

HCR

22

Alaska State Legislature

Senate Advisory Council



P.O. Box V
State Capitol
Juneau, Alaska 99811
Phone: (907) 465-3114

MEMORANDUM

TO: Senator John 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.

Economic Impact

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

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.

Senator John Binkley
February 17, 1989
Page 3

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 a day. 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 Sixth Special Report to the U.S. Congress on Alcohol and Health, 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 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.

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.

Senator John Binkley
February 17, 1989
Page 11

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", Elsevier 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: $4.8\% \times 12,900 \text{ births} = 79.8\% \times 24.6 \text{ FAS births} + p \times 12,869 \text{ non-FAS births}$, 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.

	<u>1987</u>	<u>1988</u>
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 babies 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 admission, 1988: \$900/day (MLBW average length of stay, 12.5 days; VLBW stay, 16.2 days).

C. Costs associated with mental retardation.

Streissguth in a 1986 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.

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.

Senator John Binkley
February 17, 1989
Page 18

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 Educatn (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			
ANNUAL FAE BIRTHS AT TWICE FAS RATE (58)						
20 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. Audio Check-up. 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. Otitis Media Surgery. Estimate is from the Geneva Woods Ear Nose and Throat Associates. Source of 53% 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. Hearing Aid. 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. Hearing Aid Mold. A \$50 ear mold must be replaced annually. Estimate from Alaska Treatment Center.
9. Heart Surgery. 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. Cleft Palate. 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 can 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.

Senator John Binkley
February 17, 1989
Page 24

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)

Senator John Binkley
February 17, 1989
Page 25

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.

ALASKA STATE LEGISLATURE

Representative Georgianna Lincoln

HESS Committee, Co-Chair
Resources Committee, Vice-Chair

Budget Subcommittees
Health and Social Services
Revenue



P. O. Box V
Juneau, Alaska 99811

Phone: (907) 465-3732
FAX: (907) 465-2652

Memorandum

Alatna
Allakaket
Aniak
Anvik
Arctic Village
Beaver
Bettles
Birch Creek
Chalkyitsik
Chuathbaluk
Crooked Creek
Evansville
Fort Yukon
Galena
Grayling
Holy Cross
Hughes
Huslia
Kalskag
Kaltag
Koyukuk
Lake Minchumina
Lime Village
Lower Kalskag
Manley Hot Springs
Marshall
McGrath
Minto
Mountain Village
Nikolai
Nulato
Pilot Station
Pitkas Point
Rampart
Red Devil
Ruby
Russian Mission
Shageluk
Sleetmute
St. Mary's
Stevens Village
Stony River
Takotna
Tanana
Telida
Tuluksak
Tyonek
Venetie
Wiseman

TO: House Health, Education and Social Services Committee
FROM: Representative Georgianna Lincoln
DATE: April 12, 1991
RE: HCR 22 - Alcohol Related Birth Defects Awareness Week

Children born with Fetal Alcohol Syndrome suffer from a multitude of physical development, and mental problems. These problems may include permanent growth retardation, central nervous system damage, mental retardation, and abnormal facial features. FAS children may have heart defects, cleft palate, bone deformities, kidney and vision problems. They are never able to lead totally independent lives. The loss of a productive healthy life is impossible to measure, but in terms of medical and other societal costs these individuals conservatively cost society more than \$1.4 million over each lifetime.

Data suggests that 29 FAS children are born in Alaska each year. Fetal Alcohol Effects, a less severe form of Alcohol Related Birth Defects which may be caused by as little as one to three drinks per day, affects between two to fifteen that number each year. Some experts believe the number of FAE children in Alaska to be 10 times the number of FAS children. As more is becoming known about the lifelong impacts to children born with FAE, including learning disabilities and behavior problems that block the individual's "fit" into society, there is a growing suspicion that FAE children may ultimately be even more costly than FAS children in medical and social services.

Alcohol Related Birth Defects are irreversable, yet 100% preventable; a woman must simply abstain from drinking alcohol during her pregnancy.

HCR 22 asks the Governor to declare Mother's Day Week, May 12-18, as Alcohol Related Birth Defects Awareness Week. Having healthy babies was once thought to be the woman's responsibility. Today we know that this is a responsibility shared by partners, families, and friends---by each and every one of us.

