foster care and independent living) plus initial vocational rehabilitation costs of $20,000, for a total of $45,000. Initial vocational rehabilitation costs average between two and five years. Estimate by Christine Hagmeier.

18. Developmentally Disabled Adult Supervised Work. After initial rehabilitation costs (see #17 above), costs can "fade" to between $10,000 and $25,000 for lifetime residential care plus $5,000 lifetime vocational rehabilitation care (Hagmeier). The average of this $15,000 to $30,000 range is $22,500.

19. Institution. Estimate by Ellen Ganley, Governor's Council for the Handicapped and Gifted.

20. FAE Births. Annual FAE births are calculated in this report at twice that of FAS births. This is a conservative estimate. Hild believes the actual number of FAE births annually is ten times the FAS births (or 290 FAE births and 168 developmentally disabled FAE persons.) In this report, cost estimates for FAE births are limited to mental retardation. They do not include costs associated with mild learning disabilities, physical anomalies, child abuse, sexual abuse or the justice system.

21. See #11.
22. See #15.
23. See # 14.
24. See # 17.
25. See # 18.

SOURCES

Ernest L. Abel and Robert J. Sokol, "Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies", Department of Obstetrics and Gynecology, Wayne State University, Drug and Alcohol Dependence, Vol. 19, 1987, pp. 51-70.

James Berner, M.D., Letter to George Brenneman, M.D., February 10, 1988 and Letter to Chief, Area Community Health Services Branch, Alaska Area Native Health Service, February 3, 1988.

Henrick J. Harwood and Diane M. Napolitano, "Economic Implications of the Fetal Alcohol Syndrome", Alcohol World Health & Research, National Institute on Alcohol Abuse and Alcoholism, Fall 1985.

Ruth Little, "Moderate Alcohol Use During Pregnancy and Decreasing Infant Birthweights", American Journal of Public Health, Vol. 67, 1977.

Ann P. Streissguth, A Manual on Indian Adolescents and Adults with Fetal Alcohol Syndrome, University of Washington Medical School, July 1, 1986.

PERSONS CONSULTED

James Berner, M.D., Chief, Area Community Health Services Branch, Alaska Area Native Health Service.

Tom Buckner, Special Education, Alaska Department of Education.

Mary Diven, Infant Learning Program, Alaska Department of Health and Social Services.

Ellen Ganley, Governor's Council for the Handicapped and Gifted.

Robert Gregovich, formerly with Mental Health and Developmental Disabilities, Alaska Department of Health and Social Services.

Christine Hagmeier, Mental Health and Developmental Disabilities, Alaska Department of Health and Social Services.

Henrick Harwood, National Institute of Medicine, Rockville, Md. (202-334-3017)

Vicki Hild, FAS Coordinator, Alaska Native Health Board.

Kathy Robinson, Handicapped Children's Program, Alaska Department of Health and Social Services.

Sandra Randalls, R.N., University of Washington Medical School, Seattle (Ann Streissguth was out of town).

John Van Den Berg, Mental Health and Social Services, Alaska Department of Health and Social Services.

Lisa Wolf, Providence Hospital.

Sec. 47.37.190. Involuntary commitment of alcoholics. (a) After a hearing initiated by petition of a spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of a private or public facility by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that the person (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the administrator in charge of the approved public treatment facility in which the committed person has been committed for emergency care; and (5) any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

(c) If, not less than two days before the date fixed for the hearing, the person sought to be committed or the person's counsel or advisor files a written request with the superior court, the court shall summon and impanel a jury of six adult residents of the judicial district in which the court officiates, preferably from the court's jury list or the last voters lists, if available, to hear and consider evidence concerning the condition of the person sought to be committed. (§ 1 ch 207 SLA 1972; am § 7 ch 150 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "a private or public facility" for "the office" near the end of the first sentence of subsection (a).

Sec. 47.37.200. Hearing on petition for involuntary commitment of alcoholics. (a) At the hearing required under AS 47.37.190(b), the court or the jury, if requested under AS 47.37.190(c), shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that being present is likely to be injurious to the person, in which case the court shall appoint a guard-

ian ad litem to represent the person throughout the proceeding. The court may examine the person in open court, or if advisable, examine the person out of court. If the person has refused to be examined by a licensed physician, the person shall be given an opportunity to request examination by a court-appointed licensed physician. If the person fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may issue a temporary order committing the person to a private or public facility for a period of not more than five days for purposes of a diagnostic examination.

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the private or public facility, the court or the jury finds that grounds for involuntary commitment have been clearly established, the court shall issue an order of commitment to the private or public facility. A court may not order the commitment of a person unless it determines that a private or public facility is able to provide adequate and appropriate treatment for the person.

