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FETAL ALCOHOL SYNDROME

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY AND FAMILY POLICY

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

DECEMBER 10, 1990

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MONDAY, DECEMBER 10, 1990

U.S. SENATE,
SUBCOMMITTEE ON SOCIAL SECURITY AND FAMILY POLICY,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Tom Daschle presiding.

[The press release announcing the hearing follows:]

[Press Release No. H-57, Nov. 30, 1990]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON FETAL ALCOHOL SYNDROME; WITNESSES TO TESTIFY ON PREVALENCE, EFFECTS AND SOCIAL SERVICES AVAILABLE

WASHINGTON, DC—Senator Daniel P. Moynihan (D., New York), Chairman of the Senate Finance Subcommittee on Social Security and Family Policy, announced Friday a hearing next month to examine the problem of Fetal Alcohol Syndrome (FAS).

The hearing will be on *Monday, December 10, 1990 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

"The Surgeon General of the United States has stated that there is no safe level of alcohol consumption for pregnant women. Over the past two decades, FAS has come to be known as the leading cause of mental retardation," Moynihan said.

"This hearing is intended to call attention to the prevalence and effects of prenatal exposure to alcohol, and inform the committee about the problems with respect to the availability of social services and foster care for women at risk and their children," Moynihan said.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. The hearing will come to order. Chairman Moynihan is not able to be here today, but I want to thank him for scheduling this important hearing and acknowledge his leadership in the area. An earlier hearing of this Subcommittee focused on the children of crack cocaine and their abusing mothers. That hearing was the impetus for this follow-up hearing on the consequences of alcohol-abusing mothers, fetal alcohol syndrome and fetal alcohol effect.

I also want to thank our witnesses. Some of them have traveled long distances to tell their difficult but important stories. Too many Americans are unaware of the devastating consequences of alcohol use and abuse during pregnancy. Because alcohol is a legal drug few people realize that alcohol, if used during pregnancy, can be just as harmful as crack cocaine or heroin. It's legal so people think it's okay.

That's what Kathleen Tavenner thought. Kathleen has shown a great deal of courage by appearing today to tell her story. She is a recovering alcoholic who has turned her life around completely and is now helping other women do the same for themselves and their children.

When Kathleen was pregnant she abstained from other drugs, to which she was addicted, and replaced them with alcohol, the legal, acceptable thing. But alcohol consumption when a woman is pregnant is not okay. Its use can result in permanent damage to the fetus, damage with which the child and his or her family will live for the rest of their lives.

Kathleen will speak to those consequences this morning. Fetal alcohol syndrome or fetal alcohol effect (FAS or FAE) affects all races and all nationalities and crosses all social and economic boundaries. It is the leading cause of mental retardation in the Western world. The costs associated with it are astronomical.

Every year more than $1.25 billion is spent in this country on medical, residential and support services for FAS victims. Yet very few people understand what a tragic impact FAS and fetal alcohol effect, the less severe form of FAS, are having on the country's children and their families.

I began to understand the enormity of the FAS problem after reading Michael Dorris', "The Broken Cord," which tells the story of his relationship with his adopted child, Adam. Michael's story was particularly moving to me as Adam was born on the Pine Ridge Indian Reservation which I represent.

In his book Mr. Dorris tells of returning to South Dakota to develop a better understanding of his FAS child. I am pleased that he could be with us today to tell his story.

Although FAS has no boundaries its effects are especially felt in Indian country. The rate of FAS on some reservations is seven times the national average. On Pine Ridge, one of every four children is born with fetal alcohol syndrome or fetal alcohol effect, according to some sources.

Jeaneen Grey Eagle comes from Indian country. She lives with these statistics along with the statistics that reflect the many social illnesses associated with poverty, like unemployment rates as high as 85 percent. But I will let Jeaneen Grey Eagle tell her story. She does it convincingly.

Finally, I am troubled by the fact that the American public has not faced up to alcohol's impact on the quality of lives of our children. That a pregnant woman can permanently impair the young life she carries and that that damage, though irreversible, is 100 percent preventable.

I am troubled by this fact because it doesn't have to be this way. I am convinced the American public is well aware of the consequences of smoking. I am convinced the American public knows what can happen when they drink and drive. I am not convinced that the American public is as informed as they should be on the consequences of drinking during pregnancy.

This hearing is intended to focus the public attention on a preventable problem of tragic proportions, to assess the Federal response to that problem, and to begin to look at ways of solving it.

Our first panel this morning will be comprised of Mr. Mark Barnes, the counsel to the Secretary for Drug Abuse Policy, the U.S. Department of Health and Human Services; and Dr. Craig Vanderwagen, the Director of Clinical and Preventive Services at the Indian Health Service. He'll be accompanied by Dr. George Brenneman, the Chief of the Maternal and Child Health Branch, Indian Health Service, U.S. Department of Health and Human Services.

I understand that Mr. Barnes will be late, but I will call him to the table just as soon as he arrives. So let us begin with Dr. Craig Vanderwagen.

Dr. VANDERWAGEN. Good morning, sir. I'm sorry to hold you up. I was having a very nice visit with a couple of the other witnesses here. I think we're going to hear some very interesting things from them.

Senator DASCHLE. Thank you, and thank you for coming, Dr. Vanderwagen. If you'll proceed any way you see fit. The entire text of your statement will be made a part of the record and we encourage you to proceed however you feel comfortable.

Dr. VANDERWAGEN. Okay. Thank you.

I wish that that would be entered in the record and I'll extemporize here for a little bit if I might.

Senator DASCHLE. Without objection.

STATEMENT OF DR. CRAIG VANDERWAGEN, DIRECTOR, CLINICAL AND PREVENTIVE SERVICES, INDIAN HEALTH SERVICE, ACCOMPANIED BY DR. GEORGE BRENNEMAN, CHIEF, MATERNAL AND CHILD HEALTH BRANCH, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. VANDERWAGEN. I think you've highlighted a very significant and important component of our concern about fetal alcohol syndrome, particularly in Native American communities, which is the awareness and the level of commitment to communities to change.

Notwithstanding, I think there is a Federal role that Indian Health Service is working towards. I want to review a couple of basic assumptions and the approach that we take to dealing with fetal alcohol syndrome.

Fetal alcohol syndrome to us is a sentinel event. It indicates a breakdown in a variety of community and family dynamics, and it requires focused and intense intervention. It requires multi-disciplinary teams. It requires outreach, case finding, identification of at-risk mothers and children; and it requires in the first instance a registry of those children who may be affected by fetal alcohol syndrome and fetal alcohol affect.

We have taken an approach in Alaska, for example, and we think this is really a strong and positive way to approach this, of trying to identify all children who may be affected by alcohol, having specialized physicians and staff work with those families, ensure the accuracy of the diagnosis, and work with those mothers to prevent fetal alcohol affect in future children.

We are now attempting to extend this same kind of approach to targeted areas of high risk, including the Aberdeen area which you represent here today, sir. This would include bringing in those

same kind of specialists to assist in identifying children who were affected by this problem and their families, and to provide outreach and family support services.

We believe fetal alcohol syndrome is basically a community problem requiring community change and the Indian Health Service is there to facilitate and support that community change. We think there are model programs in some communities. In Tuba City, Arizona, the Navajo chapter has taken strong responsibility for this and said that we do not want this in our community. And through the Office of Substance Abuse Programs in ADAMHA and through the IHS a very nice community outreach program has been established in Tuba City to identify mothers at risk.

We think this demonstrates the need for our role of full assessment of the situation, providing meaningful data to communities along with technical assistance, so that community policy can be developed to address this. We can also provide program support to assure that the most effective programs are in place.

This summarizes, in general our approach to the issue. There are a number of little vignettes. As a clinician, the thing that always has struck me about Indian Health Service, at least in the last eight or ten years, is that it's hard to walk into an Indian Health Service facility without seeing a poster of FAS affected children, reminding parents, medical staff, and nursing staff to be aware of and to look for FAS.

These posters also usually identify diagnostic criteria which should be employed in identifying these children. And we've gone further, I think, in that our policy and procedures for prenatal care require screening of mothers for an alcohol history. We still think there's a long way to go in training our providers and in training community members about the devastating affects of this problem.

Beyond that, I'd be happy to answer any questions that you have, sir.

Senator DASCHLE. Well thank you, Dr. Vanderwagen. I know this is an area that needs a good deal of study. And even those involved on a daily basis feel frustrated in their inability to develop solid data on the scope and response to the problem.

The first question I have relates to the Office of Fetal Alcohol Syndrome. That was established 2 years ago and it is my understanding that as of today we still haven't staffed that office. Is that correct?

Dr. VANDERWAGEN. Yes. We began recruitment about a year ago this summer for specialists who would come in and provide the kind of insight and guidance that we could use. And, in fact, we were unable to recruit and hire individuals for those positions.

Last year, when we could not find people to fill those positions we have hired outside consultants to perform some of the services we would expect that office to perform. However, the positions are in recruitment phase actively again at this time.

Senator DASCHLE. We don't seem to have any trouble recruiting in other areas. I'm amazed, frankly, that that would be our reason for a two-year delay. You said we started a year ago. The office was authorized 2 years ago. First of all, why would there be a 12-month delay before recruitment would even begin?

