

ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

5660 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 225
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Commerce & Economic Dev.
Title: Payment of Disability Insurance BRU: Insurance
Claims
Sponsor: Gruenberg and Menard Components: _____
Requester: House HESS

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
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
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of dollars)

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

POSITIONS:

FULLTIME	0	0	0	0	0	0
PARTTIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Paul Roller, Director
Division: Insurance

Phone: 465-2515
Date: 4-10-89

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development

Phone: 465-2500
Date: 4/10/89

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requester
- Office of Management and Budget
- Impacted Agency(ies)

page _____ of _____

Sec. 21.51.110. Time of payment of claims. There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment, will be paid immediately upon receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof." (§ 1 ch 120 SLA 1966)

Sec. 21.51.120. Payment of claims. (a) There shall be a provision as follows:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment which shall be prescribed herein and effective at the time of payment. If no designation or provision is then effective, the indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities will be payable to the insured."

(b) The following provisions, or either of them, may be included with the provision in (a) of this section at the option of the insurer:

(1) "If an indemnity of this policy is payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding \$ (insert an amount which shall not exceed \$1,000), to a relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be equitably entitled thereto. Payment made by the insurer in good faith under this provision shall fully discharge the insurer to the extent of the payment."

(2) "Subject to written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person rendering the services; and it is not required that the service be rendered by a particular hospital or person." (§ 1 ch 120 SLA 1966)

Sec. 21.51.130. Physical examination, autopsy. There shall be a provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law." (§ 1 ch 120 SLA 1966)

sidered representations and not warranties, and that a statement made for the purpose of effecting insurance may not void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the insured person or the beneficiary of the insured person,

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy. (§ 1 ch 120 SLA 1966)

Collateral references. - Group medical and hospital service plan as constituting insurance. 167 ALR 323.

Sec. 21.54.020. Direct payment of hospital, medical services. A group disability policy may on request by the group policyholder provide that all or a portion of any indemnities provided by the policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. (§ 1 ch 120 SLA 1966)

Sec. 21.54.030. Required provisions of blanket policies. An insurer authorized to write disability insurance in this state shall have the power to issue blanket disability insurance. A blanket policy may not be issued or delivered in this state unless a copy of the form of the policy has been filed in accordance with AS 21.42.120. Every blanket policy shall contain provisions which in the opinion of the director are at least as favorable to the policyholder and the individual insured as the following:

(1) a provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud be considered a representation and not a warranty, and that no statements shall be used in defense to a claim under the policy, unless contained in a written application; the person, a beneficiary, or assignee, shall have the right to make written request to the

HB 225: An Act relating to payment of disability

This Act pertains to the payment of both group and individual disability insurance claims. It provides for a requirement that, when benefits are assigned to a medical care provider, the benefits must be paid within 30 days after receipt of a final and complete billing, and, if the insurer mistakenly pays the insured, then the insurer must also pay the medical care provider.

Section 1 - AS 21.52.120 - Individual Disability Contracts

Essentially, the repeal and reenactment of AS 21.51.120 does not change the existing law's intent. This section pertains to required contract provisions pertaining to payment of claims in individual disability insurance contracts. Two elements have been added in the situation when benefits have been assigned to a medical care provider:

1. payment must be made within 30 days after receipt of final and complete billing; and
2. if the insurer mistakenly pays benefits to the insured, it must also make payment to the medical care provider. It is assumed that the insurer is penalized for this mistake by the required double payment. Assumedly, both payments would tend to increase future rates.

It should be noted that this section does not create an irrevocable assignment and the insured could change his or her mind and request in writing that the insurer now pay direct to him or her (under AS 21.42.270 and AS 21.51.150). Furthermore, it should be noted that individual subscriber contracts issued by a hospital or medical service corporation that provide indemnity benefits would not be covered by this proposed change in the law.

Section 2 - AS 21.54.020 - Group Disability Contracts

Direct payment of benefits to medical care providers by insurers may provide for:

1. medical care providers not requiring patients to pay for treatment before treatment is given so as not to create a barrier to receiving appropriate medical care; and
2. assurance that at least some portions of the charges for medical care will be paid to the medical care provider.

Most group disability insurance contracts will allow the choice of direct payment to medical care providers to be made by the individual persons covered under the group contract. This election is required to be made in writing and may only be changed by a subsequent written request received before claim payment is made. However, many insurers do retain the contractual option of whether paying direct to the person covered or to a medical care provider. If the covered person has made the written election for direct payment to a provider, the insurer will pay to the provider. If the covered person does not make the written election for direct payment, the insurer must pay any benefits to the covered person.

However, if no direct payment election is made and the amount of the claim is substantial, many insurers will require the covered person to provide proof that the medical care provider has been paid. (An insurer will do this because, if a covered person is paid but the provider ultimately is not paid, those reimbursed charges will be factored into and result in higher charges being made for future medical service.

The new language removes the insurer's discretion in regard to making direct payment to a provider. If the insurer allows for the election of direct payment, then the direct payment must be made unless the election is revoked in writing. It's assumed that the term "insured" means the covered person and not the group policyholder (e.g. the employer, association, union, or trust). If it does include the group policyholder, the policyholder may also make the election of whether or not direct payment must be made. If that is the case, it would seem if the group policyholder made the decision that all payments would be made direct, the covered person would not have the option. Additionally, in such a circumstance, if a provider required full payment before rendering service, the provider would receive double payment and would have to reimburse the covered person the amount in excess of the total charges.

Included in the new language is reference to blanket disability policies. This reference provides conflict with AS 21.54.050 which pertains to payment of benefits under disability policies. This reference either needs to be removed or AS 21.54.050 needs to be amended.

The same 30-day criteria for payment of claims and the double payment features are evident in this amended provision as are in the section pertaining to individual disability contracts.

It should also be noted that group subscriber contracts issued by a hospital or medical service association that provide indemnity benefits would not be affected by this Act. Additionally, it should be noted that this Act would not have any effect on self-insureds nor on group contracts issued in another state even though coverage is provided to Alaska residents.

The department's position is neutral.

Amendments Proposed

1. If it is the sponsor's intent to include both individual and group subscriber contracts issued by a hospital or medical service corporation that provide indemnity benefits, then AS 21.87 would need to be amended. This could be accomplished by adding references to AS 21.51.120 and AS 21.54.020 to the list of other applicable provisions found in AS 21.87.340.
2. AS 21.54.050 needs to be amended so it does not conflict with the proposed language in AS 21.87.340.

3. AS 21.54.020 should be amended to clarify that the option of the election of direct payment is up to each covered person as opposed to the group policyholder if that is the intent. This is required because technically the "insured" is the group policyholder.
4. In both AS 21.51.120 and AS 21.54.020, the proposed language would trigger the 30-day claim payment upon the insurer receiving a "complete and final billing." Technically this is but one element of the required "proof of loss." For example, other elements include whether or not the person was an eligible group member at the time the loss was incurred either through being employed full time or having premiums paid up-to-date. Therefore, it is recommended that the term "complete and final billing" be replaced with the term "proof of loss."



Larry Mercurieff, Commissioner

Date: 4/12/89

LM/JB/3829D
041289a



Official Business

Alaska State Legislature

Pouch V
State Capitol
Juneau, Alaska 99811

April 4, 1989

MEMORANDUM

TO: Representative Johnny Ellis
Chair, House HESS Committee

FROM: Representative Max Gruenberg *M*

RE: House Bill 225

HB 225 provides that an insured under a disability insurance policy can require the insurer to pay a provider of health services directly. Under current law, direct payments are at the insurer's option. The bill adds that if an insured asks for direct payments and the insurer instead pays the insured, the insurer remains liable to the provider.

These minor changes in the current law will make insurance payments responsive to the needs of consumers.

I would appreciate your scheduling HB 225 as soon as possible.
Thank you.

6-1033E
Ford
4/17/89

Original sponsors: Gruenberg and Menard

1 IN THE HOUSE

2 CS FOR HOUSE BILL NO. 225 ()

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to payment of disability insurance
7 claims."

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

9 * Section 1. AS 21.51.120 is repealed and reenacted to read:

10 Sec. 21.51.120. PAYMENT OF CLAIMS. (a) A disability policy
11 delivered or issued for delivery must contain the following provi-
12 sions:

13 (1) indemnity for loss of life shall be paid according to
14 the beneficiary designation and payment provisions contained in the
15 policy that are effective at the time of payment; if a beneficiary has
16 not been designated, indemnity shall be paid to the estate of the
17 insured; accrued indemnities unpaid at the insured's death shall be
18 paid to either the beneficiary or the estate, at the option of the
19 insurer; all other indemnities shall be paid to the insured;

20 (2) the insurer may, and upon request of the insured shall,
21 within 30 days after receiving a proof of loss statement, pay indemni-
22 ties for hospital, nursing, medical, dental, or surgical services
23 directly to the provider of the services; an insurer who pays indemni-
24 ties to an insured, after the insured has given the insurer written
25 notice in the proof of loss statement of an election of direct payment
26 of indemnities to the provider of the services, shall also pay indem-
27 nities to the provider of the services; this paragraph does not
28 require that services be provided by a particular hospital or person.

29 (b) A disability policy delivered or issued for delivery may, at

1 the option of the insurer, require that an indemnity in an amount not
2 to exceed \$1,000 that is payable to the estate of the insured, an
3 insured or beneficiary who is a minor, or an insured who is not compe-
4 tent to give a valid release, be paid to a relative by blood or mar-
5 riage, or a beneficiary that the insured determines is equitably
6 entitled to the payment. A good faith payment by the insurer under
7 this subsection fully discharges the insurer to the extent of the
8 payment.