(c) A person committed under AS 47.37.190 — 47.37.200 shall remain in the custody of a private or public facility for treatment for a period of up to 30 days. At the end of the 30-day period, the person shall be discharged automatically unless the office, before the expiration of the period, obtains a court order for recommitment upon the grounds set out in AS 47.37.190(a) for a further period of up to 90 days. If a person has been committed because the person is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists.

(d) A person recommitted under (c) of this section who has not been discharged by the private or public facility before the end of the 90-day period shall be discharged at the expiration of that period unless the office, before expiration of the period, obtains a court order on the grounds set out in AS 47.37.190(a) for recommitment for a further period not to exceed 90 days. If a person has been committed because the person is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

(e) Upon the filing of a petition for recommitment under (c) or (d) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the original petitioner under AS 47.37.190(a), if different from the petitioner for recommitment; (5) any other person the court considers

appropriate. AS 47.37.180(c) applies to hearings for recommitment under this section. At the hearing the court or the jury shall proceed as provided in (a) of this section.

(f) A private or public facility shall provide adequate and appropriate treatment for a person in its custody. A public facility may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

(g) A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which the person has been committed if either of the following conditions is met:

(1) when an alcoholic committed on the grounds of likelihood of infliction of physical harm on another is no longer considered an alcoholic or the likelihood of the person inflicting physical harm no longer exists; or

(2) when, in the case of an alcoholic committed on the grounds of the likelihood of infliction of physical harm on another, either

(A) further treatment will not be likely to bring about significant improvement in the person's condition, or

(B) treatment is no longer adequate or appropriate.

(h) The court shall inform the person whose commitment or recommitment is sought of the right to contest the application, be represented by counsel at every stage of the proceedings relating to commitment and recommitment, to have counsel appointed by the court or provided by the court, if the person is unable to obtain counsel, and to a jury trial, if requested, as specified in AS 47.37.190(c). If the court believes that the person needs the assistance of counsel, the court shall require counsel, by appointment if necessary, regardless of the person's objection. The person whose commitment or recommitment is sought shall be informed of the right to be examined by a licensed physician of the person's choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician for the examination.

(i) If a private treatment facility agrees with the request of a competent patient or the patient's parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer the patient to the private treatment facility.

(j) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75.010 — 12.75.230. (§ 1 ch 207 SLA 1972; am §§ 8 — 12 ch 150 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "private or public facility" or "a private or public facility" for "the office" or "office" in several places throughout the section, and substituted "A public facility" for "The office" at the beginning of the second sentence of subsection (f).

NOTES TO DECISIONS

Actionable duty imposed on municipality. — This section imposes upon a municipality an actionable duty to take persons incapacitated by alcohol in a public place into protective custody. Busby v. Municipality of Anchorage, 741 P.2d 230 (Alaska 1987).

Sec. 47.37.270. Definitions. In this chapter

(1) "alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that the person's health is substantially impaired or endangered, or the person's social or economic function is substantially disrupted;

(2) "approved private treatment facility" or "private facility" means a private agency meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(3) "approved public treatment facility" or "public facility" means a treatment agency operating under the direction and control of the office or providing treatment under AS 47.37.010 — 47.37.270 through a contract with the office under AS 47.37.130(g) or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(4) *[Repealed, § 23 ch 71 SLA 1988.]*

(5) "commissioner" means the commissioner of health and social services;

(6) "coordinator" means the coordinator of the office of alcoholism and drug abuse;

(7) "department" means the Department of Health and Social Services;

(8) "emergency service patrol" means a patrol established under AS 47.37.230;

(9) "hazardous volatile material or substance"

(A) means a material or substance that is readily vaporizable at room temperature and whose vapors or gases, when inhaled,

(i) pose an immediate threat to the life or health of the person; or

(ii) are likely to have adverse delayed effects on the health of the person;

(B) includes, but is not limited to,

(i) gasoline;

(ii) materials and substances containing petroleum distillates; and

(iii) common household materials and substances whose containers bear a notice warning that inhalation of vapors or gases may cause physical harm;

(10) "incapacitated by alcohol" means a person who is unconscious or whose judgment is otherwise so impaired that the person is incapable of realizing and making a rational decision with respect to a need for treatment, as evidenced objectively by extreme physical debilita-

tion, physical harm or threats of harm to others or chronic inability to hold regular employment;

(11) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(12) "inhalant abuse" means the misuse of a hazardous volatile material or substance by inhaling its vapors;

(13) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(14) "office" means the office of alcoholism and drug abuse within the Department of Health and Social Services;

(15) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling;

(16) "work therapy"

(A) means an activity that involves a patient in basic employment skills and assists the patient in reintegration into a community;

(B) does not include

(i) activities such as personal housekeeping chores or cooperative responsibilities expected of each patient in the program; or

(ii) work that produces goods or services for sale or distribution, the proceeds of which would be returned to the owners, operators, or businesses of the rehabilitation program. (§ 1 ch 207 SLA 1972; am § 4 ch 116 SLA 1978; am §§ 15 — 18 ch 150 SLA 1980; am § 3 ch 58 SLA 1983; am § 69 ch 37 SLA 1986; am E.O. No. 71, § 23 (1988); am § 5 ch 75 SLA 1989)

Revisor's notes. — Paragraphs (9) and (12) were enacted as (15) and (16), respectively. Renumbered in 1989, at which time the remaining paragraphs were renumbered accordingly.