Dr. VANDERWAGEN. Identification of the funds, development of the position descriptions, organizational location, a variety of things which are necessary to proceed and actually hire to fill the positions, constitute some of the prerequisite steps.

We did seek the people who we are most interested in recruiting. We sought their input and guidance as to how this might best be developed. National experts, such as Dr. May, gave us a lot of input as to how this program could be established. And before we promulgated those position descriptions, we wanted to make sure that they were guided and targeted at the right kind of efforts. There was a consultation phase as well that interfered with the speedy hiring of these individuals.

Senator DASCHLE. Well speedy hiring is one term for it. Has the speedy hiring, resulted now in the acquisition of qualified staff?

Dr. VANDERWAGEN. We have four individuals identified who have indicated to us that they are ready to come to work for Indian Health Service and we're now in the process of negotiating reporting dates for some of those staff.

Senator DASCHLE. Dr. Vanderwagen, I know this isn't necessarily your responsibility or let me ask you. Whose responsibility is it?

Dr. VANDERWAGEN. That is within my Division.

Senator DASCHLE. It is in your Division?

Dr. VANDERWAGEN. And I would be the responsible party.

Senator DASCHLE. I'm frankly amazed that we weren't able to move any faster than that. Can you give us any assurance that there is a time certain within which these very important positions will be filled?

Dr. VANDERWAGEN. Yes, within the month of January we will have positions filled or at least reporting dates finalized for those individuals who have indicated they would like to come to work for us.

Senator DASCHLE. Including someone to direct the office?

Dr. VANDERWAGEN. Correct.

Senator DASCHLE. Could you give us, as soon as that becomes clear, a specific report on who those people are and their qualifications?

Dr. VANDERWAGEN. Certainly.

Senator DASCHLE. Very good.

I understand that the Fiscal 1991 budget includes $4 million for CDC and IHS to establish a surveillance epidemiology project at the Center for Disease Control to be followed by an IHS prevention and intervention program. Would this be something for the Office of Fetal Alcohol Syndrome to coordinate?

Dr. VANDERWAGEN. Correct.

CDC has recently established their own FAS activity and the collaboration. Coordination between those two would be from that office on the CDC side and from the Director of the program on the Indian Health Service side.

Senator DASCHLE. Could you tell us about the CDC/IHS conference scheduled to be held this spring in Atlanta?

Dr. VANDERWAGEN. CDC is the primary sponsor of that conference and again their focus is not limited to Indian populations but rather would be a national focus on FAS and the known epidemiologic data regarding FAS. The idea behind the meeting, I think, is

to provide pertinent and useful information on a national basis as best we have it, both within CDC and IHS.

Senator DASCHLE. Who will be participating?

Dr. VANDERWAGEN. A wide variety of folks, including people from Indian communities as well as providers and employees of the Indian Health Service. But again, as I noted, this is not primarily noted to Indian populations but has a national focus. So other experts and interested parties would be involved.

Senator DASCHLE. Will tribal representatives be there?

Dr. VANDERWAGEN. We have that as a target population we'd like to attend, yes.

Senator DASCHLE. They have been invited? Is that what you're telling me?

Dr. VANDERWAGEN. I believe the letters have been sent. But I'm not sure about that. It's being handled primarily by CDC and at this point we've given them some names, but I'm not sure that those letters have gone out.

Senator DASCHLE. Could you share that with us as well? I would sincerely hope that tribal representatives from most of the major reservations would have an opportunity to participate in a conference of that kind.

What about physicians and professionals who deal with FAS mothers and children? Will they be invited to come?

Dr. VANDERWAGEN. That's part of the target population for attendance.

Senator DASCHLE. They will be there too?

Dr. VANDERWAGEN. Yes.

Senator DASCHLE. Very well.

Well, Dr. Vanderwagen, I appreciate your coming. We have a lot of witnesses today. I have a practice in my hearings that sometimes works very well, and to the extent you can participate, it would be helpful to me. After all the witnesses have presented their testimony I would like to bring them back to the table so we can discuss many of the issues that were brought up today. To the extent your time would allow or that of Dr. Brenneman, I would be very grateful if you could stay for participation in that discussion.

Dr. VANDERWAGEN. Thank you for the invitation.

Senator DASCHLE. Very good.

[The prepared statement of Dr. Vanderwagen appears in the appendix.]

Senator DASCHLE. Mr. Barnes, we appreciate your presence and we understand the complications, and especially appreciate your willingness to come in spite of your busy schedule. We thank you for being here and would invite you to proceed as you see fit.

STATEMENT OF MARK BARNES, COUNSEL TO THE SECRETARY FOR DRUG ABUSE POLICY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. BARNES. Thank you, Senator. I do appreciate your understanding in the matter. I was delayed with the Secretary at another meeting. But I am very pleased to be here and the Secretary sends his best regards to you and the rest of the members of the Committee, and applauds you for holding this hearing.

Senator, I am Mark Barnes, Counsel to the Secretary for Drug Abuse Policy. And I am pleased to be here today to discuss the problem of fetal alcohol syndrome and other effects of alcohol on pregnancy outcome. As you know, with me at the table are Dr. Craig Vanderwagen and Dr. George Brenneman, both of the Indian Health Service.

The harmful effects of prenatal exposure to alcohol we now know exists on a continuum, ranging from gross morphological defects at the more severe extreme to more subtle, cognitive behavioral disfunctions at the other. As you are aware, most identified cases of FAS in the United States have come from study sites where the mothers were black or American Indian and of low socioeconomic status.

As the Secretary's drug counsel I can tell you there is no public health problem which Dr. Sullivan finds more disturbing than the effects of prenatal exposure to alcohol and other drugs on unborn babies. FAS and FAE are now costing nearly one-third a billion a year to treat and are among the leading causes of mental retardation in the Western world.

But what Dr. Sullivan finds even more appalling is that both are totally preventable. HHS has a wide variety of programs which address the issues related to alcoholism and/or substance abuse. My purpose here today is to give you a brief overview of those programs and activities.

First, let's turn to the research front. Research to determine the nature and extent of exposure to licit and illicit drugs to assess the health consequences of such exposure on the mother, developing infant and child, and to develop improved prevention techniques and treatment is a critical component of the Department's multifaceted approach to dealing with maternal drug abuse.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the preeminent Federal agency for research focused on improving the treatment and prevention of alcoholism and alcohol-related health problems, and in particular the effects of maternal alcohol consumption on pregnancy outcome.

Now prior to the 1970's there were virtually no treatment options for women with alcoholism and other drug addictions. But through the early efforts of NIAAA funding for women's treatment programs, this has increased. Briefly, the Institute supports a wide range of extramural and intramural research projects. The extramural research program awards go to scientists and academic settings and other independent organizations.

In addition, NIAAA maintains an intramural program of biological, epidemiological and clinical research. NIAAA supports cooperative agreements and contracts for studies in areas of special need and for dissemination of scientific findings and research results.

In 1991 the appropriation for NIAAA research is about $140 million. NIDA or the National Institute on Drug Abuse is tracking the incidents and prevalence of alcohol use through its national household survey, the high school senior survey, the drug abuse warning network and the in utero drug abuse survey.

The latter involves personal interviews with pregnant women in hospitals to collect information about their consumption of alcohol in each trimester of their pregnancy.

The Public Health Service Centers for Disease Control, which I understand Dr. Vanderwagen has been going into some detail on this morning, monitors the rate of FAS in its national birth defect monitoring system. The data were used as the basis for the year 2000 prevention objectives for FAS. Since FAS is underreported, CDC is working to improve FAS and FAE surveillance methods in the metropolitan Atlanta congenital defects program and State and local health departments.

Effective in November 1989 it became unlawful to manufacture, import or bottle any alcohol beverage unless the container in which it was sold had a warning about the risks of drinking while pregnant. Future research will assess whether this requirement has had an impact on knowledge, attitudes or behavior related to alcohol consumption during pregnancy.

Briefly I'd like to turn to our prevention programming. Now although many people are aware of increased risk associated with heavy drinking during pregnancy, there is still a need to educate young adults on the specific harmful affects of alcohol exposure on the developing fetus.

Prevention of FAS, as you would expect, is geared to women of childbearing years. In keeping with the 1981 Surgeon General's advisory, which recommended abstinence during pregnancy, these activities are focused a clear no alcohol use message.

The Department has several programs to accomplish this. The Office of Substance Abuse Prevention (OSAP) within the Alcohol, Drug Abuse or Mental Health Administration (ADAMHA) was created by the Anti-Drug Abuse Act of 1986 to lead the Federal Government's efforts toward the prevention and intervention of alcohol and other drug abuse among the Nation's citizens, with special emphasis on youth and families living in high risk environments.

OSAP manages the model program for pregnant and postpardum pregnant women and their infants. This program offers funding for the development of community-based service demonstration projects that propose promising models or innovative approaches to prevent or minimize fetal exposure to alcohol and other drugs. This program is being done in conjunction with the Office of Maternal and Child Health.

In fiscal year 1991 the funding level for the high risk youth and model projects for pregnant and post-pardum women is expected to come in at about $112 million. OSAP's goal is to promote the concepts of no use of any illegal drugs and no illegal or high risk use of alcohol or other legal drugs.