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

10 Sec. 21.54.020. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES.
11 An insurer may, and upon request of the covered person shall, within
12 30 days after receiving a proof of loss statement, pay indemnities
13 under a group disability policy directly to the provider of the hospi-
14 tal, nursing, medical, dental, or surgical services. The policy may
15 not contain a provision requiring that services be provided by a
16 particular hospital or person. If the insurer pays indemnities to the
17 covered person after the covered person has given the insurer written
18 notice in the proof of loss statement of an election of direct payment
19 of indemnities to the provider of the service, the insurer shall also
20 pay those indemnities to the provider of the service.

21 * Sec. 3. AS 21.54.050 is repealed and reenacted to read:

22 Sec. 21.54.050. PAYMENT OF BLANKET DISABILITY POLICY BENEFITS.
23 All benefits under a blanket disability policy shall be paid to (1)
24 the person insured; (2) the designated beneficiary or beneficiaries of
25 the person insured; (3) the estate of the person insured; (4) the
26 parent, guardian, or other person actually supporting the person
27 insured, if the person insured is a minor or otherwise not competent
28 to give a valid release; or (5) the employer, if the entire cost of
29 the insurance has been paid by the employer. An insurer may, and upon

1 request of the covered person shall, within 30 days after receiving a
2 proof of loss statement, pay benefits directly to the provider of the
3 hospital, nursing, medical, dental, or surgical services. The policy
4 may not contain a provision requiring that services be provided by a
5 particular hospital or person. If the insurer pays indemnities to the
6 insured after the covered person has given the insurer written notice
7 in the proof of loss statement of an election of direct payment of
8 indemnities to the provider of the service, the insurer shall also pay
9 those indemnities to the provider of the service.

10 * Sec. 4. AS 21.87.340 is amended to read:

11 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to
12 the provisions contained or referred to previously in this chapter,
13 the following chapters and provisions of this title also apply with
14 respect to service corporations to the extent applicable and not in
15 conflict with the express provisions of this chapter and the reason-
16 able implications of the express provisions, and for the purposes of
17 the application the corporations shall be considered to be mutual
18 "insurers":

- 19 (1) AS 21.03
20 (2) AS 21.06
21 (3) AS 21.09, except AS 09.090
22 (4) AS 21.18.010
23 (5) AS 21.18.030
24 (6) AS 21.18.040
25 (7) AS 21.18.120
26 (8) AS 21.21.321
27 (9) AS 21.36
28 (10) AS 21.69.400
29 (11) AS 21.69.520

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(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) AS 21.42.345 - 21.42.365

(16) AS 21.89.040

(17) AS 21.89.060;

(18) AS 21.51.120.

* Sec. 5. This Act applies to policies of disability insurance entered into or renewed after the effective date of this Act.

HB

230

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: Warning signs on liquor premises
Sponsor: Maclean; et al
Requestor: Senate HESS Committee

Agency Affected: Department of Revenue
BRU: Alcoholic Beverage Control Board
Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
OPERATING						
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	4.3	1.6	1.6	1.6	1.6	1.6
SUPPLIES	.3	.2	.2	.2	.2	.2
EQUIPMENT	0	0	0	0	0	0
LANDS & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	4.6	1.8	1.8	1.8	1.8	1.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	4.6	1.8	1.8	1.8	1.8	1.8
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	4.6	1.8	1.8	1.8	1.8	1.8

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 for analysis.

Prepared By: Patrick L. Sharrock, Director
Division: Alcoholic Beverage Control Board

Phone: 277-8638

Date: April 6, 1989

Approved by Commissioner: Hugh Malone
Agency: Department of Revenue

Date: 4/6/89

Distribution (by preparer):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

HB 230
Analysis

Initial Issue

beverage dispensary	689	
restaurant or eating place	319	
club license	87	
brewery	2	
package store	471	
common carrier	158	
recreational site	19	
pub license	1	
winery	0	
caterer's permit	663	
special events permit	110	
community license	3	
club caterer's permit	50	est.
theatre site license	2	est.
restaurant caterer's permit	<u>14</u>	
	2,588	
assume 2 signs per premises (avg.)	<u>x 2</u>	
	5,176	

Annual Issue

caterer's permits	675
special events permits	120
club caterer's permit	50
restaurant caterer's permit	25
wear and tear	<u>500</u>
approximately 50%	1,370

	<u>Initial</u>	<u>Annual</u>
Approx. \$300 per thousand (per PIF)		
Initial: \$300 x 5,176	1,553	
Annual: \$300 x 1,370		411
Postage		
Initial: 1.05 for 2 signs x 2,588	2,717	
Annual: .85 for 1 sign x 1,370		1,164
Envelopes		
Initial: 2,588 x .12	311	
Annual: 1,370 x .12		164
Letters		
	<u>26</u>	<u> </u>
	4,607	1,739



NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

ANCHORAGE REGIONAL OFFICE

1411 W 33RD AVENUE
ANCHORAGE, ALASKA 99501
(907) 274-0536

JUNEAU OFFICE

105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 546-3090

FAIRBANKS REGIONAL OFFICE

2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 456-4435

April 7, 1989

TO: Johnny Ellis, Chairman, and Members of the House HESS Committee

FROM: Kathi McCord, Teacher, Anchorage - Abbott Loop Elementary

RE: HB 230: "An Act requiring the holder of a license or permit related to selling or serving alcohol to post signs warning patrons that consumption of alcohol during pregnancy can cause birth defects."

I teach a third and fourth grade combination class at Abbott Loop Elementary School in Anchorage in the Open Optional Program, an alternate education program which is part of Abbott Loop School. To be in this program parents sign up on the waiting list, tour the seven classes, commit to working in the classroom on a monthly basis, and for the most part are committed to education of their children.

This is my 17th year of teaching and it's a job I love doing.

Over the last few years my colleagues and I have become concerned about the children coming into our classes. It appears that more and more children are needing increasing levels of special education, speech, occupational and physical therapy, resource help, self-contained special education and help for what we used to call "hyperactivity" (which we now call Attention Deficient Disorder or ADD).

There are many potential causes for this development; the breakdown of a stable family life, neglect, something we as educators are or aren't doing, increased number of working mothers, lack of proper medical care, better detection capabilities, but none of the teachers have solid answers for this phenomenon, only more questions.

Recently we have begun to hear more about Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE), as well as the effects on unborn children of a number of other drugs. I have never had a FAS child in my own class but currently I have two children who exhibit some of the characteristics of FAE - a fetal alcohol disorder of a lesser degree than Fetal Alcohol Syndrome. Both of these children have problems with their teeth, with one child anticipated to need extensive surgery to his jaw in the future.

Both of these children are currently receiving speech therapy. Both are hyperactive, with one of them receiving the drug Ritalin as treatment of ADD, while the other receives Lithium for depression. I teach 8, 9 and 10 year old children and both of these FAE children need emotional counseling, but only six elementary schools in Anchorage have elementary counselors. These children are already at least a year behind academically.

A special education teacher who was scheduled to testify last Friday spent some time with me yesterday and told me about a FAS child in her class. This teacher has had a year of nursing school, holds a dual masters degree in Education and Special Education with an endorsement in teaching of emotionally disturbed children. She teaches a first - third grade PRE-AC (Pre-academic) class at Williwaw Elementary in Anchorage. The nine children in her class are between the ages of 6 and 9 years old.

The diagnosed FAS child is a boy six years, two months old. His mother was 14 years old when he was born and she had already borne two others. She died from the effects of acute alcoholism by the time she was 19, and according to the records she drank herself into a stupor every day of her pregnancy.

This little boy who has been diagnosed as FAS, currently needs Special Education Services, speech therapy, occupational and physical therapy. He needs a special chair in which to sit as his body is too weak to support itself. He is learning slowly; his teacher says more slowly than most Special Ed students. While the teacher is at his side, this child can now make the letter "l" and a recognizable "r". He can speak and can carry on somewhat of a conversation, although he has a severe language dysfunction and his sentences are quite jumbled.

It is too soon to tell what other kinds of disabilities this FAS child may have. Pediatrician Jim Nesbitt of Anchorage told his teacher that they are now seeing so many of these children that they had an expert come up to talk to the Anchorage Academy of Pediatricians.

As an educator I am concerned with the increasing number of children we are seeing with these problems. I wonder what their future will be. I wonder what educational services they will require. I wonder what the costs will be to society, not only in health care costs, but the increasing costs to educate these children, the costs of providing foster care or institutionalizing these children, and the long-term costs from loss of their productivity.

We must educate women about the need to refrain from drinking while pregnant. Women are now heavily targeted for marketing alcoholic beverages. Although heavy drinking is the major problem, social drinkers have an 11 percent chance of bearing a FAS baby.

HB 230 is a small step in the right direction; this bill would require places selling or serving alcohol to post warning signs. Perhaps the constant reminder to pregnant women will help them to think about it and ultimately eliminate this totally preventable birth defect.

Thank you.

LE02/111230/d1

Alaska State Legislature

Senate Advisory Council



PO 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.

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 10 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 Birth (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: $4.8\% \times 12,900 \text{ births} = 79.8\% \times 24.6 \text{ FAS births} + p \times 12,859 \text{ non-FAS births}$, 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 1

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			
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. 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 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. 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 6. 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 169 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 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 Eileen Panigeo MacLean
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Selawic
Shungnak
Wainwright

TO: Representative Johnny Ellis, Chairman
Health, Education & Social Services Comm.