Effect of amendments. — The 1986 amendment at the end of paragraph (6) added "and drug abuse."

The 1988 amendment, effective July 1, 1988, repealed former paragraph (4), which defined "board."

The 1989 amendment, effective July 1, 1989, added present paragraphs (9) and (12).

Chapter 40. Purchase of Services.

Article
1. Purchase of Services for Minors (§ 47.40.041)

Article 1. Purchase of Services for Minors.

Section
41. Grants

POSITION PAPER

SENATE BILL NO. 414

For an Act entitled: "An Act relating to commitment to treatment programs for pregnant women who are alcoholics."

SB 414 would amend the Uniform Alcoholism and Intoxication Treatment Act by permitting the involuntary commitment to a public or private treatment facility of pregnant alcoholics whose continued use of alcohol is likely to harm the fetus. Under this Bill, pregnant alcoholics could be committed, if necessary to prevent potential damage to the fetus, for the term of the pregnancy subject to requirements for periodic court hearings to determine the need for continued treatment.

Background: The recognition that excessive maternal alcohol use during pregnancy can damage the fetus has occurred only in the last twenty years or so and knowledge of the prevalence of such injury is still being developed. Fetal alcohol syndrome (FAS), the best known form of injury, has a worldwide incidence of about 1.9 cases per 1000 live births. The United States rate is about 1.3 per 1000 and, according to estimates made by the Alaska Native Health Service and the Alaska Native Health Board, the rate in Alaska Natives is approximately 4.3 per 1000 live births. Rates for the non-Native Alaska population are not known.

Fetal Alcohol syndrome, in its fully developed form, is characterized by: (1) prenatal onset and persistence of growth deficiency for length, weight, and head circumference; (2) facial abnormalities; (3) cardiac defects; (4) minor joint and limb abnormalities; and (5) delayed development and mental deficiency varying from borderline to severe. Because FAS is not curable and because of its lifelong effects on physical health and mental development and because of high levels of alcohol use in the population, FAS is of special concern in Alaska.

Analysis: THe intent of the Bill is to interrupt the deleterious effects on the fetus of alcohol use by pregnant women by providing treatment and, where necessary, prolonged and involuntary confinement. In common with many other types of drugs with the potential for causing fetal injury, it is not known with certainty when alcohol use exerts its greatest effect on the fetus. In many types of fetal injury caused by drug use, the greatest sensitivity on the part of the fetus appears to be in the first trimester and that may be the case at least for those malformations which are characteristic of FAS. However, growth retardation may be affected by alcohol use later in pregnancy. FAS may result from continued use throughout pregnancy or from high dose binge drinking. It should also be pointed out that heavy alcohol use by pregnant

women does not invariably result in FAS. The 1987 edition of the Nelson Textbook of Pediatrics estimates the likelihood of harmful effect from chronic severe maternal alcoholism at 30 to 50 percent.

In order to be effective in preventing fetal injury, heavy maternal alcohol use, including binge drinking, would have to be prevented from the early stages through the remainder of the pregnancy. Since women who abuse alcohol are probably less likely than other women to seek prenatal care during the first trimester, much of the damage resulting from alcohol use would probably already have been done by the time the pregnancy is diagnosed and before commitment procedures could be instituted. It also seems likely that the possibility of involuntary commitment would serve to discourage alcohol-using pregnant women from seeking and receiving prenatal care, thus compounding the problem even further.

Position: The Department of Health and Social Services is in agreement with the intent of this Bill, but believes that involuntary commitment would probably not provide timely intervention, will likely discourage women from seeking needed prenatal care and would therefore be relatively ineffective in achieving the desired result. Consequently, the Department cannot support SB 414. The Department has not explored the legal questions which are inherent in the use of involuntary commitment.