Senator, high risk alcohol use includes drinking and driving, drinking while pregnant, drinking while recovering, drinking when using certain medications, drinking if you're the child of an alcoholic and drinking to intoxication.

The guiding principles behind OSAP's prevention work are based on several premises. First, the earlier prevention is started in a person's life, the more likely it will be a success.

Second, prevention programs should be knowledge based and incorporate state-of-the-art findings and practices drawn from scientific research and expertise from the field.

Third, prevention programs should be comprehensive, including components of education, health care, social service, religion and law enforcement, as well as family involvement.

Fourth, programs should include process as well as outcome evaluations to ensure that knowledge derived from prevention programs is synthesized usefully and disseminated in the field.

And finally, the most successful programs are likely to be those that are initiated and conducted by community members themselves.

To that end, OSAP funds a number of additional prevention programs, although they do not directly focus on maternal drug use, they do provide opportunities for primary prevention.

First, the Community Partnership Grant—which I might add we just announced this year with William Bennett, Director of the Office of National Drug Control Policy—is available to stimulate the formation of local coalitions, consortiums and partnerships for the purpose of developing comprehensive, multi-disciplinary alcohol and drug-abuse prevention systems within local communities. For this fiscal year the program is funded at about $99 million.

Second, the Community Youth Activity Program also provides funding to communities and national organizations with community- based affiliates to establish and evaluate innovative alcohol and drug abuse prevention service programs for youth, especially for those that are in school. This year the funding level will be at about $20 million.

The Centers for Disease Control and the Indian Health Service are exploring ways to work together to prevent FAS and FAE among native Americans. These agencies will work this year in Alaska to evaluate current surveillance efforts and prevention programs. I gather Dr. Vanderwagen has gone into more detail on this. They are also going to be developing a plan to work together in the Aberdeen and Billings service areas as well.

From 1987 through 1989, as a part of the Office of Human Development Services Coordinated Discretionary Program announcement, the Administration for Native Americans funded 14 projects which focused on developing comprehensive prevention strategies to reduce the incidence of alcohol and substance abuse among American Indians.

A cultural approach aimed at traditional native American practices was emphasized. Additionally, ANA has entered into interagency agreements with the Indian Health Service and the BIA to fund alcohol and drug abuse prevention conferences.

The Alcohol, Drug Abuse and Mental Health Block Grant, which will be discussed further in the treatment section, requires that the States use 20 percent of their allotment on prevention activities. So this particular part of the block grant cross supports the programs I've just been mentioning. The total appropriation for the block grant in fiscal year 1991 is about $1.27 billion.

Prevention of FAS also occurs through the Maternal and Child Health Block Grant which was funded at $587 million in fiscal year 1991. The focus here is on comprehensive quality maternal or prenatal care. The Office of Maternal and Child Health also supports such activities through different discretionary grant programs. The Office has been very active in supporting one-stop shopping pro-

grams in local communities to improve access to prenatal care for pregnant women in total, and pregnant alcohol and/or drug abusing women in particular.

Finally, on treatment, again as I stated before, treatment is focused on women of childbearing years. The primary way the Federal Government assists States in their responsibility for alcohol and drug abuse services is through the Alcohol, Drug Abuse and Mental Health Block Grant.

In fiscal year 1991 over $1.2 billion was appropriated for the grant; $317.5 million will be distributed to the States for purposes of providing prevention and treatment services on alcohol abuse.

Now I should note here that the States are required under the provisions of the block grant to use at least 10 percent of their entire allotment for services on women and especially pregnant women.

The Office for Treatment Improvement, which is relatively new in Health and Human Services, only about a year old, in conjunction with the National Institute on Drug Abuse, is developing a series of treatment guidelines that will cover perinatal women and substance exposed infants. These guidelines will focus not only on effective treatment methodologies, but also on efficacious methods of outreach.

Other treatment programs, although they're not directed at maternal drug use, provide further assistance to alcohol or drug abusing individuals and were funded at approximately $60 million in fiscal year 1990. They include the Cooperative Agreement for Treatment Improvement Projects in target cities—an OTI program—which are comprehensive model treatment programs for critical populations, and model drug abuse treatment programs in correctional settings.

Before closing, I would like to speak for a moment about social services. Recent program expansions in the Medicaid program now require States to provide coverage to certain non-AFDC groups, such as pregnant and post-pardum women and their children under 6 years of age and families with incomes below 133 percent of the Federal poverty level, and children up to age 19 who were born after September 30, 1983 in families with incomes below 100 percent of the poverty level.

Medicaid also offers alcohol treatment and other health care services. For categorically eligible individuals States must provide, at a minimum, needed in-patient and out-patient hospital services, rural health clinic services, physician services, nurse/midwife services, services in Federally qualified health centers and early periodic screening diagnosis and treatment.

HCFA is carrying out several demonstration projects to further improve access to care for this population as well. Now recently Maine, Florida and Michigan were selected to test expanding Medicaid eligibility by extending coverage to pregnant women and children under age twenty in families with incomes below 185 percent of the Federal poverty level.

As a part of this initiative, employers are encouraged to become involved in funding participants coverage and premiums, are charged on a sliding scale for families with incomes above the Federal poverty level.

HCFA has also entered into an agreement with the American College of Obstetricians and Gynecologists and the Public Health Service to assist State Medicaid agencies in improving recruitment and retention of obstetrical providers. Jointly, they are addressing such issues as reimbursement levels, procedures, professional liability, provider relations, and the development of practice guides to assist providers in Medicaid participation.

In conjunction with the Office of Maternal and Child Health, the Department of Agriculture's WIC program has initiated outreach activities to the targeted population and will streamline eligibility and case management services.

The Child Welfare Grant reimburses States for 75 percent of their foster care and child welfare services. Now Headstart, which is funded at $1.9 billion for fiscal year 1991 is a comprehensive child development program which serves approximately 450,000 low- income preschool children. The Headstart program estimates that approximately 20 percent of the children in the program have a parent or guardian with substance abuse problems.

A new grant program entitled the "Emergency Child Protection Grant Program" will support a variety of activities to provide protective services of children of drug abusing parents; $19.5 million has been appropriated for this program in 1991.

In closing, Senator, I want to emphasize again that the Department of Health and Human Services considers FAS and FAE a major public health problem. What the future holds is reflected in an ongoing longitudinal study being conducted in Seattle which shows that attentional deficits in children whose mothers drank heavily during pregnancy endure in children in their school age years. How long these deficits persist, and if they hamper classroom learning, remains to be seen. But it is a question whose answer will have a profound impact on the quality of life for future generations.

At this point, Senator, you've already taken the statement from Dr. Vanderwagen and I would be happy to entertain further questions or if you so desire the panel can excuse itself.

Senator DASCHLE. Thank you, Mr. Barnes.

[The prepared statement of Mr. Barnes appears in the appendix.]

Senator DASCHLE. You have laid out in some detail the programmatic responses to the problems related to both drug and alcohol in the country. What evidence can you share with the Subcommittee relating to the success of these programs? What indication is there that all of this programmatic response is actually leading to substantive realization and improvement?

Mr. BARNES. I would say two things. One has to, I think, separate the issues as they relate to the illegal drugs and licit drugs that are being misused. On the use of illegal drugs, the NIDA Household Survey figures show a substantial improvement. Shortly we will be able to share with the American people and the Congress the results from our 1990 Household Survey, hopefully before the end of the year.

Also, in the early part of next year we'll be able to share the results of the NIDA High School Senior Survey which, of course, also gives additional data on alcohol and illegal drug use.

I would say, of course, generally alcohol misuse is still the greatest problem in terms of drug use volume nationally. But we have seen improvements in that area based on our data that has been coming in. But there are obviously still grey areas of concern, as there are on the illegal drug side.

I think you can see from looking at the Department's programs that we are not only addressing the illegal drug issue. We are addressing the issue of misuse of legal substances and putting a much greater focus on it.

The war on drugs that we have been waging, in the opinion of many of us in the Executive Branch, is not without its problems, but it has been going well. There are areas, however, that we need to pay more attention to. I think you'll see in the Administration's upcoming proposals greater efforts being reflected in our plans.

Senator DASCHLE. Let me just restate the question because I probably wasn't very clear. With regard to the legal usage of drugs and our programmatic response to what is clearly an epidemic in the country, is there evidence, and what would that evidence be that our programmatic response is actually working?

Mr. BARNES. I want to get a figure if you'll just allow me a second, Senator.

(Pause.)

Mr. BARNES. I would like to say, sir, that obviously many of the individuals that we're concerned with who are of childbearing age, the younger generation that we're looking at right now, is the generation where obviously we would like to see a drop in alcohol use. As reflected in our High School Senior Survey, we have seen a steady decline in alcohol use over a period of at least the last several years. I will submit those figures to the Committee.

[The facts appear in the appendix.]

Mr. BARNES. I would very definitely point to the decrease in user demand as direct evidence that we are making progress on the prevention side. I think what you are focusing on today is not only the area of prevention but what we can do about people that currently have a problem and have to get into treatment it's an area that, at least from the Administration's standpoint, we're going to be also clearly putting more emphasis on in terms of getting people into treatment and assisting them, not only in illegal drug problems but also for alcohol abuse problems as well.