Mother's Day Week is a timely choice to kick off a renewed awareness of the importance of healthy choices, by the woman who is pregnant and her support system.

Alaska Federation of Natives, Inc.

April 12, 1991

Representative Georgianna Lincoln
Alaska State Legislature
House of Representatives
Post Office Box V
Juneau, Alaska 99811

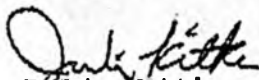
Dear Representative Lincoln:

Thank you for your concern and effort to raise the level of awareness regarding Fetal Alcohol Syndrome. It's true that FAS is preventable; however, the tragedy of FAS and Fetal Alcohol Effects can only be prevented through awareness and understanding of the dangers of alcohol abuse by pregnant women.

The Alaska Federation of Natives and the Alaska Native Blue Ribbon Commission both strongly support an awareness week.

June is traditionally the time wedding bells start ringing. May will be an appropriate month to heighten awareness of those who are looking to start their family.

Sincerely,



Julie Kitka
President
Alaska Federation of Natives



John Schaeffer
Chairman
The Alaska Native Blue Ribbon
Commission on Alcohol and Drug
Abuse

Southcentral Foundation

April 12, 1991

The Honorable Georgianna Lincoln
House of Representatives
Alaska State Legislature
Juneau, Alaska 99811

Dear Representative Lincoln:

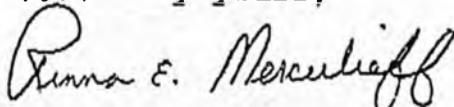
I would like to give my wholehearted support to House Concurrent Resolution No. 22, designating May 12 through 18, 1991, as Alcohol Related Birth Defects Week. It is most appropriate for Mother's Day to start a week of awareness of the dreadful damage that can result from the use of alcohol during pregnancy.

Professionally, I am involved with the problems of fetal alcohol syndrome, fetal alcohol effects, and alcohol related birth defects. As you know, Southcentral Foundation operates a screening program for pregnant women at the Alaska Native Medical Center to detect those who are at high risk for alcohol related birth defects and refer them into treatment. Until this year there has not been a residential program available for pregnant substance abusing women. However, with the help of both the Federal Department of Health and Human Services and the Alaska Department of Health and Social Services, Southcentral Foundation is about to open a new Prematernal Treatment Center for services to residents throughout the State. This is the first residential treatment center of its kind in Alaska, and we trust it will have a significant impact on the problem.

Personally, I have also been touched by alcohol related birth defects, as my extended family has not escaped "the scourge of the Alaska Natives." I know how heart-wrenching the birth defects can be, and I have watched as years of suffering and sorrow have unfolded, years that could so easily have been prevented, with only a few months of abstinence.

Please let me know what Southcentral Foundation can do to assist you in this worthy cause. And please know that once House Concurrent Resolution No. 22 passes, it will be honored and loudly proclaimed by the Board and staff of Southcentral Foundation.

Sincerely yours,



Rinna E. Mercurieff
Executive Director

STATE OF ALASKA

Executive Proclamation

by

Steve Cowper, Governor

Fetal Alcohol Syndrome (FAS) is a leading cause of birth defects in Alaska and is the most common cause of mental retardation.

FAS usually results in serious health problems for these children. Children with FAS often need extraordinary medical attention and lifelong special care. The cost of care for FAS children is enormous for families and government and the quality of life of FAS children is diminished.

The burdens FAS creates can be reduced if pregnant women and women who plan to become pregnant abstain from alcohol consumption. Additionally, research is now indicating the father's alcohol consumption may impact the health of his unborn children.

FAS is preventable through public education about the effects of alcohol on unborn children and through individual efforts on the part of pregnant women to abstain from alcohol consumption.

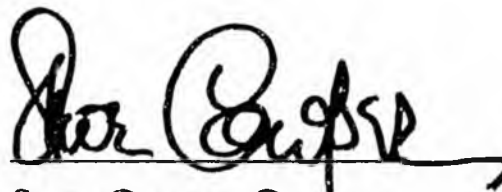
NOW THEREFORE, I, Steve Cowper, Governor of the State of Alaska, do hereby proclaim the week of May 13-19, 1990 as:

Alcohol-Related Birth Defects Awareness Week

in Alaska, and urge all residents to learn the effects of alcohol on unborn children and to give support to women who make the wise decision not to drink during pregnancy.