Recommended by: [signature] for
Katherine A. Kelly, Dr.P.H.
Director, Division of
Public Health

Date: ____________

Approved: [signature]
Myra M. Munson
Commissioner
Department of Health
and Social Services

Date: Feb 21, 1990

MEMORANDUM

State of Alaska

TO: Frank Baxter, Commissioner
Department of Administration

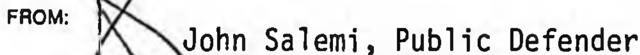
DATE: February 14, 1990

FILE NO:

TELEPHONE NO:

THRU: Sioux Plummer, Special Assistant
Office of the Commissioner

SUBJECT: SB 414



FROM: John Salemi, Public Defender

It appears the intent of SB 414 is to protect the unborn fetus in situations where the pregnant woman is abusing alcohol. While this is a laudable objective, I believe implementation of such legislation would raise serious constitutional questions regarding the rights of individuals. While facially a noncriminal piece of legislation, the effect is to criminalize the use of alcohol among pregnant women. There is a significant restriction of liberty based on the individual's status as an abuser of alcohol. "Status offenses" have previously been deemed unconstitutional by the United States Supreme Court. For example, one cannot be punished for the mere fact that he or she is a narcotics addict. Additionally, the hotly debated issue of rights of a fetus, when life begins, etc. will play itself out in the courts if this legislation is enacted. Once implemented, the Public Defender Agency will undoubtedly carry the burden of constitutional litigation/argument in these types of cases. Incidences of fetal alcohol syndrome are on the rise. These cases present themselves disproportionately in the lower socio economic strata. As such the vast majority of individuals who might be committed under this law would be entitled to Public Defender representation.

Based on the fact that a strong constitutional attack will have to be mounted involving both extensive evidentiary hearings at the trial court level and appellate court briefing and argument, there will be noticeable fiscal impact on the Public Defender Agency. Even assuming no constitutional infirmity, the procedural mechanism which permits this type of commitment will involve considerable time and expense on the part of the attorney charged with representing the woman who is the subject of the potential commitment. Over the period of the pregnancy, the statute allows the state to request three separate 90-day periods of commitment. There will be hearings on each of these three occasions to determine the appropriateness of continued commitment. Prior to the hearings the defense will undoubtedly request that an independent medical expert evaluate the client to determine the potential for alcohol abuse, efforts at rehabilitation, indicators of any damage to the fetus and so on. Medical evaluations of this nature along with expert testimony are very expensive. Hearings involving medical experts are often lengthy. Because the individual client is not being charged with a criminal offense, but is subject to the equivalent of incarceration, these matters will not be dealt

with perfunctorily. The litigation will be adversarial rather than conciliatory.

If this legislation is enacted, the Public Defender Agency will need additional personnel to advance the constitutional concerns at the trial court and appellate levels. Assuming the statute passes constitutional muster, it is unclear as to how many cases of this nature will be "prosecuted" by the state on a yearly basis. As previously mentioned, incidences of fetal alcohol syndrome are on the rise in Alaska. This very well could be a commonly used vehicle for commiting pregnant women who have alcohol problems. As the Department of Law has not yet submitted a fiscal note on this bill, the Public Defender Agency is unsure as to the precise fiscal impact. It appears that at least one attorney and support person would be required to handle the additional load created by such legislation. This is especially true in light of the fact that these cases would fall into the laps of attorneys who now do mental health commitment hearings. As the number of those cases have risen rather dramatically in recent years, this additional burden could not be absorbed without further resources within the agency.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 414 (b)
PUBLISH DATE: 2/27/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: Relating to commitment to treatment programs for pregnant women . . .
Sponsor: Binkley
Requestor:

Agency Affected: Health & Social Services
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: (Attach a separate page if necessary)

Fiscal impact for FY90 is "0".

Prepared by: Katherine Kelly, Director
Division: Division of Public Health
Phone: 465-3090
Date:

Approved by Commissioner: Myra M. Munson
Agency: Department of Health & Social Services
Date: 2/21/90

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

Although the Department has sunmitted a "O" fiscal note on this legislation, we believe that this fiscal note deserves additional explanation.

Few individuals are involuntarily committed to alcohol programs under the current commitment law. This occurs for two reasons. First, there are few available beds in treatment programs into which the individual can be committed. In the absence of a bed, the commitment does not take place. Secondly, the commitment law has been criticized by some as very difficult to use. These individuals claim that, regardless of the availability of space in treatment programs, few individuals are able to be committed.

The Department's "O" fiscal note assumes that if a pregnant woman is committed, she will either fill a bed that is already being paid for through State funds or bump an individual off an existing waiting list for the treatment slot. If no bed is available, we assume that the comittment will either not be sought or will not be granted. To the extent that the existing commitment law is changed or that sufficient additional treatment capacity becomes available, additional state funds to pay for this treatment may be necessary.

The Department wishes to emphasize that our "O" fiscal note does not imply that additional resources are not needed to provide appropriate programs for pregnant women who abuse alcohol. The peciliarities of the committment law, rather than our assessment of available resources, have dictated the submission of this fiscal note. The Department recognizes that additional resources are needed to develop appropriate alcohol treatment services for pregnant women and we have included an increment in the FY 91 budget to expand these services.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 414 (a)
Publish Date: 2/27/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to commitment to treatment programs for pregnant women...
Sponsor: Binkley, Zharoff, Coghill, Pourchot...
Requestor: HESS

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL						

REVENUE						

FUNDING: (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact.