And as I'm sure Dr. Vanderwagen or others will testify today, we find that most people have polydrug problems, especially on the illegal drug use side. We find that there's a mixture of illegal drugs and alcohol that are being used. So the treatment modalities that have to be brought to bear have to address both of those areas.

Senator DASCHLE. Someone in the Surgeon General's Office reported to my staff that it was their view that HHS was focusing on teenage drinking—and that's laudable—but that there was very little focus on fetal alcohol syndrome (or FAS) that that problem really hadn't received any kind of prioritization within HHS. Can you rebut that statement?

Mr. BARNES. I can tell you about that. Not that I wish to take issue with the statement, but I would expand upon it to say the Secretary is vitally concerned with the misuse of alcohol by young

people, by substance abusing—women, and all Americans who are misusing alcohol.

To that extent we are establishing a special group in the Department of Health and Human Services that will specifically design and improve upon our long-term alcohol strategy. Senator, I might say that it will address many of the issues that you have pointed out—in particular, fetal alcohol syndrome and FAE——not just problem drinking on the part of teenagers and those underage.

We do have programs which address issues of concern to the Committee; we are expanding those programs and emphasizing them. But more importantly, at the senior policy level, we are going to be setting up a long-term vision of how we can move away from the types of horrors that are being described before the Committee today in terms of fetal alcohol syndrome.

Senator DASCHLE. I have been given all kinds of estimates on the degree of the problem that exists, that is fetal alcohol syndrome and effect—how many children are affected, and for that matter how many crack cocaine children are born. How pervasive a problem is it?

I'm concerned, frankly, that no one appears to have a definitive estimate as to how many children afflicted with FAE, FAS or some other drug-related illness are born annually. Can you give me that definitive number?

Mr. BARNES. Well on FAS and FAE I would turn to Dr. Vanderwagen. On the illegal drug side I could comment on that, but I think first Dr. Vanderwagen can comment on FAS and FAE.

Senator DASCHLE. Dr. Vanderwagen.

Dr. VANDERWAGEN. That's a very difficult number. I think in part because of the relative newness of the diagnostic entity of FAS and FAE. I think many physicians, providers in the private sector as well aren't real clear necessarily about the diagnostic criteria and how to employ them.

The best data we have, however, comes from a study that is a surveillance document that CDC does of hospitals and their admitting and discharge diagnoses. And it would indicate that there's a wide variety of rates or incidences of this disease across various ethnic groups.

I don't believe that we feel that these are the best data we could get, but it's the best we have at this time and they show a range of 0.9 or 10,000 births in anglo populations, up to 29.9 in American Indian and Alaska native births per 10,000 births. With black populations being in the range of about 6 per 10,000 births and Hispanics and Asians below those levels.

Senator DASCHLE. Twenty-nine per 10,000 among Indian people?

Dr. VANDERWAGEN. Right.

Senator DASCHLE. We held a hearing with the Indian Affairs Committee and asked a similar question and this probably illustrates the concern that I have. Witnesses at that particular hearing indicated that it may be 20 to 25 with FAS or FAE per 100, not per 10,000.

Would you strongly disagree with that?

Dr. VANDERWAGEN. Again, the data, of course, in this study indicate 29 per 10,000. In the Areas where we have our best IHS data and most comprehensive surveillance systems, based on morpholo-

gic assessment by experts and so on, the rates in those Areas, Alaska and Billings—are about 4 per 1,000 live births.

Now, these rates are based on a follow-up assessment by the dysmorphologist. In fact, does this child meet the criteria and so on. In some other Areas it may be higher. Certainly research data by some academic researchers have indicated higher rates in other IHS Areas. And as I said earlier, we're beginning to focus on that with a dysmorphologic follow-up for the diagnosis.

Senator DASCHLE. So you wouldn't be surprised if it were higher than the figure CDC has listed?

Dr. VANDERWAGEN. In some locations, certainly it could be higher. And that's what we want to learn.

Senator DASCHLE. Yes. Maybe we can flush that out a little bit more in our discussion.

Mr. Barnes?

Mr. BARNES. I was just going to comment real quickly, Senator, that on the illegal drug side, NIDA's epidemiological branch, is greatly expanding its efforts to find out more information on populations we traditionally have not known a great deal about—the homeless, those that are in institutions, those that are simply not picked up in the NIDA household survey in drug abuse or our National Treatment survey that we do every year.

And you will see an expansion in those areas that we feel will not only provide greater information to us in planning Executive Branch policy, but also I think in providing much greater insight for members of Congress into the nature of the drug problem in the country. The expansion would touch upon the drug exposed-infant problem, in particular.

Senator DASCHLE. Are you familiar, Mr. Barnes, with the conference to be held in Atlanta this spring?

Mr. BARNES. I'm sorry, sir, I am not. But I'm sure the IHS physicians are.

Senator DASCHLE. Okay. We talked about it.

Well very well. I thank you both for coming and for participating this morning. Let me just read a statement just handed me by my staff. "A recent study dated October of 1990 show that within the sample of physicians there was 100 percent failure to diagnose FAS/FAE among newborns."

Are you familiar with that, Dr. Vanderwagen?

Dr. VANDERWAGEN. I'm not familiar with that particular study. But as I indicated earlier I think that there is a paucity of knowledge, again given the fact that this is a relatively new diagnostic entity first described in the early 1970's. I think many people who were trained prior to the mid-1980's probably are not fully familiar with FAS. Now newer doctors coming out of residencies may, in fact, be familiar. But older physicians probably aren't. And I think you may hear that from other witnesses today as well.

Senator DASCHLE. Isn't that the problem? I mean how can you categorize, how can you associate any number, how can you associate the instances of FAS/FAE if people don't even know what to look for when the children are born?

Mr. BARNES. I think that's one area that we have a great deal of concern about and the alcohol policy group I described to you, Senator, is established, meeting and formulating the Department's

long-term policies for recommendation to the Secretary. It will definitely be addressing the training of professionals in this area. All key components in Health and Human Services are a part of this alcohol work group.

We see it, quite frankly, strengthening the overall position, policies and programs that the Department has had in substance abuse in general. So that is one area that we would very much want to address.

Senator DASCHLE. I would assume from what you just told me that IHS, HHS would support even more comprehensive work and study to evaluate the scope and the specific problems within the scope that have to be addressed if we're going to effectively deal with this from a national perspective.

Would that be an accurate statement?

Mr. BARNES. I think that would be an accurate statement generally, yes. I think we already are doing that to a great extent. But as we pointed out this morning, more needs to be done and we will be pursuing that.

Senator DASCHLE. Well thank you. Mr. Barnes, you may not have been here, but I encouraged Dr. Vanderwagen and Dr. Brenneman to stay until the end of the hearing if possible in order to participate in a discussion with all the witnesses. To the extent your schedule would allow, I would be very grateful if you could do the same.

Mr. BARNES. Senator, unfortunately I have to return to HHS because there is a White House meeting that I have to attend.

Senator DASCHLE. Very well.

Mr. BARNES. I appreciate very much the invitation. We have however, two very capable physicians here from IHS who would be pleased, I think, to remain behind if that's possible for them.

Senator DASCHLE. Thank you.

Mr. BARNES. Thank you.

Senator DASCHLE. Thank you both.

Dr. VANDERWAGEN. Thank you.

Senator DASCHLE. Our second panel consists of Mr. Michael Dorris the author of "The Broken Cord" and a distinguished professor at Dartmouth College in New Hampshire; and Mrs. Linda Will, the co-founder of the Fetal Alcohol Network, of Coatesville, PA; and Jeaneen Grey Eagle, the director of the Project Recovery from Pine Ridge, SD.

If those three witnesses could come we would appreciate your testimony. Let me welcome each of our panel members and express my sincere gratitude to you for participating in this hearing. To my knowledge it is the first, at least here in the Senate, and I hope not the last hearing on FAS.

I have no particular preference with regard to the order, but we may take then in the order that I called them, Mr. Michael Dorris, Mrs. Linda Will, and Ms. Jeaneen Grey Eagle.

Michael Dorris?

STATEMENT OF MICHAEL DORRIS, AUTHOR, THE BROKEN CORD, CORNISH, NH

Mr. DORRIS. Thank you, Senator. It's a pleasure to be here. I don't speak as an expert in general sense but only as a parent. And as such I am a living encyclopedia of what has not worked in curing or reversing the damage to one child prenatally exposed to too much alcohol.

Certain drugs temporarily curbed his seizures and hyperactivity but their dampening affects on his learning ability and personality development are unknown quantities. Fifteen years of special education, isolation in a classroom, repetitive instruction, hands-on learning, maximized his potential but they didn't add up to a normal IQ.

Psychological counseling, introspective techniques, group therapy have had no positive results and may even have encouraged his ongoing confusion between what is real and what's imagined. Nothing will manufacture brain cells that were never formed in utero. No treatment will ever create in him the ability for normal abstract thought—telling time, dealing with money, relating an act to its eventual consequences.