DATED: APRIL 4, 1990

DONE BY



Steve Cowper, Governor,
who has also authorized the seal
of the State of Alaska be
affixed to this proclamation.



FAS FACTS

- The rate of FAS in Alaska Natives of 4.2 per 1,000 live births is the highest rate for any population thus far studied.
- In Alaska, a non-Native woman with seven FAS children is the highest number reported in the state.
- In Alaska, the dollar cost to care for one FAS child for his/her lifetime can exceed one million dollars.
- FAS children suffer permanent growth retardation; permanent central nervous system damage, often with mental retardation; and altered morphogenesis (abnormalities), especially of the face.
- Other physical problems often seen with FAS:
 - heart defects
 - kidney defects
 - bone/joint deformities
 - abnormal liver functioning
 - immune deficiencies
 - cleft lip or cleft palate
 - failure to thrive
 - vision defects
- Costs to society:
 - lost productivity and potential
 - special care (long term) facilities
 - medical costs
 - special education needs
 - physical, intellectual, and behavioral impairments
- FAS has become the number one identifiable cause of mental retardation.
- FAS is a totally preventable birth defect.
- No amount of alcohol is safe to consume during pregnancy.
- Women who breastfeed should continue to abstain from drinking alcohol because alcohol readily enters breast milk and is transmitted to the nursing infant.

Ideas for Community Activities on the Prevention of Alcohol-Related Birth Defects

- Adopt a pregnant woman and be her support person throughout the pregnancy and postpartum period.
- Make a written contract with a pregnant patient not to drink during the pregnancy.
- Offer pregnant patient \$\$\$ off their total prenatal and delivery bill if they do not drink during the pregnancy.
- Offer pregnant patients a gift, such as an infant safety seat, if they do not drink during the pregnancy.
- Work with local taverns and restaurants to offer free non-alcoholic drinks to their pregnant customers.
- Work with local school board and teachers to incorporate a class on Alcohol-Related Birth Defects in junior and senior high schools.
- Work with schools to have special ARBD presentations made in the schools by the health aide, community health representative, public health nurse, or doctor.
- Arrange to have ARBD presentations made to the PTA.
- At local health fairs, have an ARBD display.
- Encourage Native Health Corporations, Indian Health Service and State Alcohol Programs to develop prevention and intervention programs for pregnant women.
- Launch an ARBD media campaign, including television, radio and newspapers, in your area.
- Contact local childbirth educators (LaMaze Childbirth Association) in hospitals and family planning clinics, and encourage and support their efforts by providing them with information on Alcohol-Related Birth Defects.
- Develop a one-hour ARBD presentation targeted to youth that can be presented to youth groups and clubs.
- Conduct ARBD presentations to women's groups in your community.
- Conduct ARBD presentations to men's groups in your community.
- Work with AA to have ARBD presentations made at regular AA meetings, and also at Al-Anon and Al-A-Teen meetings.
- Prepare educational display on ARBD for local clinic.
- Develop an ARBD prevention network in your own community by identifying persons who are interested in working to prevent Alcohol-Related Birth Defects.
- Work with local government to develop ordinances regarding drinking while pregnant; and on displaying warning signs at point of purchase.
- Set up a support group for pregnant women that would not only provide prenatal and parenting education, but social activities.
- Work with local stores to do promotional display on non-alcoholic beverages, focusing on pregnant women.
- Conduct ARBD presentations at prematernal homes.
- Encourage your local Medical Association to promote education on ARBD for medical professionals.
- Sponsor a poster contest in the schools on the topic of prevention of ARBD.

Anchorage Daily News

VOL. XLIV, NO. 47 90 PAGES

ANCHORAGE, ALASKA, THURSDAY, FEBRUARY 16, 1989

PRICE 25 CENTS

Study finds new danger in drinking

Pregnant women may harm children with small amounts

By DANIEL GOLEMAN
The New York Times

NEW YORK — Even moderate drinking by women in the first month or two of pregnancy, often before they realize they are pregnant, can impair the child's intellectual ability upon reaching school age, a new study indicates.

Researchers found significant effects for women who consume a daily average of one to three drinks each containing half an ounce of pure alcohol. That is equivalent to one to three daily cocktails, bottles of beer or glasses of wine.

The scientists interviewed 491 Seattle women in the fifth month of pregnancy and followed up with assessments of their children, men-

asuring intelligence, reaction time and attentiveness.