Prepared by: Jan Strandberg, General Counsel
Division: Alaska Court System
Phone: 264-8228
Date: 02/21/90

Approved by: Arthur H. Snowden, II, Administrative Director
Agency: Alaska Court System
Date: 02/21/90

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Senator Johne Binkley

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

Finance Committee
Co-Chairman

March 28, 1990

Joan Hamilton
Box 1275
Bethel, Alaska 99559

Re: SB 414 - Relating to commitment to treatment programs for pregnant women who are alcoholics

Dear Joan:

I've received your public opinion message regarding Senate Bill 414. We need to talk.

I'm sure you would agree that fetal alcohol syndrome and fetal alcohol effects are enormous problems in our state. Over the past three years I introduced resolutions which resulted in Mother's Day Week being proclaimed as Fetal Aclohol Syndrome Awareness Week. We asked all Alaskans to become involved in public education and support of pregnant women in this important issue. By and large, except for those individuals and organizations who were already involved in prevention efforts, these resolutions seemed to fall on deaf ears.

This past fall I read Michael Dorris' book, The Broken Cord. I also listened with growing concern as Dr. Ann Streissguth, one of the pioneers in FAS research, talked about the FAS and FAE kids as adolescents and young adults in our society and the problems both they and society are facing because of their birth defects--*preventable* birth defects.

Every year in Alaska a *minimum* of between 87 and 319 children are born with alcohol-related birth defects, twenty-nine of these with the more severe defects labeled FAS. News of the danger of drinking during pregnancy is beginning to spread, but not fast enough to make a difference for these children--and probably for their brothers and sisters not yet born.

Alcohol-related birth defects affect children of all races and social structures. In fact, the record holder in Alaska is non-Native. This woman has given birth to seven FAS children, and is pregnant again. What are we going to

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do about her? None of her children live with her; they're all out in foster care, and she resists efforts to get her into treatment voluntarily.

Senate Bill 414 simply expands the alcohol commitment statutes to allow for a petition to the court for commitment of a pregnant alcoholic woman to the custody of a treatment center. The current alcohol commitment statutes allow for petition of an individual who is incapacitated or who has threatened or islikely to harm another. A pregnant woman doesn't have to meet the measure of being legally incapacitated to be causing permanent damage to her unborn child. And under Alaska law, the unborn child is not defined as "another" so the pregnant alcoholic can't be committed under that provision. That's why SB 414 would establish the new category, one for "pregnant women who are alcoholic and whose continued use is likely to harm the fetus."

Even so, this commitment procedure would be used only in those most grevious circumstances, when every effort at voluntary treatment had been exhausted. The petition is a court document. It must be accompanied by a certificate of a physician who has examined the individual within the previous two days. From a practical standpoint, the treatment agency has be involved, to verify they are willing and able to take the person into custody. And the individual has the right to request a jury trial. It would be a difficult process, as is the case with the current alcohol commitment statutes.

There are critics who say we need increased public information campaigns and more treatment instead. My FAS package includes measures that address increased public education and treatment opportunities. It includes initiatives to help those children who have already been afflicted with these birth defects. What more is needed? I think its time we start talking about the issue of society taking a stand in those cases where a woman's addiction is causing such catastrophic damage to innocent lives.

I've enclosed a copy of a graph my staff prepared, based on the State Division of Alcohol and Drug Abuse's estimates of the costs of inpatient treatment and research which conservatively averages the costs of newborn neonatal services and the lifetime costs of an FAS child. Dollars are hard, cold facts, and the imbalance of the graph in terms of costs is staggering. Even so, if we could measure the imposition of a few months of a woman's life against the years of lost productivity, health problems, and lower quality of life to the damaged child, I believe that chart would be frightening.

I have to tell you, Joan, the really positive thing SB 414 has done already is to get more people concerned and involved in this issue. This is an

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enormous, growing problem in Alaska, and we need to be more involved as caring people and communities in changing attitudes and findings answers.

I'm sending you a copy of Michael Dorris's book, Joan, and would like to ask as a favor to me, that you read it and get it started into circulation. I know what a tenacious worker you are when you're committed to a cause, and I would welcome your support.