FROM: Representative Eileen P. MacLean *Eileen P. MacLean*

DATE: April 7, 1989

SUBJ: HB 230 Relating Alcohol Warning Signs

This legislation was introduced as a companion bill to Senator Binkley's SB 175, currently in the Senate Rules Committee.

HB 230 would require the holder of a license or permit related to selling or serving alcohol to post signs warning patrons that consumption of alcohol during pregnancy can cause birth defects.

Section 1. Amends AS 04.21 regarding the posting of warning signs.

- a) requires the holder of certain licenses or permits to post a sign or signs.
- b) specifies size, wording, and placement of signs. ABC board shall determine compliance

WARNING: Drinking alcoholic beverages such as beer, wine coolers, and other distilled spirits during pregnancy can cause birth defects.

- c) requires ABC board to furnish signs
- d) provides for issuance of a citation by a peace officer
- e) provides for issuance of a citation by ABC Board employee
- f) sets fines for violation: \$20 to \$300

page 2

Section 2. addresses procedure for citation process

The Senate version of this bill has had a few changes in the committee process. A summary of the changes to the Senate Bill are listed below.

SB 175 Senate HESS CS amended the following:

- 1) added a new Section 1, page 1 line 11: provides and exemption to the law requiring a violation of posting signs a Class A misdemeanor.
- 2) page 1 line 19: required licensed and designated premises to post signs.
- 3) deleted language requiring the ABC Board to determine how many signs must be displayed and whether they are conspicuously posted.
- 4) page 2 line 22: allows and employee of the ABC Board who is designated by the board to enforce the law to issue citations.
- 5) page 2 line 8: deletes brew pubs and provides for an other license or permit issued by the board authorizing consumption of alcoholic beverages.

The Senate Finance CS of SB 175 amended the following:

- 1) page 2, line 29: Reference to "A person who violates this section" is changed to A holder of a license or permit who violates this section
- 2) page 3, line 29: A new section (m) provides that the board may not suspend or revoke a license for violation.
- 3) the Senate Finance Committee also added a letter of intent specifying that the Alaska Women's Commission would include a brochure on Fetal Alcohol Syndrome with their next mailing.

THE FACT IS . . .

Alcohol and Other Drugs Can Harm an Unborn Baby

Every pregnant woman wants a healthy, normal baby--and there are many things a woman can do to help ensure that she has one. In addition to regular prenatal check-ups and a nutritious diet, an expectant mother should also be extremely careful about the kinds and amounts of all drugs she takes--including alcohol, illicit drugs, and drugs available at the pharmacy or grocery store.

Alcohol

Drinking alcohol during pregnancy, especially in the early months, can be very dangerous to a developing baby. Alcohol passes freely from the mother's body to the baby's body and affects the developing systems of the unborn baby. The more a pregnant mother drinks, the greater the chances of harm to the unborn child.

Children whose mothers drink frequently or heavily during pregnancy may be born with fetal alcohol syndrome (FAS). Between one and three of every 1,000 babies born has FAS. FAS is one of the leading known causes of mental retardation in this country.

There are many more children who have been affected by alcohol in utero but who lack the full set of characteristics that define FAS. These babies may be at higher risk because they are too small at birth, or they may have some, but not all of the features of FAS. These problems, when attributable to alcohol, are called fetal alcohol effects.

Unfortunately, the lower limits of how much alcohol a woman can drink without any risk to her baby is still unknown. Some studies link an average of 1 to 2 drinks a day to decreased birth weight, and abnormal behavioral attributes.(1) The safest choice is not to drink any beer, wine, or hard liquor while pregnant. Since most women do not know they are pregnant until a month or more has passed, it is best to stop drinking before becoming pregnant. Women who have difficulty abstaining from alcohol use during pregnancy should consult their physician. It is never too late to seek help--whenever drinking is stopped during pregnancy, the risks of fetal alcohol effects and consequences of alcohol exposure are decreased.(2)

Illegal Drugs

Any drug that can cause addiction or alter basic body functions (including thinking or feeling) is dangerous. They may be particularly damaging to a pregnant woman and her baby.

Recent studies suggest that pregnant women who smoke marijuana are frequently at higher risk of still-birth, miscarriage, low birthweight babies, and fetal abnormalities, especially of the nervous system. Women who use marijuana during pregnancy also deliver infants 5 times more likely to have features like those with FAS. In addition, the active ingredient in marijuana, THC,

MS 353

National Clearinghouse for Alcohol and Drug Information

☐ P.O. Box 2345 ☐ Rockville, MD 20852

passes through the placenta to the baby--in other words, the baby of a mother who recently smoked marijuana may be born "high." All of these effects are greatest toward the end of pregnancy, but may occur at any time. Like other unnecessary drugs, marijuana should not be used during pregnancy.

Heavy cocaine use has been linked to higher rates of miscarriage and premature onset of labor. Infants born to women using cocaine often experience painful withdrawal from cocaine at birth. Such infants can actually suffer prenatal strokes before birth because of the fluctuations in blood pressure that cocaine can produce.(3) Children born to women who use cocaine during their pregnancy also experience a higher than normal rate of kidney and breathing disorders and an increased risk of sudden infant death syndrome (SIDS).(4) Such children also suffer from an increased incidence of visual and coordination problems and developmental retardation.(5) Cocaine use during pregnancy poses serious risks for the unborn child.

Infants of women addicted to heroin, methadone, or other narcotics are more likely to be stillborn or to have low birthweights. These women usually give birth to addicted babies who must go through withdrawal soon after birth.

Pregnant addicts often forget their own health care, adding to their unborn babies' risk. Pregnant women addicted to cocaine or narcotics should consult a physician or treatment center to establish a safe detox or methadone maintenance plan.(6)

Other Substances

Cigarettes. Women who smoke while pregnant have a higher percentage of stillborn babies, miscarriages, and premature deliveries than women who don't smoke. Mothers who smoke are also more likely to have low birthweight babies who are at greater risk of dying soon after birth. These effects are directly related to the number of cigarettes smoked daily, so

the fewer the better (changing to low-tar cigarettes will not correct smoking-related problems in pregnancy). However, if a woman quits smoking by the fourth month, her risk of delivering a low birthweight baby is similar to that of a nonsmoker.(7)

Prescription and Over-the-Counter Drugs. Almost all drugs get passed through to a growing fetus. Because the effects of most of these drugs to unborn babies are not known, every pregnant woman should tell all doctors and dentists caring for her that she is pregnant and discuss the use of any drugs she is taking at her first prenatal visit. Some prescription drugs are known or thought to cause birth defects or other complications in a baby's development when taken during pregnancy. Among them are birth control pills, tranquilizers, and some antibiotics. Tetracycline, for example, may cause a child's first or permanent teeth to be discolored or may affect bone growth. The acne drug Accutane (generic name isotretinoin) is known to cause birth defects.

Some over-the-counter drugs should also be discussed with the doctor. For example, many doctors recommend sodium-free antacids for their pregnant patients. Aspirin used in the later stages of pregnancy may prolong pregnancy and labor and cause excessive bleeding in the mother and child before and after delivery. Pregnant women should not take ibuprofen (the active ingredient found in several aspirin alternatives) without first discussing it with their physician--especially during the last 3 months of pregnancy when it may cause problems in the unborn child or complications during delivery.

Seemingly unharmed, even some vitamins can "pile up" in the body and cause damage to an unborn baby.(8) Although the obstetrician may prescribe a prenatal vitamin supplement, eating a variety of foods most likely will supply all the vitamin needs of a pregnant woman and her unborn child.

Caffeine. Caffeine is found in tea, coffee, colas, some medications, and chocolate. Experiments with animals show that high doses of

and the fathers role, and the Surgeon General's warning on drinking during pregnancy. 1986. 7 pp.

Availability
Do It Now Foundation
P.O. Box 21126
Phoenix, AZ 85036
(602) 257-0797
\$.25, bulk discount

No Thanks . . . I Want a Healthy Baby is a brief succinct pamphlet of facts about the effects of drinking during pregnancy. Poster with the same message is also available. 1986. 2 pp.

Availability
Prevention Resource Center
901 South Second Street
Springfield, IL 62701
1-800-252-8951
Single copies free

Alcohol, Tobacco, Caffeine, and Pregnancy encourages women to avoid alcohol, tobacco, and caffeine during pregnancy and while breastfeeding. It explains the dangers of these substances and the benefits of a healthy pregnancy. 1985. 8 pp.

Availability
Do It Now Foundation
P.O. Box 21126
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(602) 275-0797
\$.25, bulk discounts

What Everyone Should Know About Fetal Alcohol Effects is an illustrated, easy-to-read booklet of information on the effects of alcohol on the growing fetus, alternatives to drinking, and places women can go to get help with a drinking problem. 1985. 15 pp.

Availability
Channing Betz Co., Inc.
200 State Road
South Deerfield, MI 01373
(413) 665-7611 or
(800) 628-7133

25 minimum order, \$19.50 postpaid; complimentary review copies available

What You Should Know About . . . Babies and Booze, a brochure geared toward young women, provides basic data about alcohol consumption, explains the dangers of drinking alcohol during pregnancy, and encourages expectant mothers not to drink. 3 pp.

Availability
Oakland County Health Division
1200 N. Telegraph Road
Pontiac, MI 48053
(313) 858-1308
Single copies free

Fetal Alcohol Syndrome and Other Drugs Update, a newsletter for health providers and others interested in the effects of alcohol and other drugs during pregnancy, contains general information on topics such as alcohol and mental retardation, reviews of conferences and workshops, and updates on awareness campaigns.