When you're the parent of an FAS or FAE child your goals change with the passing years. At first you start seeking solutions, ideas and regiments to penetrate the fog that blocks your son's or daughter's ability to comprehend rules, retain information or even be curious. You firmly believe because it has to be true that the answers are out there, it's just a matter of locating them.

My wife and I and our extended families have had no choice but to become a kind of full-time social service agency specializing in referrals, the admissions policies of various expensive institutions, the penalties meted out under the juvenile justice system, the nightmares of doing with uninformed, often smug bureaucrats and physicians given by default responsibility for people who can't make it on their own in contemporary America.

We were forced to progress from attending increasingly sour PTA meetings to learning the intricacies of intelligence testing hoping all the while that the score will come in below 70 and thus qualify for legal disability. We've had to become acquainted with the admissions policies and maximum lengths of stays at institutions like Covenant House, Boys Town and the Salvation Army.

We've paid out well over $150,000, not counting what our insurance has covered for our children's primary and secondary special school tuitions, counseling, doctors of every sort, experimental, medical procedures, outward bound for troubled youth and private camps for the learning disabled.

We have managed to try every single avenue that's been suggested to us by well meaning people who should know what might benefit our children and nothing has consistently worked for more than a few months.

Our FAS and FAE children, now all adults, or nearly so cannot function independently, cannot hold jobs, tell the truth, manage money, plan a future. They have all at one time or another been arrested or otherwise detained for shoplifting, inappropriate sexual conduct, and violent behavior. Despite all of our efforts to protect

them, they have periodically come under the influence of people who, for instance, worship satan or who take advantage of them physically, mentally and/or financially.

They maintain no enduring friendships, set for themselves no realistic goals, can call upon no bedrock intervoice to distinguish right from wrong, safe from dangerous. And, Senator, let me point out that we are not talking when we're speaking of FAS and FAE just of children. These children grow up and they don't get better.

In the year and a half since "The Broken Cord" was published my wife and I have heard from more than 1,000 parents, rich and poor, religious and agnostic, of all ethnic groups and every economic strata. Some live in cities, some in small towns, some on reservations. Some are adoptive parents like us; some are biological. All love their children and almost none have given up hope.

They write with the weary echo of experience, the products of many cycles of raised expectations followed by dejection. They tell of their 50-two-year-old child, their FAE adult daughter who has just given birth to her third FAS baby and is pregnant again and still drinking.

They tell of children serving 20-year prison terms or in one case of a sweet son sentenced to the death penalty for an impulsive murder for which he has never shown the slightest remorse. They tell of children raised in privilege who are now lost among the homeless in distant city streets, of children once so loving and gentle who have been maimed from drug use or knife fights or as is so often the case, who have been raped.

They tell of innocents become prostitutes of inexplicable suicide attempts and always, always of chemical dependency. They tell of children whose whereabouts are unknown or who are dead at 25. This is not the way this was supposed to happen these parents cry. It's not fair; it's not right.

To what extent does this preventable scourge affect American Indian people? The answer, like so much about FAS is ambiguous. On the one hand prenatal exposure to ethanol impairs the individual fetus in exactly the same way, whether its mother is the member of a country club in Greenwich, Connecticut or an ADC mom on White Earth.

Every human being during development is vulnerable, fragile, easy to poison. Ethnicity acts as neither a shield, nor a magnet. Yes, drinking age matters; diet counts; smoking or other drug use will exacerbate the damage done by alcohol, but all things considered physically no woman needs to give birth to an FAS baby.

The factors that really make a difference have to do with the femoral things—strong family and community support for abstinence, access to good prenatal care and chemical dependency treatment, clear and widespread information on the dangers of drinking during pregnancy. And here, native American women are at a severe disadvantage.

Health programs on reservations have been among the first things cut when the Federal budget gets tight. Clinics are shut down, counselors laid off, preventive education campaigns scrapped. Access to organizations like Planned Parenthood is in many tribal communities impossible. Poverty, unemployment, despair, familiar elements in the daily lives of too many Indian

people lead to alcohol and other drug abuse. The long-range roots of the problem and their solution are so much bigger and more complex than just saying no.

When you factor into the statistics on FAS and FAE those having to do with prenatal exposure to crack cocaine which seems to produce in children many of the same learning disabilities as too much alcohol, we are looking at something like 300,000—and that's a conservative figure—impaired babies born in this country annually. In ten years that's three million people. By the time the first generation is counted is twenty, it's 6 million; and that's assuming a stable rate, not the current geometrically accelerating one.

How does our society handle this on slot, either on a local or a national level? How do we make laws that equally apply to those of us who can understand the rules and to a significant minority, who through no fault of their own can't? How do we preserve individual liberty, free choice, safe streets, mutual trust, when some members of society have only a glancing grasp of moral responsibility? How do we cope with the growing crime rate among young people with wielding, with trying to teach the unteachable?

The thorny ethical issue that has troubled me most in thinking about the social impact of FAS and other such life long but preventable afflictions concerns responsibility. When, if ever, are we one-on-one or collectively obliged to intervene?

It's becoming increasingly clear that FAS victims beget more FAS victims. A pregnant woman who can't calculate the long-term consequences of her decisions is a hard case for prenatal counseling. It's difficult, if not impossible, to convince her to defer an immediate gratification because 9 months or nine years later her hypothetical child might suffer from it. That child is an abstraction, a hazy shadow at best, and it's argument is a great deal less compelling than the draw of another drink or fix.

Some studies have suggested that compared to the average woman female FAS and FAE victims start having children younger, continue having them longer, and ultimately conceive and bring to term more offspring. They are less likely to seek prenatal care to abstain from dangerous activities during their pregnancies or to keep custody of their babies.

Statistically a woman who has given birth to an FAS baby has an almost eight out of ten chance to do so again if she continues drinking and subsequent siblings are likely to be even more impaired than the first.

These often abandoned or removed children, whether adopted or institutionalized, are ultimately our culture's victims and therefore are its responsibilities. How do we cope?

At the absolute minimum how do we, especially in a recession economy, pay the medical bills, build the prisons, construct the homeless shelters? How do we train special education teachers how to function indefinitely with no hope of success or ordinary citizens how to forgive behaviors that are irritating at best, threatening or dangerous at worst?

How do we teach compassion for a growing class of people who are likely to exhibit neither pity, nor gratitude, who take everything society has to offer and have almost nothing constructive to give back? How do we maintain the universal franchise to vote the

cornerstone of our political system? How do we redefine not guilty by reason of insanity to apply to heartless acts committed by people who are fundamental incapable of comprehending the law?

To me these questions boil down to a simple analogy. Imagine if we saw a blind woman holding a child by the hand attempt to cross a busy street, the traffic was fast, she guessed wrong and before our eyes her child was struck by a child and killed. A tragedy we would never forget. Then a year later we come by the same intersection again and there is the woman, but with a new child. The light is against her, but she doesn't see and tries to cross to the other side. The child is hit, terribly injured and we stand by helplessly and watch. The next year it happens again, and the next and the next. How many times must it happen before we become involved? Before we take the woman's arm or hold up our hand to stop the cars or carry her child or at least tell her when the signal is green.

How many children are too many? When do their rights to safe passage assert themselves? And how long before the mother herself is killed? For remember, she's a victim and at grave risk too.

It does no good to blame her, to punish her in retrospect for her blindness. Once the street is crossed the child is dead. She needs help and we need to find a decent way to provide it. If we turn our backs and walk away, we stop being innocent bystanders and become complicit in the inevitable accident, accessories after the fact.

Let us make no mistake about one point. We are not facing a crisis; we're in one. FAS is not a problem whose impact is restricted to its victims. It's not just a woman's issue; not just a man's. No one is exempted. These are everybody's children.

Thank you.

Senator DASCHLE. Thank you very much, Michael.

I'll next call on Linda Will.

[The prepared statement of Mr. Dorris appears in the appendix.]

STATEMENT OF LINDA D. WILL, CO-FOUNDER, FETAL ALCOHOL NETWORK, COATESVILLE, PA

Mrs. WILL. I was hoping you were going to ask him some questions so I could recover. Am I close enough now?

Senator DASCHLE. Yes, we can hear you very well.

Mrs. WILL. I'd like to thank you, Senator, for entering my written testimony into the record. I believe the word that Craig Vanderwagen used was extemporanize. I'm going to do that too.

Senator DASCHLE. You're welcome to do anything you want.

Mrs. WILL. Let me say that I am small and I am blind, but I do not have fetal alcohol syndrome. I am very fortunate. My disorder is not changeable either, but it didn't and doesn't prevent me from being a productive person in society.

No matter how you define productivity it's what a person feels about him or herself that matters most. The button that I wear, "NO FAS" really says it all. But in order to prevent FAS/FAE we need to understand a few things. The first drug of choice is alcohol. We are not dealing with drug and alcohol abuse. We are dealing

with drug abuse. No matter what people use to turn on, tune in, trip out, get up, fly away, they always come down with alcohol.

I believe the research supports this statement. So we need to educate those people who have the most impact—the prenatal clinic staff and physicians, social workers. We need to have frequent public service announcements like those which warned us against giving aspirin to our children when they have cold and flu symptoms because of the connection with reye's syndrome. We shouldn't be willing to give alcohol to our unborn either.