Sincerely,

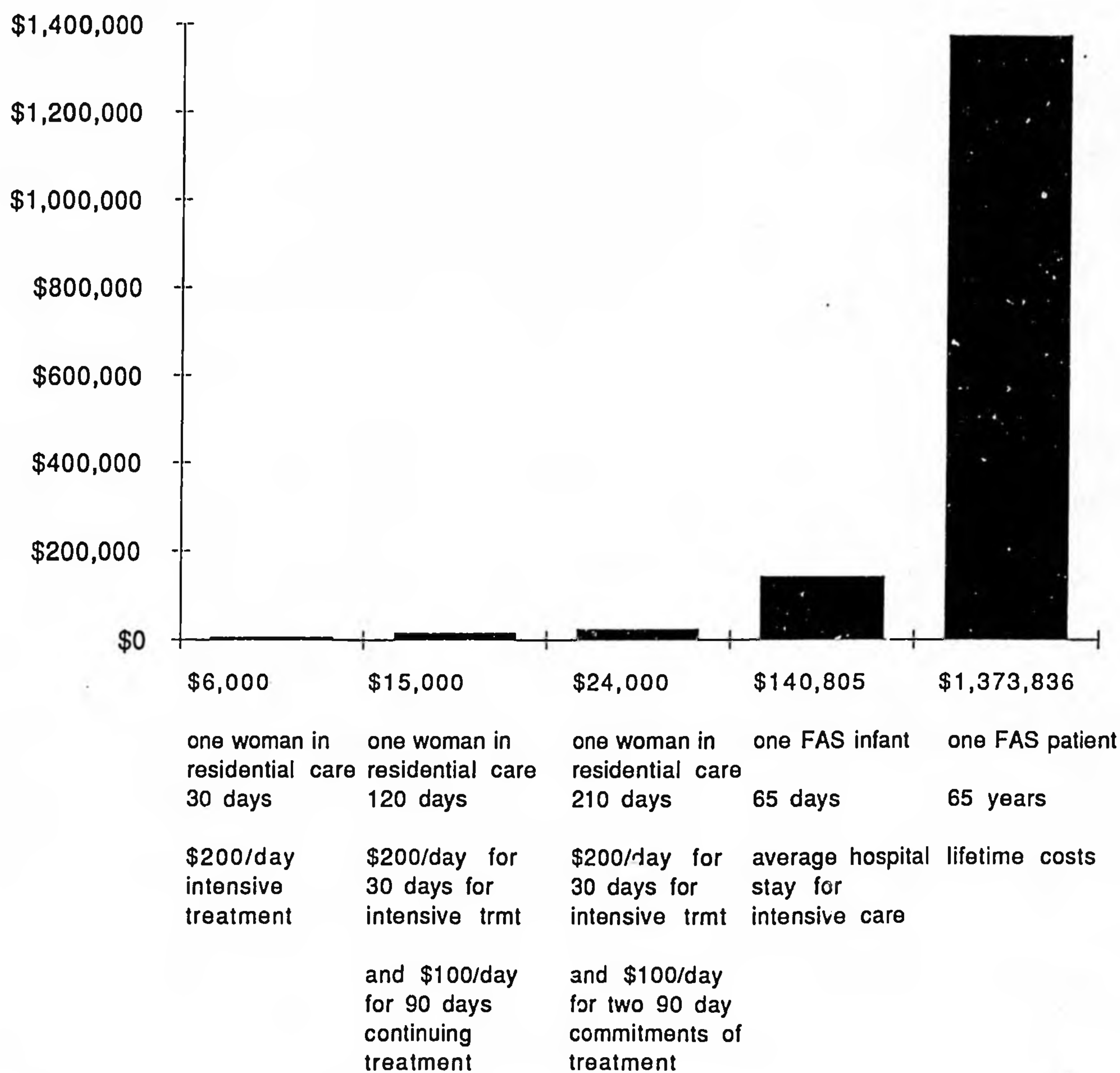
Senator Johne Binkley
Yukon-Kuskokwim and
Interior Rivers

paj

enclosures

cc: Senator Adams
Senator Duncan
Senator Faiks
Senator Halford
Senator Pearce
Senator Rodey
Senator Szymanski
Senator Zharoff
Representative Davis
Representative Foster
Representative Goll
Representative Grussendorf
Representative Hoffman
Representative Jacko
Representative Kubina
Representative MacLean

Costs of Treatment as Compared with Costs of FAS



Bill would reduce birth of FAS babies

OPINION

by Sen. Johne Binkley
for the Tundra Times

JUNEAU — We can take an important step to reduce the number of Fetal Alcohol Syndrome babies born in Alaska if my bill providing for involuntary commitment of pregnant alcoholic women passes the Legislature. But one thing we *won't* be doing is putting drinking moms in jail.

It's understandable that people unfamiliar with this legislation might think the police will be prowling the bars, looking for pregnant women to haul off to jail if this bill passes. That's not true.

And even if an alcoholic woman did find herself in court under this law, she wouldn't be sent to jail. The judge would be able to order her to check into a residential alcohol treatment program.

Here's exactly what the bill — Senate Bill 414 — would do as it is currently written:

If a pregnant woman is showing signs of serious alcoholism, the bill allows the court to be petitioned to determine whether she needs professional help to avoid harming the baby she is carrying. And, while there is plenty of evidence to show that even a couple of drinks a day during pregnancy can cause some damage to the baby's health, this bill is aimed only at the hard core alcoholic, not the casual drinker.