Availability
Prevention Resource Center
901 S. Second Street
Springfield, IL 62704
(217) 525-3456
Free: New issue mailed out quarterly

The Growing Child With Fetal Alcohol Syndrome describes some of the social, physical, and intellectual consequences of fetal alcohol syndrome on the growing child. A case study of a 6-year-old child is presented, as is a comprehensive list of clinical features of the syndrome. 1985. 5 pp.

Availability
Thomas W. Perrin, Inc.
One Madison Street
East Rutherford, NJ 07073
(201) 777-2277
\$.81 postpaid

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

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Caffeine. Caffeine is found in tea, coffee, colas, some medications, and chocolate. Experiments with animals show that high doses of

caffeine may cause birth defects. In addition, excessive caffeine consumption (more than six cups a day) can cause anxiety, interfere with a pregnant woman's rest, and suppress her appetite. Thus, doctors recommend that a pregnant woman drink fewer than four cups of coffee a day and that she not drink colas excessively.

Summary

The use of all drugs is a serious matter for pregnant women. Virtually all drugs she uses enter her baby's body as well and the effects on the developing fetus can be much different than for the mother. Even drugs we may take for granted, like aspirin, vitamins, and other over-the-counter items may cause harm to the unborn child. Scientists have learned a lot about the effects of alcohol and other drugs in pregnancy. But they would be the first to say they still don't know enough. Therefore, every pregnant woman should play it safe and avoid the use of all but the most necessary drugs.

References

- (1) "Facts on Alcohol-Related Birth Defects," National Council on Alcoholism, Inc., NY, NY. 1987.
- (2) Ibid.
- (3) "Cocaine" by Steve Newman and Bryn Anderson, The Drug Education Center, Charlotte, NC. 1986.
- (4) Ibid.
- (5) Ibid.
- (6) "Drugs and Pregnancy, a Guide for Women." The Drug Program Office, Santa Barbara County Health Care Services, Santa Barbara, CA. 1987.
- (7) Ibid.
- (8) "Drugs, Alcohol, Tobacco Abuse During Pregnancy," March of Dimes, White Plains, NY. 1985.

Resource List

Fetal Alcohol Syndrome and Other Drug-Related Risks During Pregnancy

The following list is general up-to-date information on fetal alcohol syndrome, fetal alcohol effects and other drug effects resulting from substance use during pregnancy. Materials were selected for their information, appropriateness and availability. Using these resources, health professionals and community program providers can inform pregnant women, and women planning a pregnancy, about the risks of using alcohol or other drugs during pregnancy. The media can be encouraged to air public service announcements, and publish articles on these risks as well. For more information on preventing alcohol and other drug related birth abnormalities, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20852, or call NCADI at (301) 468-2600 and ask to speak to an information specialist. Your comments and recommendations for additional materials to be included in future updates of this publication are welcome.

Brochures, Pamphlets and Fact Sheets

Alcohol and Birth Defects: The Fetal Alcohol Syndrome and Related Disorders reviews advances in research and in our understanding of this topic. It is intended primarily for lay readers but is

and the fathers role, and the Surgeon General's warning on drinking during pregnancy. 1986. 7 pp.

Availability
Do It Now Foundation
P.O. Box 21126
Phoenix, AZ 85036
(602) 257-0797
\$.25, bulk discount

No Thanks . . . I Want a Healthy Baby is a brief succinct pamphlet of facts about the effects of drinking during pregnancy. Poster with the same message is also available. 1986. 2 pp.

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Prevention Resource Center
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Springfield, IL 62701
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Availability
Thomas W. Perrin, Inc.
One Madison Street
East Rutherford, NJ 07073
(201) 777-2277
\$.81 postpaid

also useful for health professionals who are not specialists in this area. 1987. 56 pp.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH238

Program Strategies for Preventing Fetal Alcohol Syndrome and Alcohol-Related Birth Defects provides program planners with a foundation for developing a comprehensive community-based program aimed at reducing the number of alcohol-related birth defects. This "how-to" manual is filled with practical advice, based on the latest research. It also contains appendices rich in referral and bibliographic information. 1987. 78 pp.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH236
(out of stock until 8/88)

My Baby . . . Strong and Healthy recommends that women not drink if pregnant or planning to become pregnant. The brochure describes the risks and potential effects of drinking on an unborn baby. 1986. 16 pp. (Also available in Spanish; see Spanish Language Publications.)

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH225
(out of stock until 8/88)

Taking Care of Your Baby Before Birth, A Message for Pregnant Women is an easy-to-read, action-oriented brochure for women that recommends that they not drink if pregnant or planning a pregnancy. 1988. 4 pp. (Also available in Spanish; see Spanish Language Publications.)

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH239

Marijuana and Reproduction reviews current research findings about the effects of marijuana on the reproductive system. This is a useful booklet for researchers and health care professionals who study or treat young adults and pregnant women. 1982. 30 pp.

Availability
American Council for Drug Education
5820 Hubbard Drive
Rockville, MD 20852
(301) 984-5700
\$2.50

Prenatal and postnatal care, a brochure for parents or parents-to-be, advocates a good diet and abstaining from drinking and smoking during pregnancy and using safety restraints after the baby is born. 1986. 3 pp.

Availability
American Medical Association
Auxiliary, Inc.
535 North Dearborn Street
Chicago, IL 60610
(312) 645-4470
\$10.00 per 100

Cause and Defect. Questions and Answers About Fetal Alcohol Syndrome reviews current medical knowledge on risks and damage to the fetus of fetal alcohol syndrome. The pamphlet includes signs of the syndrome, prevention,

Fact Sheet: Fetal Alcohol Syndrome is a one-sided fact sheet providing a definition of fetal alcohol syndrome (FAS), the process by which FAS is contracted, symptoms of FAS, incidence and prevalence data, and recommendations to women who are pregnant or anticipating a pregnancy. 1987.

Availability
Missouri Department of Mental Health
Division of Alcohol and Drug Abuse
1915 Southridge Drive
P.O. Box 687
Jefferson City, MO 65102
Single copies free

Facts on Alcohol-Related Birth Defects is a fact sheet providing information on the incidence of fetal alcohol syndrome, its symptoms, and some reasons that women continue to drink during pregnancy. 1987.

Availability
National Council on Alcoholism, Inc.
12 West 21st Street
New York, NY 10010
(212) 206-6770 or
or
1511 K Street, NW
Washington, DC 20005
(202) 737-8122
or
(800) NCA-CALL
Single copies free

Healthy Mothers, Healthy Babies Quiz focuses on the extent of low birthweight and infant mortality in the United States. It is useful for generating group discussions and for educating students and the general public. National and State-by-State statistics are included. 1987.

Availability
Contact your local March of Dimes chapter
or

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$2.00, postpaid

Facts You Should Know About Teenage Pregnancy spells out the physical and psychological risks of teenage pregnancy. It is designed as a reference for both teenagers and adults. (Also available in Spanish; see Spanish Language Publications. 1987.

Availability
Contact your local March of Dimes chapter
or

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$2.00, postpaid

You Are Pregnant, You're In Your Teens, and You Need Help is a pamphlet for pregnant teens on ensuring healthy beginnings for their babies. It stresses the importance of regular prenatal care; eating right; and not smoking, drinking, or taking drugs. The teen is reassured that she is not alone and is guided to other sources of help. 1986. 3 pp.

Availability
Contact your local March of Dimes chapter
or

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$3.50, postpaid

Be Good To Your Baby, Before It Is Born is a booklet that guides the pregnant woman from the first prenatal visit through the delivery. It covers the first checkup, diet

and weight gain, risks to the baby from smoking and alcohol, exercise, rest, and more. (Also available in Spanish; see Spanish Language Publications.) 1986. 2 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$3.00, postpaid

Bookmark reminding mothers-to-be to eat nourishing foods, see the doctor regularly, and be aware of the dangers of alcohol, tobacco, and drugs.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
100 for \$2.50, postpaid

D*A*T*A--Drugs, Alcohol, Tobacco Abuse During Pregnancy helps the mother-to-be understand the effects of these substances on her unborn baby so she can avoid them--and increase her chances for having a healthy baby. 1987. 5 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
100 for \$3.50

Will My Drinking Hurt My Baby? answers common questions about fetal alcohol syndrome. Describes the effects to the baby and encourages mothers-to-be to abstain from drinking during their pregnancy. (Also available in Spanish; see Spanish Language Publications.) 1987. 2 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
100 for \$2.50, postpaid

Babies Don't Thrive In Smoke-Filled Wombs is a folder outlining the risks of smoking during pregnancy to the baby, including premature birth. The pregnant woman is advised to stop smoking now--for her own health and her baby's. 1987.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
100 for \$2.50, postpaid

Alcohol Warning Signs: How To Get Legislation Passed In Your City is a manual designed to assist citizens groups secure the passage of alcohol-warning legislation in their city, county, or State. Focuses on laws requiring the posting of signs warning of the dangers of drinking during pregnancy. 1986. 52 pp.

Availability
Center for Science in the Public
Interest
1501 16th Street, NW
Washington, DC 20036
(202) 332-9110
\$4.95

Keep the Pride briefly describes
the Fetal Alcohol Syndrome Project
being carried out among the Indian
population in the southwestern
United States. 2 pp.

Availability
Alcoholism and Substance Abuse
Program, Indian Health Service
Room 6A-53
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4297
No cost
(Limited quantities presently
available; plans for reprinting
in 1988.)

**Alcohol and Pregnancy: How
Drinking May Harm the Unborn Baby**
describes fetal alcohol symptoms,
including facial abnormalities,
abnormal brain development,
physical deformities, growth
problems, and personality problems.
Written for the American Indian
Community but useful for a wider
audience. 2 pp.