If we are pro life, then let's be pro life. Let's give people the quality of life that we all would want. We have to be our brother's keeper. We, you and I, must not feel threatened by the particular prohibition unless, of course, we ourselves are pregnant.

But what about those children already affected? What about those adults already affected? Can we or rather do we want more people imprisoned or homeless, always been jobs, always between relationships, always between living arrangements?

My husband and I have adopted three children who have FAS/FAE. We have very little support, but more than most. For we can speak freely and openly with social workers at Children and Youth, with special education directors and assistant directors at the Intermediate Unit, with MH/MR social workers. There's very little that they can do for us because two of the three children have IQ's above 70.

For us the two of our children who are not mentally retarded are the most difficult to care for because of their behaviors. I recently got a call from a mother whose child had just gotten kicked out of school again. This child has a positive prenatal history for alcohol abuse. He exhibits many of the learning and behavioral characteristics, and yet this child is not diagnosed.

He was denied entrance into special ed because his IQ is average. Even worse, the mother now has no break because he's kicked out of school. She still has to care for him. She is responsible for providing 24-hour structure and supervision. She gets no respite care, no medical assistance, no SSI, no nothing.

She called from Iowa to Pennsylvania in the middle of the day to hear that she wasn't crazy. She needed an empathic ear, someone to listen. These benefits—SSI, medical assistance and so on—are not luxuries. They are necessities and should be provided to people, I would think, without having to be 100 to 185 percent below Federal poverty levels.

Somehow we have to begin educating those persons whose education up until now has been limited or lacking. Social workers who place these children in foster and adoptive homes should be in-serviced and updated so that families caring for their children are prepared adequately. Physicians must become educated and informed, particularly those doctors specializing in obstetrics, pediatrics, developmental pediatrics, family practice, neurology, endocrinology, cardiology, opthamology, psychiatry, and dentistry, just to name a few.

These doctors need to understand that without a diagnosis, without a label, the children and the family will be without services. And yes, of course, I am asking for something from you, Senator, and from your colleagues. We need a redefinition of "developmen-

tal disabilities." One that doesn't rely strictly on IQ to determine severity of handicap. Regulations governing services from town-to-town, county-to-county, state-to-state should be standardized.

In closing, Senator, I'd like to thank you. I guess thank Jeaneen Grey Eagle too, and also your staff, Sarah and Steve, who have been so generous with their time with me. This is a first time testimony for me. I'm willing to entertain questions. I'm very glad to among such knowledgeable people.

Senator DASCHLE. Let me just say that if this is your first time, I can't wait for your 10th or 11th.

Mrs. WILL. Thank you.

Senator DASCHLE. You did a commendable job. I must say I only wish every one of my colleagues would have had the good fortune to have listened to your testimony. It was excellent.

Mrs. WILL. Thank you.

[The prepared statement of Mrs. Wills appears in the appendix.]

Senator DASCHLE. Jeaneen Grey Eagle.

STATEMENT OF JEANEEN GREY EAGLE, DIRECTOR, PROJECT RECOVERY, PINE RIDGE, SD

Ms. GREY EAGLE. Thank you. I'm honored to be here.

On the Pine Ridge Indian Reservation abuses take place in many different forms. We have alcohol abuse, drug abuse, spouse abuse, elderly abuse and the most hideous abuse of all, child abuse.

The abuse of a child is probably one of the most devastating things that can happen over the course of a life time. We all know that if one is abused as a child, the probability to grow up and abuse others is very strong. One of the saddest abuses is prenatal child abuse.

During the time before birth the child should have the right to exist free of any harmful chemicals that cause birth defects or mental retardation. A child's birth right should include the ability to learn, the ability to reason, and most of all a promising future. Many children born to drinking parents will never have the ability to enjoy the simplest things in life, let alone know how to reason or how to plan a future.

During the 1950's and 1960's a drug was prescribed to pregnant women called Thalidomide. This drug caused a variety of birth defects which included children born without arms and legs and also miscarriages. The Food and Drug Administration quickly traced the source of these birth defects and banned the use of Thalidomide by pregnant women. Fortunately, women stopped using Thalidomide as it had no addictive properties.

People clearly understood the direct cause and effect of use equals birth defects and possible death. Each year across this Nation there are thousands of children born to mothers who use alcohol and drugs. Even though it is well documented that alcohol and drugs cause birth defects and miscarriages, the FDA is very slow to act against a very powerful lobbying force, the liquor industry.

As we are all aware chemical dependency is just that, dependency. Simple warning statements on cigarette packages are never read or if they are many people suffer from "it will never happen

to me" syndrome. But maybe there would be more attention paid to this topic if agencies were to get involved and scream from every rooftop about the dangers of alcohol and drugs, much like what happened with Thalidomide. Maybe this approach would also bring much needed funding to provide treatment for pregnant women and their family members.

This is not just a woman thing; this belongs to all of us, men, women equally. We both share responsibility over what happens to our future generations.

In 1988 and 1989 out of a total population of 18,000 people there were 10,269 arrests on my reservation—the Pine Ridge Indian Reservation. Approximately 25 to 30 percent of this total were females. In 1989 and 1990 there were 11,250 arrests with approximately 40 percent of this total being female.

In a review of juvenile arrests most months have an equal amount of female, male arrests with certain months showing more female arrests. The Chief Judge, Pat Lee, feels that 95 percent of all arrests can be attributed to alcohol and drugs. And yet, Pine Ridge is still considered a dry reservation where the use and sale of alcohol is supposed to be prohibited.

The prohibition of liquor on the reservation has led to the same scenario the United States witnessed in the 1920's. Bootlegging, manufacturing and sale of alcohol is rampant on the reservation. The lack of regulation has often resulted in the sale of liquor to children, leading to extremely high rates of juvenile delinquency and teenage pregnancy and consequently harm to unborn children.

As we spend more time and energy in working to rehabilitate many of these juvenile offenders we have discovered a very difficult situation. Many treatment programs we currently use have programs of rehab based on 12-step philosophies. Within this concept behaviors are focused on past, present and future behavior.

A child born with FAS or FAE does not have a basis to work within that realm. The infant mortality rate on the Pine Ridge Reservation and in the Aberdeen area is worse than the countries of Cuba, Bulgaria, and Peru.

In this great land of plenty, many babies are born exposed to such high levels of alcohol and drugs. Before birth they die, are born intoxicated and experience life threatening withdraw shortly after birth. They are doomed to spend the rest of their life with birth defects and/or mental retardation, which is all 100 percent preventable.

According to a 1986 study done by the Children's Defense Fund the State's infant mortality rate per 1,000 life births was 13.3 percent compared to a national average of 10.4 percent. Among nonwhites in South Dakota, 90 percent of whom are native American, the rate was 27.5 percent.

This number means that out of 1,000 babies born in the State of South Dakota 13.3 percent die before reaching age one. For native Americans in the State of South Dakota 27.5 percent of our babies die before their first birthday. I have heard that that number has now increased to 30 plus babies per 1,000. Yet, nobody is asking why.

In 1986 the Children's Defense Fund spokesperson, Joseph Lewis, is quoted as saying, "Generally a 1 year increase like that doesn't

amount to a trend, but what it obviously does indicate, something went wrong that year. South Dakota can't wait another year for a trend to emerge; it has to look into it right away." I remind you this was in 1986.

I am upset that 3 years later we are obviously still waiting to see if a trend has developed and there are more babies dying.

I would like to share a story with you, and sometimes this story is very hard to talk about, but I think it's very necessary. A friend of mine who is a midwife in Pine Ridge talks about a woman who came to the hospital and ready to delivery, and had never been to the prenatal clinic before.

The woman was obviously intoxicated. When the baby was born she couldn't cry and she wasn't breathing. The baby was taken to another room and medically cared for. And when the baby did start to cry she had a strong odor of alcohol on her breath and she was technically passed out.

I know we are all tired of studies, tired because we never see the results or we don't have an understanding of why it is necessary. I advocate that we find out how many amongst us are affected—how many adults, how many children have been born with less than a normal life. An ongoing comprehensive study would allow us the knowledge base to demand resources to address the problem. Many children with special health and educational needs are presently unserved or underserved as we've all heard. Because the extent of their disabilities or cause has never been determined.

It is also felt that in the general population, that if the general population is made more aware of the high numbers of children that are affected, then the implications for future generations could be addressed.

At the present time my tribe is lulled into believing we don't have a problem. This problem has been created by Indian Health in their incomplete and inaccurate study which would have us believe that we only have four to five births per 1,000 are affected with fetal alcohol syndrome.

I have a few recommendations here that I shared with you before and I would just like to mention a few of them that I feel are really important. In listening this morning I would hope that if it takes 2 years to recruit, advertise and select positions for something so vital that maybe the responsibility for that be given to CDC; and we begin as concerned individuals to research a properly legal forum throughout the Nation for prenatal alcohol and drug exposure; and that the Indian Health Service take more of a leadership role in the FAS and FAE field and help us with FAS education, prevention, not only to tribes but to medical staff; and I know that my reservation would definitely benefit from a special needs clinic to determine how many children we do have affected at the present time.

At the present time we have an appropriation of $20,000 which comes to the Aberdeen area, which serves the four State for prevention, education, special needs and I don't feel that that level of funding is very adequate for our needs.