The only peopole who could make a complaint in court against the woman would be her spouse, guardian, relative, a doctor or the administrator of a treatment facility. Because the bill also requires a doctor to file a certificate supporting the court petition, we've tried to protect against a situation where an angry husband or relative files an unjustified complaint.

The doctor must have examined the woman sometime within the two days prior to the petition being submitted to the court, or must have at least given her the opportunity to reject a physical examination.

If, after reviewing the evidence and the physician's certificate, the court decides that only intervention can prevent damage to the baby, the judge can then order the woman committed to a private or public facility for treatment of alcoholism.

The commitment period would be 30 days, with provisions for extension until the baby is born if the court is convinced during a second hearing that there is a need for continuing treatment.

As the treatment goes on, the patient would be provided reasonable opportunities to see the doctor of her choice.

And even if an alcoholic woman did find herself in court under this law, she wouldn't be sent to jail. The judge would be able to order her to check into a residential alcohol treatment program.

And, at any point during the treatment period, if the woman either is determined to be no longer alcoholic or she is no longer pregnant, she would be released.

Most mothers obviously want to take good care of their babies from the moment they find out they're pregnant, and they don't need or deserve anybody from the state telling them how to do it. But alcohol and drug addiction can override that natural protective instinct, and helping those mothers addicted to alcohol protect their babies is the aim of this bill.

Some would say we have no right to intervene in a pregnant woman's life. I'd point out that we already have laws on the books making it illegal to provide alcohol or drugs to children from the moment they are born. Shouldn't we provide that same protection — if only in the most serious cases of alcohol abuse by the mother — in the months before the child is born?

Others might argue that by the time a woman is obviously pregnant and her alcohol abuse is documented well enough to go to court, the fetus has already been damaged. That some damage already would have occurred probably is true, but medical research has documented the fact that the brain is developing through the whole term of the pregnancy.

So even if the mother didn't stop drinking until the latter stages of her pregnancy, the child would still have a chance of having fewer defects than if the alcohol abuse were allowed to continue right up until birth.

Finally, some opponents of this bill would argue that it would discourage women from seeking medical care during pregnancy, out of fear that the doctor might file a complaint to get her committed to an alcohol program. But again, this bill is aimed only at the most serious abusers, and we've found that many pregnant women who are seriously alcoholics don't get proper medical care during their pregnancy anyway.

Fetal Alcohol Syndrome saddles a child with lifelong defects that are directly attributable to the mother's behavior. And since most these mothers have no financial resources, they create expensive financial problems we end up paying for. It costs an average of $1140,000 just to get a newborn FAS child through the period of intensive care it requires at birth and $1.4 *million* to care for it over a lifetime.

When I filed this bill, I thought a lot about a woman in Southcentral Alaska who has had seven FAS babies. All of those children are in foster families now, and the last we heard, this woman is pregnant again.

If we had had this law on the books, we might have been able to save not only her first FAS baby from some degree of damage, but the other six as well. Being committed to a treatment program might have brought an end to her alcohol abuse for good, and those other six babies could have been born healthy.

I don't claim to have written the perfect bill in this or any other case, but it will be debated and people surely will offer changes as it makes it way through the Legislature's committee process. An important part of that process is public input, and if you've got ideas on this subject, I encourage you to contact us.

Right now there are about 30 FAS babies being born every year in Alaska. This bill won't save them all, but it would at least give us the hope of saving some of them.

Marshall F. Goldberg, M.D.
Chinook Medical Building
1905 Cowles Street
Fairbanks, Alaska 99701
(907) 451-6500

MAR 14 1990

March 4, 1990

Senator John B. Coghill
P.O. Box V
Juneau, AK 99811

Dear Senator Coghill:

As a specialist in women's reproductive health care, I am writing to request that you consider withdrawing your sponsorship of Senate Bill #414, "an act relating to 'commitment to treatment programs for pregnant women who are alcoholics'." Although I do not know your particular reasons for proposing such legislation, I must tell you that I believe the bill is ill-conceived, would not achieve the desired effect, and would do irreparable harm to the pregnant women of Alaska. I base this opinion on the following considerations:

1. Reference is made in the Bill to an approved public or private treatment facility. To my knowledge, there are no approved private or public treatment facilities for pregnant alcoholics presently in the state, which would accept such individuals on an involuntary basis.

2. Since no one knows precisely the toxic threshhold of alcohol needed for developing fetal alcohol syndrome and at what specific stage of fetal development such effects are incurred, little if any benefit to the fetus can be realized unless one is prepared to commit an alcoholic woman for the entire duration of her pregnancy.

3. I am unaware of any data that have looked at the relative costs (social, psychological, or monetary) of incarcerating a pregnant woman for the duration of her pregnancy versus the benefit of preventing a single case of fetal alcohol syndrome.