Availability
Alcoholism and Substance Abuse
Program, Indian Health Service
Room 6A-53
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4297
No cost
(Limited quantities presently
available; plans for reprinting
in 1988.)

Drugs and Pregnancy discusses how
alcohol, cigarettes, prescriptions,
and over-the-counter and illegal
drugs, when consumed by the mother,
pose a threat to the health of an
unborn child. (Also available in
Spanish; see Spanish Language
Publications.) 1987. 4 pp.

Availability
Health Department of Santa
Barbara County
300 N. San Antonio Road
Santa Barbara, CA 93110
(805) 681-5440
\$.30

Books and Journals

**Alcohol Problems In Women:
Antecedents, Consequences and
Intervention**, Wilsnack, S.C. and
Beckman, L.J., eds. Explores
specific alcohol problems
experienced by women drinkers.
Attention is given to problems that
may be experienced by both
alcoholic and nonalcoholic women,
including health consequences of
heavy alcohol consumption, fetal
alcohol syndrome and other fetal
alcohol effects, alcohol-drug
interactions, and alcohol-related
family problems. 1984. 480 pp.

Availability
Guilford Publications
72 Spring Street
New York, NY 10012
(212) 431-5800
\$50 plus \$2 postage
(NY residents add sales
tax)
Catalog #2164
or
Library

**Women and Alcohol: Health-Related
Issues: Research Monograph #16**,
Department of Health and Human
Services, Public Health Service,
Alcohol, Drug Abuse and Mental
Health Administration. Sets
forth current information on a
alcohol abuse and alcoholism among
women as reported through workshops
on research, prevention, and
treatment areas and provides
state-of-the-art reviews on
selected subjects. 1986. 375 pp.

Availability
Library

Women and Alcohol: A Dangerous Pleasure, Youcha, G. An overview of the problems faced by women who drink. The topics include the physiological effects of alcohol, effects on personality and behavior, the family, pregnancy, and treatment. Included are a guide to drug interactions with alcohol, suggestions for hostesses, a quiz, and a listing of resources. 1978. 272 pp.

Availability
Crown Publishers
225 Park Avenue South
New York, NY 10003
(212) 254-1600, ext. 763
\$7.95, plus postage (billed separately)

Special Focus: Preventing Alcohol-Related Birth Defects, a reproduction of Alcohol Health and Research World, Fall 1985. Includes articles on the effects of alcohol on pregnancy outcome and prevention strategies that have been developed in the area of alcohol-related birth defects. 1985. 75 pp.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
No cost; request RPO 560

Alcohol and pregnancy: an overview and an update, Streissguth, A.P. Substance and Alcohol Actions/Misuse 4(2/3):149-171, 1983. Reviews the literature on fetal alcohol syndrome; describes the syndrome, and includes discussions of children of alcoholic mothers, effects of alcohol use during pregnancy, laboratory animal studies, and implications. The article also suggests that pregnancy outcomes may be difficult to predict because of individual differences, timing and dose, and vulnerability of the fetus.

Availability
Library

Alcohol use during pregnancy, Kruse, J. American Family Physician 29(4):199-203, 1984. Discusses the effects of maternal drinking on the fetus, including low birthweight, congenital abnormalities, mental retardation, and behavioral and learning disabilities. Also provides a brief discussion of the history and incidence of fetal alcohol syndrome.

Availability
Library

Fetal alcohol syndrome: Implications and counseling considerations, Elliott, D.J., and Johnson, N. Personnel and Guidance Journal 62(2):67-69, 1983. Discusses the effects of maternal drinking on the fetus with a special focus on implications for counselors. Current trends in care and services for the family of the developmentally disabled child are reviewed, and the need for more prevention programs for adolescent females is stressed.

Availability
Library

Fetal Alcohol Syndrome and Fetal Alcohol Effects, Abel, E.L. Provides a historical perspective on the occurrence of FAS and FAE. An overview of recent research is presented and the physiological effects of alcohol on the fetus are described in detail. Prevention efforts are also reviewed. 1984.

Availability
Plenum Publishing Corporation
233 Spring Street
New York, NY 10013
(212) 620-8000
\$32.50 plus postage
or
Library

The Effects of Alcohol on Pregnancy Outcome, reprinted from the Fifth Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services. Provides information on the relationship between maternal drinking during pregnancy and FAS. A historical overview is presented, research findings and the results of treatment and prevention programs, including public education efforts, are reviewed. The effects of paternal drinking are also discussed.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
No cost; request RPO 496

Posters

No Thanks. . . I Want a Healthy Baby depicts a silhouette of a pregnant woman refusing a variety of alcoholic beverages. The message: "No thanks. I want a healthy baby." Accompanying pamphlet also available. 1986.

Availability
Prevention Resource Center
901 South Second Street
Springfield, IL 62701
(800) 252-8951
Single copies free

An Inner Voice Tells You Not To Drink is a colorful poster with the image of a pregnant American Indian woman. Suitable for audiences of all ethnic backgrounds. 1987

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request AV161

No One That Young Should Drink is a bright poster of a baby in the womb with the message: "Alcohol can cause birth defects. When you drink so does your baby. If you're pregnant. . . DON'T DRINK!" Can be adapted with local phone numbers. Oakland County has also printed this poster on plastic tote bags.

Availability
Oakland County Health Division
1200 N. Telegraph Road
Pontiac, MI 48053
(313) 858-5102
Single copies and single bags are free

Audiovisuals

Drugs, Smoking and Alcohol During Pregnancy discusses the confusion many pregnant women face about what may be harmful to their unborn babies. Facts about smoking, alcohol, and drug use during pregnancy are provided, and the effects of over-the-counter medications, such as cold and headache remedies, are discussed. 20 min., 1985.

Availability
Milner-Fenwick, Inc.
2125 Greenspring Drive
Timonium, MD 21093
(301) 252-1700 or call toll free (800) 638-8652
Videotape, \$250
Preview, \$15

One For My Baby presents information about fetal alcohol syndrome and its symptoms, risks, and prevention through abstinence. Also, two couples who have children with the syndrome--one natural born, one adopted--share their feelings. 27 min., 1982.

Availability
AIMS Media
6901 Woodley Avenue
Van Nuys, CA 91406-4878
(800) 367-2467 or
(818) 785-4111
16-mm film, \$430;
Videocassette, \$225
Preview, Free

Cocaine's Children a videotape documentary outlining the harmful effects of cocaine on the fetus and newborn. Stunning pictures of cocaine-affected babies are included. The infants bring home the message that pregnant women who use cocaine are exposing their young to suffering at birth and the risk of long-term developmental problems. 9 min., 1987.

Availability
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
16mm film, \$70
1/2" VHS, \$40
3/4" VT, \$40
\$10 preview fee for the film only

I Didn't Mean to Hurt You Baby depicts a young woman confronted with the question of whether or not to give up casual, "social" drinking during the term of her pregnancy. The film confirms that the risk of drinking during pregnancy is great. Designed as an educational tool for the classroom and for community education programs. 16 min., 1984.

Availability
Virginia Department of Mental Health/Mental Retardation Prevention/Information/Training
P.O. Box 1797
Richmond, VA 23214
(804) 786-3909
Loan: 1/2" VHS and 3/4" Beta

Curriculum Guides and Kits

Fetal Alcohol Syndrome Education Guide and FAS Information Packet includes an educator's guide to fetal alcohol syndrome and a packet of training materials. Fact sheets, articles, a glossary, graphs, and an annotated resource guide are provided.

Availability
State of California
Alcohol and Drug Programs
111 Capitol Mall, Room 250
Sacramento, CA 95814
(916) 324-7260
Single copies free

Healthy Mothers, Healthy Babies Curriculum Package is designed to help educators in preschool through high school integrate information about healthy pregnancy and birth into their lessons. The guide covers four concept areas (with resources for each): nutrition, environment, genetics, and human growth and development. Fold-out chart supplements the guide and outlines the key objectives at each grade level. 1987. 64 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
Concept guides: 5 for \$13, postpaid

A Secondary Level Curriculum on Fetal Alcohol Syndrome is a booklet of activities and topic areas for secondary-level educators who want to include sessions on fetal alcohol syndrome in their classes. Includes material for three sessions--including a fact sheet about the effects of alcohol in humans and videotape/film discussion guides for "One for My

Baby," "Born Drunk," and "I Didn't Mean to Hurt You Baby." Also lists further resources. 1986.

Availability
Minnesota Prevention Resource Center
2829 Verndale Avenue
Anoka, MN 55303
(612) 427-5310
\$3.25, postpaid
\$5 rental fee per film or videotape

Better Beginnings for Babies is a workbook for program planners and health care providers working with high-risk youth or pregnant women. It describes the dangers of drinking during pregnancy and provides guidelines for conducting a successful campaign against fetal alcohol syndrome. 1982. 115 pp.

Availability
Washington-Greene Prevention Corporation
87 East Maiden Street
Washington, PA 15301
(412) 228-0810
\$7.50, postpaid

Fetal Alcohol Syndrome Community Education Kit can assist in educating a community on fetal alcohol syndrome (originally written for the American Indian Community). The kit contains 17 components, including kit script, poster, bumper stickers, recipe cards, fact sheets, bookmarks, a brochure entitled "Techniques for Approaching Women at Risk," resource guides, and much more. The kit also contains information on video rentals, handbooks, and manuals. 1980.