I have a list of people that I think—agencies on reservations, tribal court, social services, Indian Health Service again—receive

training in fetal alcohol so that people are more aware of the extent of the problem and what they're dealing with.

In closing, I would just like to thank you. It's been many years that I think we've felt like Chicken Little and finally that's beginning to change. I would like to thank you for taking the time and the energy necessary to hold this hearing.

Thank you.

Senator DASCHLE. Thank you very much, Jeaneen.

[The prepared statement of Ms. Grey Eagle appears in the appendix.]

Senator DASCHLE. Let me begin by asking a specific question of Linda, and that relates to your desire to redefine developmental disabilities. How would you redefine it?

Mrs. WILL. I've thought a lot about this. Most of the time what happens is that when developmental disabilities are defined that the chief or primary testing is IQ testing. I think it's really significant when you understand that my son, Peter, who has an IQ of 50, a full scale IQ of 50, has a mean mental age in the vineland adaptive behavior scale of 4 years.

That's got to count for something. This child, in other words, is functioning one-fourth of what he could have functioned or should be functioning had he not been exposed to alcohol in utero. I think adaptive behavior scales have to count as much as IQ has to count. I think what a person can show with regard to his or her ability to abstract, as Michael referred to, money and time and just everyday issues that you and I take for granted. When does the bus leave? How do you know? How do you know if you've waited too long? Who's a stranger? Questions like that.

If they are answered—if you ask a lot of these questions and if you get really weird answers you've got to know that this person is not developing normally or has not developed normally and that's got to account for something. This person will never be able to care for him or herself.

And those of us who are caring for them know that we will never be free of responsibility. Not that you're ever free when you're a parent, but I can't ever see a time coming when I won't have to worry about the basic life necessities for children who really will never become adults.

Did that answer your question?

Senator DASCHLE. Well you certainly gave me a much better understanding of the need for the change. I'm not sure I'd be able to write out what that change is at this point. But you clearly have answered my question.

How many children do you have that are FAS/FAE?

Mrs. WILL. We have two children who are FAS, and one child is the older biological sibling of one of the FAS children. So while we can't get a diagnosis he's FAE. He's got the behaviors and some of the specific learning disabilities, although he again doesn't qualify for special ed or any other special services.

We have also another child whom we adopted who was abused at 13 months of age, who is not alcohol-involved. The bonding, I might say, with her, has been, very, very different.

Senator DASCHLE. And they're all teenagers now?

Mrs. WILL. Yes.

Mrs. WILL. 16, 15, 14 and 13. The 15-year-old is not FAS/FAE.

Senator DASCHLE. Michael and Jeaneen, do you share that appreciation for the need for changing the definition of developmental disabilities for purposes of eligibility for programs?

Mr. DORRIS. Absolutely. I think another way of putting it would be functional adaptability. And without a recognition that certain things are permanently impossible what happens is that the child gets mainstreamed if they have a normal IQ and ultimately ejected from the system and into a society that also mainstreams, which has done away with institutions that provide care.

If you're the parent of an FAS—especially with an FAE child who does not qualify for services, you are probably ultimately looking at private care facilities that might run $80,000 a year.

Senator DASCHLE. $80,000?

Mr. DORRIS. $80,000. Some of them up to $18,000 a month. And these are places by in large that don't hold out any prospect of rehabilitation or that your child is going to come out functional within society. But rather, simply holds them until they reach the age of majority. And then again they're out into society.

I think as does Ann Streissguth of the University of Washington, a psychologist, one of the foremost experts on this subject, that as Linda says, the child who is fetal alcohol affected and therefore not clearly diagnosable from a medical point of view or dysmorphological point of view is by far the more complicated child to raise and the more complicated individual in society for the rest of his or her life.

Senator DASCHLE. Some of us are a little more familiar with your family. You have one FAS and two FAE children; is that correct?

Mr. DORRIS. Twenty-two, 16 and 19.

Senator DASCHLE. Jeaneen, would you add anything to what Michael and Linda said about developmental disabilities?

Ms. GREY EAGLE. I would even go more base than that. If you can get a child diagnosed with developmental disabilities that's great from where I come from. Because we can't even get a child diagnosed as FAS or FAE, even if they are born—like the little girl that was born technically passed out has never been diagnosed.

And within Indian Health Service on my reservation, and I can speak this very loud and very clear, that there is a taboo against diagnosing or labeling any child as FAS or FAE. So even just a developmental disability would be like a major step for us to start that child receiving services.

Senator DASCHLE. Now you don't have any adoptive children that are FAS or FAE, but you work with them every day.

Ms. GREY EAGLE. Yes.

Senator DASCHLE. How many children in the course of a week or a month do you deal with who are directly affected by FAS or FAE?

Ms. GREY EAGLE. We refer approximately—well we work with approximately 25 youth a week and out of that number we send maybe seven or eight to treatment a week. And we have never gotten a firm diagnosis from any Indian Health Service organization or agency that any of these children are FAS and FAE. And yet when they get into the State system or go into a treatment system I would say out of eight we get back five suspected FAS or

FAE, five that are suspected of being prenatally exposed to alcohol and their behaviors are representative of that.

One of the things that we have found, and what I mentioned briefly, was treatment or rehab programs work on focusing on future behavior and looking at the past. And if a child is born with FAE just the basics of what is a stranger, how do I make change is something that is so difficult for them to grasp, let alone a 12-step rehab program where you project your future over a period of a life time and say, just say no doesn't work, because it doesn't have any consequences and I just feel for these kids because at the present time there is not a course of rehab. Nobody has discovered a course of rehab that's going to change them unless they're in a constant supervised living situation.

Senator DASCHLE. We talked a little bit about treatment this morning before the hearing. With adequate treatment—and I'm not sure how one defines adequate—but with adequate treatment is an FAE victim capable of learning who a stranger is, and how to make change, and what is right and what is wrong, and some kind of a value system?

Mrs. WILL. Not without supervision and structure constantly. I would——

Senator DASCHLE. You mean perpetual, all the way to year 75?

Mrs. WILL. Yes, sir.

That's what I would say. Wouldn't you?

Mr. DORRIS. Yes, I would. One of the features of this particular problem is an inability to learn from experience so that each case is in effect discreet. You know, you can learn that that person is a stranger. You can learn that this bus goes at this time. But to alter that schedule or to go into a new situation you have to learn it by route all over again. It is not a cumulative kind of learning experience.

And because of that perpetual nature of this problem, the fact that it doesn't change, that it's chronic, I think for the Finance Committee there's a special concern here, if only economic; and that is, that the cost of an FAS or an FAE child to society medically and then in terms of jail or homeless shelters or lost income or theft or any of the things that are likely in the lifetime of an FAE victim or FAS victim, I've heard it said that one could spend more than $20,000 per healthy baby born in preventive education and maintenance and still save money by the society at large.

This is a problem whose cost is growing geometrically and ultimately can overcome our society. I mean FAS victims beget FAS victims; and if we ignore the problem and underrepresent it and talk about these absurdly small figures of people who can be only clearly unambiguously, positively without a doubt diagnosed as opposed to those who workers and teachers and social workers all know absolutely exhibit the unmistakable behavior of FAS and FAE, if we don't look at the big picture, we face the situation of creating a continuing underclass within out society who can't function and who probably will be disruptive of the society as a whole and ultimately make necessary laws that are restrictive to all of us because some of us can't follow them.

Senator DASCHLE. You're talking about an underclass that is completely without the ability to be rehabilitated; is that correct?

Mr. DORRIS. I'm afraid so. So far nothing has worked.

Mrs. WILL. And they have never been habilitated. I think that's the—ycu know, that's the real important issue for me. These kids can't even be habilitated. I'll give you a really basic example. It doesn't matter if I'm talking about the child who has a 50 IQ or the child who has a 100 IQ, an IQ of 100, if my child gets up and his sequence in any way, the sequence of his morning, is broken, he cannot function.

He must literally go back to bed, lie down—This is sounding familiar; isn't it?

Mr. DORRIS. Yes. Yes.

Mrs. WILL. He must lie down. I must awaken him and he must start the whole sequence over. This sometimes means that the child will be illegally absent from school. Because by the time you get him through his sequence it's probably about noon and it doesn't matter if his IQ is 100 or 50. It's the same.

As a matter of fact the child with the IQ of 100 needs more direction and structure and supervision than does the child of 50. The child of the IQ of 50 is perfectly willing to sit and let people do things for him.

Can you agree with—I mean——

Mr. DORRIS. Absolutely.

Senator DASCHLE. Let me just clarify what you said. You said there are estimates that have been provided that we could spend $25,000 per every live healthy birth and in doing so, negate some of the impact of what we're experiencing now with fetal alcohol affect and syndrome. That would be cheaper than what we're doing now, relative to the costs involved with dealing with FAS and FAE victims?

Mr. DORRIS. Absolutely. Most FAS victims are born premature and the cost of getting that child through the first 2 years of life is often several hundred thousand dollars. Then you get into the cost of special education and counseling. You get into the cost of incarceration later in life or of these special holding tank programs or of thefts that are committed by them of lost income, of all of the costs to society that this absolutely preventable problem entails. And it is cheaper to have a decent prenatal education program and drug-free prevention program than to allow this kind of thing to continue.