4. The Bill, as it is currently written, could commit an alcoholic pregnant woman a minimum of 30 days. In that time period she would be "drug free" and would very likely be released at the end of that 30 day period. She would then return to her previous ethanol exposure and would most likely not be recommitted until another 30 days had passed. Hence you have the likely scenario of a woman being incarcerated on and off during the duration of her pregnancy, thereby creating a legal/judicial nightmare.

5. Also not addressed in the Bill is the eventual disposition of the infant, who was formerly a fetus under the State's protection, who is now ex-utero and has to be a ward of the state in order to continue to be in a protected environment. It makes little or no sense for this fetus, and now infant, to be protected for eight or nine months and then suddenly have it be placed back in a home environment where its mother is an alcoholic and unlikely to care for him or her in the best possible manner.

6. Also not addressed in the Bill are the various liabilities incurred by the persons seeking to commit a pregnant alcoholic to a treatment facility. Failure to commit or to release such a person prematurely may raise an individual's medical/legal liability, especially as it relates to an adverse outcome, i.e. an alcoholic affected infant.

7. If indeed such a bill were to pass both Houses, be approved by the Governor and withstand judicial review, what further restrictions on the "habits" of pregnant women, which indeed could impact on fetal well-being, would then be imposed? What about the women who smoke during pregnancy, take cocaine or other abusive substances, or fail to get adequate prenatal care? Would these women then in turn be subject to incarceration to "protect the fetus?"

8. Also not addressed is the potential impact on a pregnant woman's access to care. If she is an alcoholic and subject to commitment, is she likely to present in a timely and continued fashion for prenatal care and admit readily to her substance abuse? More than likely, she would bypass those agencies, institutions and individuals who are there to help her the most.

9. Finally, what about the obligations to report a pregnant woman who is an alcoholic. Are the individuals named in the Bill subject to civil penalties if they fail to report a pregnant woman who is an alcoholic and what about the violation of physician/patient confidentiality, which is so necessary to promote maternal and fetal well-being?

I have raised just some of the issues that need to be addressed seriously by you and the other co-sponsors of this Bill. Although I believe your intentions are noble, i.e. to prevent fetal alcohol syndrome, the approach is entirely misguided and ill-advised. Providing treatment facilities statewide for alcoholic pregnant women on a <u>voluntary</u> basis will achieve the same desired result because it will allow such women to come forward early in their pregnancies and be identified by the authorities and agencies that can provide the appropriate assistance.

Thank you for your prompt attention to this matter. I look forward to hearing your response in the very near future.

Sincerely yours,

Marshall F. Goldberg, M.D., MPH, FACOG

MFG/wjr

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION CSSJR 63(St Affairs)
PUBLISH DATE

FISCAL NOTE

REQUEST:

Revision Date:
Title: Proposing an amendment...
... duration of a regular session.
Sponsor: Senator Frank
Requestor: Senate State Affairs

Affected Agency: Legislative Affairs Agency
BRU: Legislative Council
Components: Session Expens Legal Services
Admin. Serv.,Public Serv.,Leg. Salaries&Allow

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING	FY91	FY92	FY93	FY94	FY95	FY96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>
TOTAL OPERATING	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>

CAPITAL	0	0	0	0	0	0

REVENUE	0	0	0	0	0	0

FUNDING: (THOUSANDS OF DOLLARS)

General Fund	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>
Federal Fund	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>	<1,000.0>

POSITIONS:

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY)

CSSJR 63 (State Affairs) reduces the length of the legislative session from 120 days to 100 days. The estimated daily cost of the session is $50,000 a day. If the session is reduced by 20 days a savings of $1,000,000 is calculated.

Prepared By: Pamela A. Stoops, Director — Phone: 465-3850
Division: Administrative Services — Date: 4/11/90

Approved By: Warren Endicott, Executive Director
Agency: Legislative Affairs Agency — Date: 4/11/90

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REQUESTOR
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AGENCY (IES)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION SJR 63
PUBLISH DATE

FISCAL NOTE

REQUEST:

Revision Date:
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... duration of a regular session.
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Components: Session Expenses, Legal Services
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Land & Structures						
Grants, Claims						
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TOTAL OPERATING	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (THOUSANDS OF DOLLARS)

	FY91	FY92	FY93	FY94	FY95	FY96
General Fund	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>
Federal Fund	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>	<1,500.0>

POSITIONS:

	FY91	FY92	FY93	FY94	FY95	FY96
Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY)

SJR 63 reduces the length of the legislative session from 120 days to 90 days. The estimated daily cost of the session is $50,000 a day. If the session is reduced by 30 days a savings of $1,500,000 is calculated.

Prepared By: Pamela A. Stoops, Director — Phone: 465-3850
Division: Administrative Services — Date: 4/11/90

Approved By: Warren Endicott, Executive Director
Agency: Legislative Affairs Agency — Date: 4/11/90

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