The study took into account factors such as parents' incomes and educations, which are known to affect a child's intelligence, and found that drinking had an effect apart from these influences.

The impairment was noticed even when the pregnant woman cut back her drinking in the first or second month of pregnancy.

The most recently published finding from the research involved 53 mothers who had on average of three drinks or more a day in the first month or so of pregnancy.

Their children were found

Please see Back Page, RISK

RISK IN DRINKING: Unborn may be harmed

Continued from Page A-1

at age 4 to score substantially lower on intelligence tests than the other children in the study. Specifically, the average score on IQ tests for these children was 105, 5 points below the average for all children in the study.

Separately, the researchers have reported that children born to mothers who had as little as one to two drinks a day in the first months of pregnancy were found by their early school years to have a slower reaction time and to have difficulty paying attention. These conclusions were also based on the 491 women and their children.

While previous studies have indicated that very heavy drinking by a pregnant woman can cause mental retardation in her children, the Seattle research is the first to show serious effects to the intellectual capacities of children at school age whose mothers drank at moderate levels while pregnant.

It is also the first to distinguish the effects of alcohol from that of other factors such as smoking or caffeine use.

"We recommend that women who are trying to become pregnant or might become so do not drink alcohol at all," said Dr. Ann Streissguth, a psychologist in the department of psychiatry and behavioral sciences at the University of Washington school of medicine, who directed the Seattle study.

"The effects on children occur even at the social drinking level. The women in our study did not see themselves as having alcohol problems."

Experts in the field see the two reports from the Seattle study as particularly significant.

"This is the first good study of the relationship between normal drinking levels in pregnant women and intellectual effects in their children," said Dr. Claire D. Coles, a psychologist at the Human Behavior Genetic Research Laboratory at the Emory University medical school in Atlanta.

Coles is conducting similar research but is not involved in the Seattle study.

The Seattle researchers asked the 491 pregnant women in their study about drinking, smoking, the use of marijuana, as well as the use of aspirin, caffeine and

other substances. Their children have been assessed regularly since the initial interviews.

The latest findings, which detected the differences on intelligence tests, were reported in the February issue of *Developmental Psychology*.

The findings on attention levels were published in 1987 in the journal *Neurobehavioral Toxicology and Teratology*. (Teratology is the study of substances that can harm the development of a fetus.)

Not all children whose mothers drank had problems. The study found that while there is a strong relationship on average between a mother's drinking while pregnant and harmful effects on a child's intellectual development, there is no certainty that a given child will show the effects.

"The effects vary greatly in individual cases," Streissguth said. "There are many children who were exposed to alcohol who were not affected at all."

But of all the substances thought to have ill effects on children, the studies indicated that alcohol had a more severe impact than tobacco, caffeine, aspirin or marijuana.

"The worst effects by far were from alcohol," said Helen Barr, a statistician in the Department of Psychiatry and Behavioral Science at the medical school of the University of Washington, and one of the study's co-authors.

The findings call into question earlier studies that seemed to show impaired cognitive development in children born to mothers who smoked.

The researchers said those studies failed to take into account the effects of the mother's drinking, which they said was a serious mistake, since mothers who smoke also tended to drink.

The report noted that some of the heaviest drinkers in the study, and thus the mothers of the children most at risk, were the most highly educated professionals.

"Many career women seem to assume the drinking habits of professional men — a few glasses of wine at dinner, some drinks over lunch or at a cocktail party," Streissguth said.

The least educated women in the study were among the heaviest drinkers, the researchers said.

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HCR 22

Revision Date: _____ Department Affected: Legislature

Title: Alcohol-Related Birth Defects Awareness Week BRU: _____
Component: _____

Sponsor: Lincoln

Requestor: _____ COMPONENT SERIAL NO.

--	--	--	--

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-					

CAPITAL	-0-					
---------	-----	--	--	--	--	--

REVENUE	-0-					
---------	-----	--	--	--	--	--

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

Prepared By: [Signature] Phone: 465-3732
Division: House Health, Education & Social Serv. Committee Date: April 12, 1991

Approved by Commissioner: _____ Date: April 12, 1991
Agency: _____

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

HOUSE COMMITTEE REPORT

4/17/91
Rubs

(7)
Date Referred: April 2, 1991

FURTHER REFERRALS:

Date of Committee Action: _____

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HCR 22

HOUSE CONCURRENT RESOLUTION NO. 22

ALCOHOL-RELATED BIRTH DEFECTS AWARENESS

Relating to Alcohol-Related Birth Defects Awareness Week.