Availability
California Urban Indian Health Council, Inc.
2422 Arden Way, Suite A-32
Sacramento, CA 92825
(916) 920-0313
\$78

Spanish Language Publications

Tenga Beun Cuidado de su Bebe Antes de que Nazea (Be Good To Your Baby, Before It Is Born) is a booklet that guides the pregnant woman from the first prenatal visit through the delivery. It covers the first checkup, diet and weight gain, risks to the baby from smoking and alcohol, exercise and rest, and more. 1986. 2 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$3, postpaid

Datos Que Usted Debe Saber Sobre Las Adolescentes Embarazado (Facts You Should Know About Teenage Pregnancy) spells out the physical and psychological risks of teenage pregnancy. It is designed as a reference for both teenagers and adults. 1987.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
50 for \$2, postpaid

MI Bebe. . . Fuerte y Sano (My Baby. . . Strong and Healthy) recommends that women not drink if pregnant or planning to become pregnant. This brochure describes the risks and potential effects of drinking on the unborn baby. 1986. 16 pp.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH237

El Cuidado de su Bebe Antes del Nacimiento, Un Mensaje para Mujeres Embarazadas (Taking Care of Your Baby Before Birth) is an easy-to-ready, action-oriented brochure for women that recommends that they not drink if pregnant or planning a pregnancy. 1988. 4 pp.

Availability
NCADI
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600
No cost; request PH239

Afectara a mi bebe el tomar bebidas alcoholicas? (Will My Drinking Hurt My Baby?) answers common questions about fetal alcohol syndrome. It describes the effects to the baby and encourages mothers-to-be to abstain from drinking during their pregnancy. 1987. 2 pp.

Availability
Contact your local March of Dimes chapter
or
March of Dimes Birth Defects Foundation
1725 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
100 for \$2.50, postpaid

Las Drogas y El Embarazo (Drugs and Pregnancy) discusses how alcohol, cigarettes, prescriptions, and over-the-counter and illegal drugs, when consumed by a mother, pose a threat to the health of her unborn child. 1987. 4 pp.

Availability
Departamento De Salud Del Condado
De Santa Barbara
300 N. San Antonio Road
Santa Barbara, CA 93110
(805) 681-5440
\$.30

memorandum

DATE: February 3, 1989

REPLY TO
ATTN:

Chief, Area Community Health Services Branch

Refer to: A-CHSB

SUBJECT:

Alaska Area Native Health Service

Update: Incidence of Fetal Alcohol Syndrome (FAS) in Alaska Natives

TO:

Director

Alaska Area Native Health Service

RECEIVED FEB 9 1989

In 1986 the Alaska Area Community Health Services Branch conducted an area-wide survey to determine the incidence and prevalence of FAS in Alaska Native children. The target population included all Alaska Native children born since January 1, 1981 and before May 30, 1986. Children suspected of having FAS, by FAS diagnostic criteria, were transported with their mothers or caregivers to a regional facility to be examined. The children were examined by the same consultant, a pediatric dysmorphologist from the University of New Mexico who is a nationally-recognized expert in identification of FAS in American Indians.

The incidence of FAS calculated from the data was 4.2/1000 live births, which was the highest reported rate for any population thus far studied. It was pointed out at that time that the true incidence was higher than 4.2/1000, as case-finding was difficult in certain parts of the state and several children suspected of having FAS were, for various reasons, unable to attend the scheduled clinics.

In response to this problem, the Alaska Area IHS initiated an Area-wide FAS Prevention Program through a contract with the Alaska Native Health Board. The program was designed to obtain accurate data, provide education, offer intervention therapy, pursue follow up of high-risk mothers and infants, engage in ongoing research, and assist regional Native Health Corporations in developing their own FAS prevention programs.

Identification of new FAS cases has continued with the diagnosis being made by an IHS pediatrician either at ANMC or at a regional pediatric clinic. In instances where the pediatrician feels a second opinion is needed the child is referred to the FAS Diagnostic Clinic, which is held twice a year at ANMC.

Identification of new FAS cases for the initial study period (January 1, 1981, through May 30, 1986) resulted in the revised area-wide rate for this time period of 5.1/1000 for FAS and 1.7/1000 for FAE (Fetal Alcohol Effects).

During June 1, 1986 through December 31, 1988 the Area FAS Prevention Program began a major statewide education effort and began training and assisting the regional Native Health Corporations in the development of FAS prevention programs. Seven corporations have established FAS prevention programs, with the others involved in FAS education activities, as well as regional FAS program development.

For the period June 1, 1986, through December 31, 1988, the FAS rate is 2.7/1000, and 1.7/1000 for FAE. While the FAE rate has remained the same, the FAS rate has decreased by almost one half (47%) of the prior FAS rate of 5.1/1000. Although this is most encouraging, there is no region whose rate is equal to or below the average national rate for FAS of 1.7/1000. Regional rates vary from 1.2 to 20 times the average national FAS rate.

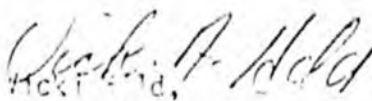
The cumulative (January 1, 1981 through December 31, 1988) FAS rate for Alaska Natives is 4.2/1000 and 1.7/1000 for FAE.

If the trend for FAS incidence holds, it would appear that the programmatic efforts may be having an impact on the FAS rate. Continuation and expansion of these efforts may in time provide strategies that will prevent FAS long before pregnancy. It is felt the FAE rate is deceptive i.e. under diagnosed, for two reasons. First, case-finding efforts have been geared for diagnosing FAS not FAE. Secondly FAE, if the major effect is developmental delay and behavior disorders, is not easily diagnosed at birth, but is noticed later, often after the child enters in school.

The Area FAS Program has also gathered information on other drug usage in our prenatal population. Reported prenatal cocaine usage has dramatically increased as have the number of infants born with cocaine-related medical problems. A cocaine education component is currently being developed, and will be incorporated into the Area FAS Prevention Program.

In response to the FAS problem, as well as other prenatal drug use and abuse, Southcentral Foundation submitted a proposal in March 1988 for the establishment of a residential treatment center for pregnant Native women in Alaska. The proposed intervention and treatment approach would be far more cost effective than the chronic care of a child born with FAS, FAS, or birth defects caused by other prenatal drug usage. There is a great need for chemical dependency treatment services for pregnant women, services which are currently unavailable.


James E. Berner, MD


Jackie A. Held,
FAS Coordinator

THE FOLLOWING DOCUMENT HAS
NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL
FILE

National Institute on Alcohol Abuse and Alcoholism

**ALCOHOL AND
BIRTH DEFECTS:
THE FETAL ALCOHOL
SYNDROME AND
RELATED DISORDERS**

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

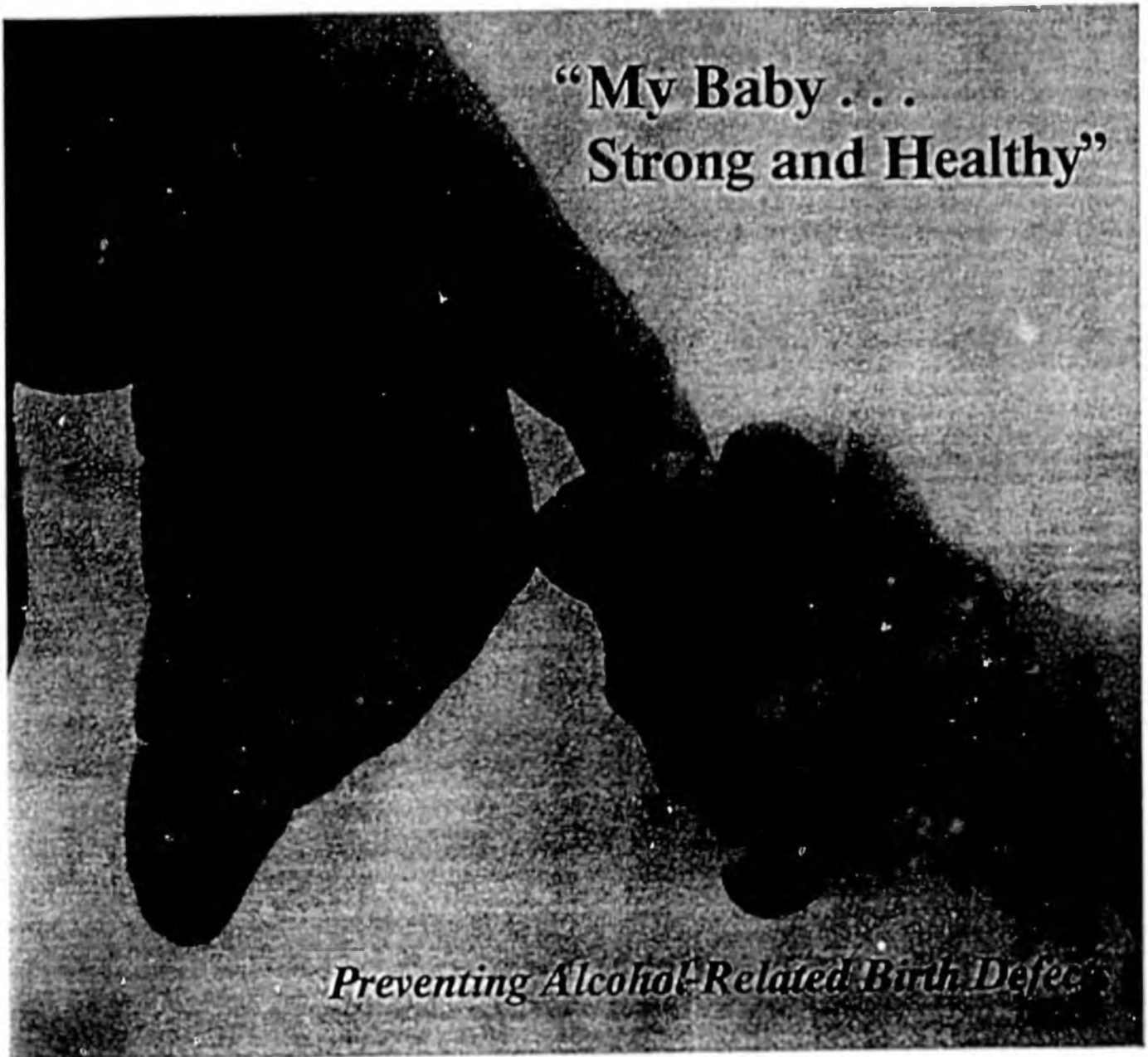
THE FOLLOWING DOCUMENT HAS
NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL
FILE

Alcohol Health & Research World

Fall 1985
Volume 10
Number 1

National Institute on
Alcohol Abuse and
Alcoholism

REPRINT



“My Baby . . .
Strong and Healthy”

Preventing Alcohol-Related Birth Defects

U.S. Department of
Health and Human
Services

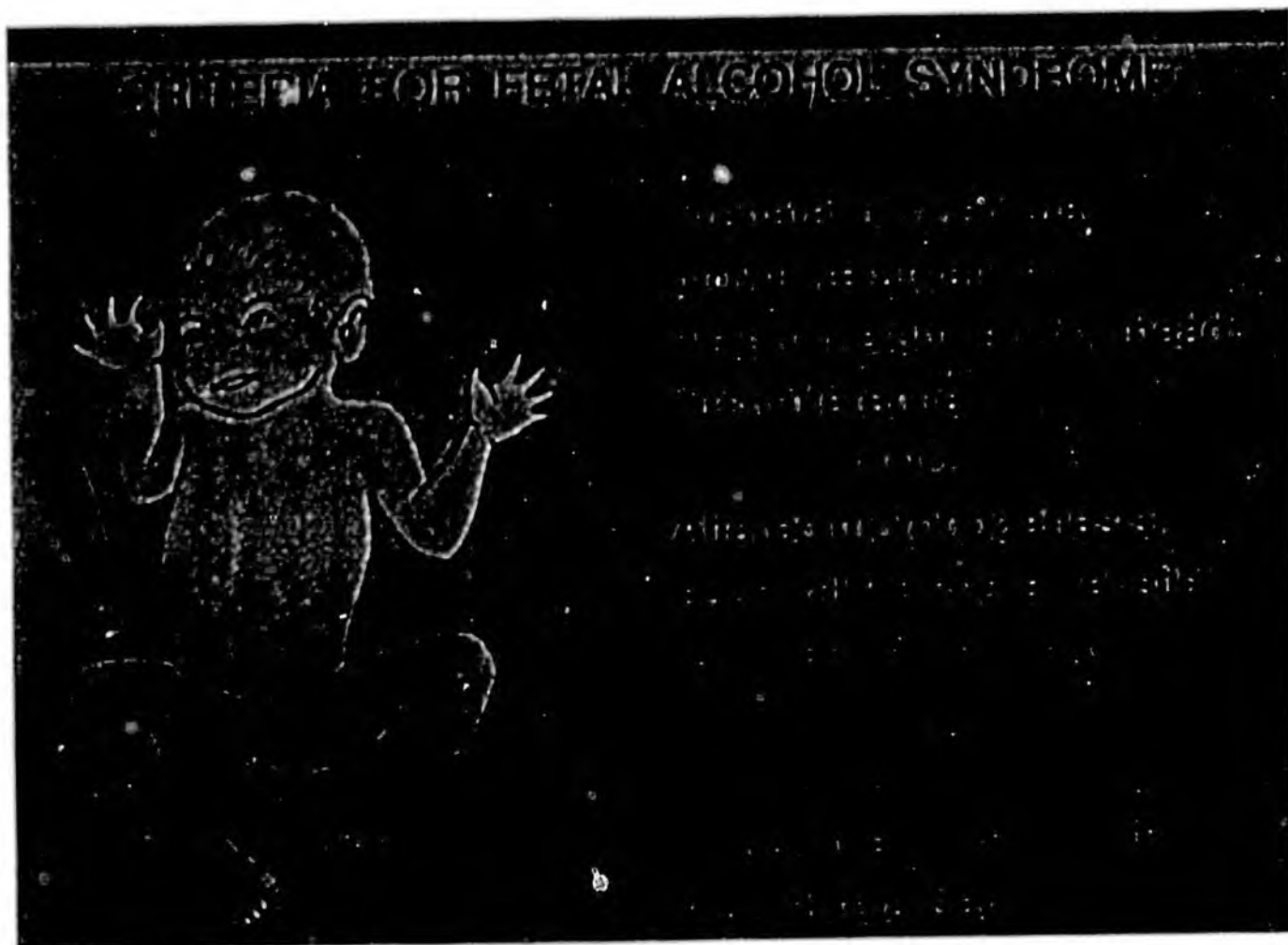
Public Health
Service

Alcohol, Drug Abuse,
and Mental Health
Administration

THE FOLLOWING DOCUMENT HAS
NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL
FILE

ALCOHOL-RELATED BIRTH DEFECTS

Fetal Alcohol Syndrome (FAS)
Fetal Alcohol Effects (FAE)



Criteria for FAS

• growth retardation • abnormal facial features • mental retardation

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!

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.

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REMEMBER, IT'S YOUR BABY TOO!

MEN,

ALCOHOL and

BABIES

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

Will My Drinking Hurt My Baby?



**March of Dimes
Birth Defects Foundation**
1275 Mamaroneck Avenue
White Plains, NY 10605

For more information on
drinking and pregnancy,
ask your doctor or your
local March of Dimes chapter.

This pamphlet is made
possible through contributions
to the March of Dimes.

For additional copies
contact your local
March of Dimes chapter.

**March of Dimes
Birth Defects Foundation**

Would You Give Your Newborn Baby A Drink of Liquor or Wine or Beer?

Of course you wouldn't. You know that a baby doesn't need or want alcohol in any form. You wouldn't think of putting an alcoholic drink in your baby's bottle because you know it's not good for him or her.

Well, exactly the same is true *before* your baby is born. When you are pregnant, every time you take a drink, your baby takes one too. The drink he gets is just as strong as the one you get, and because he is so much smaller than you are, it hits him a lot harder.

What is worse, his hangover could last a lifetime.

What Is Fetal Alcohol Syndrome?

Fetal alcohol syndrome (FAS) is a pattern of physical and mental birth defects that are the direct result of the mother's drinking alcohol while pregnant.

FAS babies are abnormally small at birth, especially in head size. Unlike many newborns who are too small, few of these children catch up to normal growth. Most of them have small brains and show some amount of mental retardation. Many are jittery and poorly coordinated. They have short attention spans and behavioral problems. Their mental problems may not improve with age.

FAS babies usually have narrow eyes and short upturned noses. Some have heart defects, which may require surgery.

I Don't Drink That Much. Could It Happen To My Baby?

We don't know how much alcohol is "safe." The best decision is not to have any while you are pregnant—or when you might be.

About *one out of every 750 babies born has FAS!** That's a lot of damaged babies. We don't realize how common FAS is because we don't hear about it as much as other birth defects. We haven't known about FAS for very long.

What Can I Do About It?

Everything. Unlike many other birth defects, FAS is *completely preventable*. By you. Nobody else can do it for you--not your doctor or your mother or the baby's father.

FAS is forever. There is no cure. But it doesn't have to happen at all. All you have to do is say "no" to the next drink, and keep on saying it until after your baby is born.

Other Than The Tragedy Of FAS, Are There Any Other Reasons Not To Drink While I'm Pregnant?

Alcohol is a drug that adds calories, but no food value, to the diet—your diet and your developing baby's. Having an alcoholic drink instead of milk or fruit juice deprives your baby of the nourishment it needs to grow and develop normally.

Women who drink heavily during pregnancy have more miscarriages and more stillbirths (babies born dead) than other women. Even moderate drinking is suspected of causing these problems. It is also suspected of causing learning disabilities and minor physical problems. There is much we still have to learn, but pregnancy is no time for guessing how much is too much.

When Should I Stop?

It's never too soon.

From the moment of conception, your baby's organs start forming. Alcohol can damage them. For example, brain, heart and blood vessels start to develop in the third week of pregnancy. The heart begins to beat by the fourth week, even though the embryo is less than ¼ of an inch long.

Since most women do not know that they are pregnant until a month or more has passed, they may have been drinking all along. So the best time to stop drinking is *before* you become pregnant. If you are pregnant and are still drinking, the time to stop is *now*. If you need help, ask your doctor.

**THE ONLY SAFE ADVICE IS:
IF YOU DRINK HEAVILY,
DON'T GET PREGNANT;
IF YOU'RE PREGNANT,
DON'T DRINK.
YOUR BABY CAN'T SAY NO.
SAY IT FOR YOUR BABY.**

* Centers for Disease Control, US Dept. of Health and Human Services, Public Health Service, *Morbidity and Mortality Weekly Report*, January 13, 1984.



**You can help
prevent
birth defects,
America's # 1
child health
problem**

**you can help your baby be
born healthy if you:**

- **Eat nourishing foods.**
- **See your doctor regularly.**
- **Don't drink or smoke.**
- **Don't take any drug
unless a doctor who
knows you are pregnant
recommends it.**



**March of Dimes
Birth Defects Foundation
National Headquarters
1275 Mamaroneck Avenue
White Plains New York 10605**

**For additional copies
contact your local
March of Dimes chapter.**

H B

231

HOUSE COMMITTEE REPORT

(7)

Date Referred: March 20, 1989

FURTHER REFERRALS: FINANCE

Date of Committee Action: 4/11/89

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 231

HOUSE BILL NO. 231 [EDUCATION: PLANNING/GRANTS/MISC. CHANGES]
"An Act establishing a state education policy; relating to powers and duties of school districts, the Department of Education, and the State Board of Education with respect to education planning and planning grants; requiring regional school boards to establish and consult with advisory boards; and providing for an effective date."