RECOMMENDATIONS:

be replaced with _____

CS HCR 22(HES)

the same title
 a new title

have attached amendments(s)

do pass

do not pass

no recommendations

individual recommendations

additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dep)

APPROVES PREVIOUS: (Dept/Date)

fiscal impact _____

fiscal note(s) _____

zero fiscal note H. HES CMTE (Legislative)] zero fiscal note(s) _____

SIGNING <u>DO PASS</u>	DP	<u>OTHER RECOMMENDATIONS</u>	DNP	NR	AM
<i>Mark Hanley</i> Hanley	X				
<i>J.C. Gonzales</i> Gonzales	X				
<i>Carney</i> CARNEY	X				
<i>C. Davis</i> C. DAVIS	X				
<i>Lincoln</i> LINCOLN	X				

Carney
CHAIRMAN'S SIGNATURE



Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

DATE: April 15, 1991

PLACE: Capitol Room 106

SUBJECT OF MEETING:

*HCR22 ALCOHOL-RELATED BIRTH DEFECTS
AWARENESS WEEK

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Sharon Zandman-Zemel	DASS	3601 C St. Anch. Ste. 358	99507	561-3222	561-4213	<input checked="" type="radio"/>	<input type="radio"/>	HCR 22
Suzanne Perry	ADIT	Box H Junction	99861		586-6201	<input type="radio"/>	<input checked="" type="radio"/>	
Paul Pearson						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	

MEN,

ALCOHOL and

BABIES

*Having a healthy baby was once
thought to be the woman's
responsibility...*

It's true that what a mother-to-be eats and drinks affects her baby. That's why pregnant women are advised not to drink alcohol - because it can cause a birth defect called **FETAL ALCOHOL SYNDROME (FAS)**. With **FAS** the baby is growth and mentally retarded, and has facial deformities as well as other physical problems.

BUT THE FATHER'S DRINKING ALSO AFFECTS HIS CHILDREN:

- It affects his ability to father children.
- It increases the chance of other birth defects in his children.
- It lowers his babies' birthweight.

The father's support of the mother during the pregnancy is the most important action a man can do to have a healthy baby. The father can:

• Make an agreement that neither you nor the mother-to-be will drink alcohol, smoke cigarettes or marijuana, or use any drugs during the pregnancy. This agreement makes it easier for a woman to maintain a healthy life style.

- Encourage regular prenatal care, and go with her to the checkups.

- See to it she eats a balanced diet, and takes prenatal vitamins and iron if prescribed.

- Remind her not to take any medicine during the pregnancy unless told to by her doctor.

REMEMBER, IT'S YOUR BABY TOO!

Office for Substance Abuse Prevention

Taking care of your baby before birth



A message for pregnant women

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration



If you need help during your pregnancy or with drinking . . .

Talk with a nurse, midwife, or doctor. You can also find help by calling your local:

- Health department
- Health clinic
- Alcoholics Anonymous groups

- Alcohol and drug abuse hotline
- Social services

To learn more, contact the
National Clearinghouse for
Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852



To help your baby be strong and healthy . . .

Don't drink alcohol . . . that means no beer, wine, or liquor. When you drink so does your baby. Alcohol can harm your baby for the rest of its life. Alcohol might cause your child to:

- Do poorly in school
- Be clumsy
- Be small for his or her age
- Look different than other children
- Have many health problems.

You can help your baby if . . .

You stop drinking *now*. Even if you have had beer, wine, or liquor, you can help your baby by not drinking during the rest of your pregnancy.

While you are pregnant . . .

- Don't drink any alcohol and
- Don't take any drugs or medications without asking your nurse, doctor, or midwife
- Don't smoke cigarettes.



You can do lots of things for yourself and your baby while you are pregnant . . .

Sometimes feeling worried, tired, or lonely is part of being pregnant. Doing these things might help you feel better.

- Talk with friends and family

- Check the library to learn more about babies
- Go for regular walks in your neighborhood
- Eat right — include plenty of milk, fish, meat, fresh fruits, vegetables, whole grain breads, and cereals
- Visit your health clinic regularly.