RECOMMENDATIONS:

- be replaced with CS HB 231 (HESS) the same title
 a new title
 have attached amendment(s)
 do pass
 do not pass
 no recommendation
 individual recommendations
 additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S): (Dept) APPROVES PREVIOUS: (Date/Dept)

- fiscal impact Education fiscal note(s) _____
 zero fiscal note _____ zero fiscal note(s) _____
 zero with analysis _____ zero fn/analysis _____

SIGNING DO PASS:

J. Ellis
Mark Boon
Cheri Davis
Becky Jones

SIGNING:

(Check approp. column)

	Do Not Pass	No Rec	Amend
<u>Pete Goll</u> Do Pass WITH AMENDMENT			
<u>Mark Boon</u>		X	
<u>Cheri Davis</u>		✓	

J. Ellis
Chairman's Signature

A M E N D M E N T #1

OFFERED IN THE HOUSE

BY MACLEAN

TO: HB 231

Page 1, lines 16 - 19:

Delete all material.

Insert "this state that the purpose of education is to help ensure that all learners will succeed now and in their next-level of education or work, shape worthwhile and satisfying lives for themselves, exemplify the best values of society, and be effective in influencing the character and quality of the world about them."

A M E N D M E N T

OFFERED IN THE HOUSE

BY MACLEAN

TO: HB 231

2nd Grants

Page 3, line 9:

Delete "\$50,000"

Insert "\$15,000"

Page 3, line 12:

Delete "three"

Insert "two"

2B

Page 3, line 17, after "plans":

Insert ", administer planning grants awarded under AS 14.03.125"

2C

A M E N D M E N T

OFFERED IN THE HOUSE

BY MACLEAN

TO: HB 231

Page 3, line 12, after "years.":

Insert "The board may withhold a grant from a district that the board determines has not actively involved students, parents, teachers, and other members of the community in education planning in the district."

3A In. 5 p. 3

A M E N D M E N T #21

OFFERED IN THE HOUSE

BY MACLEAN

TO: HB 231

Page 3, line 27, after "boards":

Insert "in each community in the regional educational attendance area that has more than 50 permanent residents"

by MacLean

#5

AMENDMENT Page 2, line 11

delete after "tests" : "and college"

Page 2, line 12

delete : "entrance examinations, with appropriate
comparisions"

ALASKA STATE LEGISLATURE

Representative Eileen Panigeo MacLean
P.O. Box 290
Barrow, Alaska 99723

WHILE IN JUNEAU
Box V
Juneau, Alaska 99811
465-4525
465-4833



Chairman
Community & Regional Affairs
Committee

Vice-Chairman
State Affairs Committee
Bush Caucus

Member Finance Subcommittee
Community & Regional Affairs
Education
Corrections

HOUSE OF REPRESENTATIVES

MEMORANDUM

District 22
Ambler
Anaktuvik Pass
Atkasuk
Barrow
Buckland
Deering
Kaktovik
Kiana
Kivalina
Kobuk
Kolzebua
Noatak
Noorvik
North Slope
Borough
Northwest Arctic
Borough
Nuiqsut
Point Hope
Point Lay
Selawic
Shungnak
Wainwright

TO: All Interested Parties

FR: Representative Eileen P. MacLean

DATE: March 21, 1989

SUBJ: HB 231 Relating to School Performance
Recommendations

Eileen P. MacLean

Enclosed please find a copy of HB 231 which would adopt some of the recommendations from the report put together by the Senate Special Committee on School Performance, chaired last year by Senator Willie Hensley.

HB 231 would do three things: 1). Establish a state education policy; 2). Add to the powers and duties of the Department of Education, and the State Board of Education and the School Districts with respect to education planning and planning grants; 3). Requires regional School Boards to establish and consult with advisory boards.

Each year, the legislature appropriates funding to schools for operating and construction needs without requiring formal reports on the performance of each school and how the funding is used. This bill would require schools to justify the use of state funds for education and require providers of education to do an assessment of program areas and services. It would also allow the public and others to be more accountable of our schools and to the quality of education that our children are receiving.

Attached is copy of the bill and a brief summary.

IF YOU WOULD LIKE TO COMMEND OR SHARE YOUR CONCERN ON HB 231 or HB 203, PLEASE CONTACT MY OFFICE AT #465-4525 OR WRITE TO MY OFFICE AT THE ABOVE ADDRESS. YOUR PROMPT RESPONSE WILL BE APPRECIATED.

HB 231 is An Act relating to School Performance

Recommendations, The bill does three things very simply:

1) It establishes a state education policy to lay the foundation of work yet to be accomplished; 2) It adds to the powers and duties of the Dept. of Ed. and the State Bd. of Ed. and the school districts with respect to Educational Planning and planning grants; 3) and it requires regional school boards to establish and consult with advisory school boards.

On a yearly basis, the legislature appropriates funding to schools for operating and construction needs without requiring formal reports on the performance of each school and how the funding is to be used. This bill would require schools to justify the use of state funds for education and require providers of education to do an assessment of programs and services.

This bill would give the public the opportunity to be more accountable within our schools and contribute towards the quality of the educational process our children are receiving. This is an important piece of legislation that we should look and decide on so that the work can be accomplished as soon as possible.

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Education
 Title: Establishing a State Education Policy: BRU Education Program Support
Education Planning & Planning Grants
 Sponsor: MacLean, Eliza Goll Components: Basic Education and
 Requestor: House HESS Instructional Improvement

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES		91.1	91.1	91.1	91.1	91.1
TRAVEL		1.2	1.2	1.2	1.2	1.2
CONTRACTUAL		14.0	14.0	14.0	14.0	14.0
SUPPLIES		1.5	1.5	1.5	1.5	1.5
EQUIPMENT		9.5				
LAND & STRUCTURES						
GRANTS, CLAIMS	-0-	950.0	950.0	950.0	950.0	950.0
MISCELLANEOUS						
TOTAL OPERATING	-0-	1037.3	1027.8	1027.8	1027.8	1027.8

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	1037.3	1027.8	1027.8	1027.8	1027.8
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME		1	1	1	1	1
PART-TIME		1	1	1	1	1
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See attached analysis.

Prepared by: Mary Hakala Phone: 465-2800
 Division: Commissioner's Office Date: 3/28/89
 Approved by Commissioner: William G. Demmert Date: 3/28/89
 Agency: Education

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

DEPARTMENT OF EDUCATION
FISCAL NOTE ANALYSIS
3/30/89

HB 231. Establishing a state education policy, relating to powers and duties of school districts, the Department of Education and the State Board of Education with respect to education planning and planning grants, requiring regional school boards to establish and consult with advisory boards.

Personal Services

1 FT Research Analyst II	\$46.5
1 PT Clerk Typist III	14.6

Subtotal	\$61.1

The Research Analyst will perform the functions required under the legislation including: 1) compile summary report to be submitted to the Legislature, School Districts and State Board of Education based on data submitted to the Department for each of the 466 schools in the state and 55 school districts; 2) review reports for compliance with statutory requirements and elements required of the plan; and 3) serve as grant administrator for award of grants. The part time clerk typist will provide all necessary clerical support for these functions.

Travel

Travel to centralized conference/training session to assist districts in establishment of their local process and develop streamlined reporting procedures. \$1.2

Contractual

Contractual costs include one additional audioconference meeting with the State Board of Education to make grant awards (1.0); printing, production and distribution of the required report (4.6); RSA for increased costs associated with accounting for an estimated 20 planning grant awards per year (3.6); telephone, postage, minimal planning resource materials purchases (3.0); maintenance of workstations (.5); and purchase software for reporting and spreadsheet functions (1.3). \$14.0

Commodities

Supplies for staff positions. \$1.5

Equipment

1st year: One PC work station to enable Research Analyst position to perform necessary reporting and drafting functions (5.0); one word processing work station (3.5); and desk, chair and needed equipment such as an adding machine (1.0)

9.5

Grants

Assuming that only one-third of the school districts receive the maximum grant award of \$50.0 per year, the annual cost of the grant programs is \$950.0. The maximum cost of the program, if all 55 school districts received the maximum grant award is \$2,750.0.

950.0

TOTAL

\$1037.3

Position Title Research Analyst II		No. of Positions 1	Range/Step 16B	Org. Unit G	
Time Status FT	Staff Months 12	Location Bureau		Election District	
Type of Expenditure		Justification			
Amount		<p>The Research Analyst will perform the functions required under the legislation including:</p> <p>1) Compile summary report to be submitted to the legislature, School Districts and State Board of Education based on data submitted to the Department for each of the 466 schools in the state and 55 school districts.</p> <p>2) Review reports for compliance with statutory requirements and elements required of the plan.</p> <p>3) Serve as grant administrator for award of grants.</p>			
1	2				3
Salary	33.6				
Benefit	12.9				
Premium Pay					
Other					
Total Personal Services	46.5				
Travel					
Contractual					
Commodities					
Equipment					
Other					
Total Cost					
Funding Source for Total Cost					
Federal Receipts	1002				
G. P. Match	1003				
General Fund	1004	46.5			
I A Receipts	1006				
CIP Receipts	1061				
Other					

**Request For
New Position**

Agency Education
 BRU Education Program Support
 Component Basic Education & Instructional Improvement

Page 3 of 4
 Revised Date

FY 90