You know, as a person who came into this issue completely unwillingly—I mean I am not a specialist; I'm a novelist; I'm a teacher—it strikes me as so weird that it has taken us so long to figure out that if you wouldn't give your baby a glass of gin the day after it's born, the same thing applies the day before it's born. It doesn't take a great leap of logic to figure out that alcohol, which everybody agrees is dangerous after birth, is even more dangerous before birth because it forms a total environment.

Senator DASCHLE. But, Jeaneen, I've heard you talk so eloquently about addressing this problem with pregnant mothers, telling them "you're going to have another FAS, FAE child if you drink while you're pregnant." And yet you tell me that they go ahead and drink anyway.

Mrs. WILL. Because they're FAS or FAE.

Ms. GREY EAGLE. I think a part of the problem is that the numbers aren't there to support what we tell them. Without documentation in the child's medical chart it's very difficult to tell a woman your other five children are potentially FAS or FAE. When the doctors will not tell them that, who are you to step in and say you've already had affected children?

Without any type of special needs clinics, without a diagnosis, without the numbers being known, it's highly unbelievable what you're saying. I mean people will not believe what you're saying opposed to what a doctor says. After all, a doctor has gone to medical school, you haven't, and he hasn't said my children are affected.

Senator DASCHLE. I don't understand. You had mentioned and you used the word "taboo" in diagnosis with FAS and FAE. My understanding of taboo is that there's almost a stigma attached to doing it. Why would there be a stigma to diagnosing a child with FAS?

Mr. DORRIS. For one thing, because it's not sometimes clear. It's not like the child is missing a hand or something. You cannot absolutely, especially with FAE, say "this and nothing else," although you can induce this by looking at all of the various symptoms, behavioral and physical and a drinking history in a parent.

The other problem is that as of now there is nothing to say after the diagnosis is made. You'd make a diagnosis to the parent and they say, okay, that's the name of it, how do we cure it, and there's no answer to that. There is no cure. There is no turning around. There is no creating things that were never created in the first place.

Senator DASCHLE. But that would lead me to think that they would be extraordinarily aggressive during pregnancy in advising pregnant mothers not to drink. But you're telling me that these pregnant mothers go to doctors and doctors are telling them nothing. They're not advising them not to drink.

Mrs. WILL. As a matter of fact, they're advising them to drink.

Senator DASCHLE. There can't be any stigma attached to that. Why is that? Why aren't they getting better advice during pregnancy from doctors on that? Can anybody respond to that?

Mr. DORRIS. As has been pointed out before, FAS was only given a name in the 1970's. In fact, the medical text books that were used up to 1975 said that the only reason not to drink during pregnancy was that a woman might gain weight. There were prescriptions in the Old Testament and elsewhere that were conveniently forgotten by modern medicine. So many of recently-trained doctors were tainted with this advice.

There is also an old wive's tale that many doctors pass on that says that you should drink beer while breastfeeding. The New England Journal of Medicine has done a study that shows that 4 months after breastfeeding ceases mothers who drank beer during breastfeeding to make the milk flow, et cetera, their children show certain gross physical deficits that are measurable contrasted with those of mothers who did not drink beer during pregnancy.

There is no, according to the Surgeon General and the March of Dimes and the American Medical Association, no safe level of alcohol intake during pregnancy. Some women can drink in modera-

tion and have healthy children apparently. Some women cannot drink much at all without having damage done to their children. And there is no diagnostic test in advance to say which kind of woman you are; therefore, the only safe thing is abstinence from conception through breastfeeding.

Senator DASCHLE. Is that a universal medically established fact now?

Mr. DORRIS. By people who know what they're talking about, yes. (Laughter.)

Mrs. WILL. In other words, there is very little that I know of that is universally medically established. I know of very few of those of such appropriations or whatever. I think the other reason is because doctors don't want to rock the boat and, you know, they want the mother to get prenatal care and if they offend her by saying, look, you're drinking, I know you're drinking. That's a confrontation. That's not something really people want to do. You know, they don't—Nobody wants to confront somebody else and say, yo, you know, not a doctor, not anybody.

I think that doctors, obstetricians, particularly, once the mother's had the baby and she's had her check up, you know, the baby's in the pediatrician's hands and it's no longer his or her problem.

Senator DASCHLE. I know that Michael has to leave here soon. Let me just ask two other sets of questions. Michael, whenever you have to go you're certainly excused. You've heard our government witnesses describe the programs that are in effect. In fact, we're now spending $140 million for the National Institute on Alcohol Abuse and Alcoholism. $140 million is a pretty good chunk of change.

I asked the question: What evidence is there that that money is producing results? And unfortunately I don't know that I got a very concrete answer. But, you know, it may not be documentable. We're throwing a lot of money at the problem today. And I don't see any evidence that that money appears to be producing results. Could you respond to that skepticism?

Mr. DORRIS. I'll respond to that, Senator, and then I do have to leave. I would just say that if we're spending $140 million—and no disrespect intended—but the Government witnesses are not aware that the problems of learning ability continue on into grade school and later life, that's money wasted.

It has been manifestly clear, since the mid-1970's, that drinking during pregnancy can impair people for life is a totally preventable problem. It took an act of Congress to get the liquor industry to make this warning available to its customers. And I think if we are spending this kind of money where is it going—$20,000 for prevention programs out of the Aberdeen area in South Dakota for a large Indian population. I don't know where it is going but it is not working. This is not a problem that is declining.

Thank you.

Senator DASCHLE. Michael, thank you for coming. I know you have to catch an airplane.

Mr. DORRIS. Thank you, Senator.

Senator DASCHLE. We certainly appreciate it and I'm quite sure we'll be in touch.

Jeaneen?

Ms. GREY EAGLE. I would like to respond to that $140 million and I also wrote another figure down here, something in the millions. I can't even phantom it.

I, this summer, had a phone call from the hospital where they had a 15-year-old who had a blood alcohol level, a lethal blood alcohol level, where she should have been in a coma. She was 3 months pregnant and we could not get one single treatment center to take her. She was a juvenile. She was pregnant. She was high risk.

So for all the millions of dollars that are being spent or appropriated, maybe just appropriated since we haven't filled the positions, I'm not sure, I would like to ask where can I send this 15-year-old for treatment with all these millions of dollars? It hasn't reached me on the reservation.

Senator DASCHLE. What happened to her?

Ms. GREY EAGLE. She is currently expecting her baby next month and we've tried to work with her on an outpatient basis as much as possible. But we cannot care for her 24-hours a day and there have been several more incidents of her consuming alcohol. She is not alone though.

There are a whole bunch of 15 and 14 and 13-year-olds who share her problem. And this millions of dollars that we talk about being appropriated, I can honestly tell you that we do not have resources and that is one of the reasons that I come here today and ask that if this money is truly appropriated, then let's get it allocated and provide the resources for these young people because some of them do want help; and there are agencies willing to help them. We just do not have the dollars to do it.

Senator DASCHLE. Well I must tell you, I may not be representative of my colleagues here, but I don't have any understanding at this point how the money is broken down once it leaves Congress, whether 70 percent of it gets eaten up in administrative costs, whether 70 percent of it actually gets into those places where it can do some good. But we're going to find out. That will be the subject of additional research on our part.

I am concerned. I wasn't aware that we were spending this much money. But, frankly, when you're out in South Dakota, you don't see traces of this money. And I'm sure that would be true in Pennsylvania as well.

Mrs. WILL. Yes, absolutely. Yes, you really don't see it. There aren't any or many treatment centers who will take pregnant women who are alcoholics. And I think very frankly a lot of the interest has gone to, and I was told this by my prevention folks in West Chester, Pennsylvania, that really the interest and the money is in illegal drugs.

And I think that's real sad because you don't use those without using alcohol. You can't separate them. In my mind they're inseparable.

Senator DASCHLE. Let me ask the final question and then we'll go to our final panel. I've been given a number of different recommendations with regard to what our priorities ought to be. Before the hearing, Michael Dorris and I had a chance to visit and he suggested strongly that our first priority ought to be better research with regard to the scope of the problem.

How many people are affected? How many people today are not being diagnosed? Try to get as much information about the pervasive nature of this problem prior to the time we start to address it.

You've also, Linda, recommended that we change the definition of developmental disability. Jeaneen has suggested that we've got to deal with diagnosis a lot more effectively by educating physicians and committing them to respond more effectively on the scene at the time of birth. Those are three priorities.

There was a time when in another hearing when Jeaneen suggested, and I thought very convincingly, that one might even under certain extreme circumstances propose institutionalization, either of a pregnant mother during a pregnancy to keep her from taking alcohol or in some extraordinary cases, perhaps even of FAS victims themselves. Could you give me any sequence in the order of priorities that you would suggest we consider at this point?

Mrs. WILL. I think you have to start with education. I think you have to start with doing a big publicity campaign, I guess, on this. National Public Radio did it; ABC has done it. But I'm not—I'm not aware that it gets very much publicity.

And physicians are just real—If I've heard it once, I've heard it a million times from parents across the country. They say, well, yeah, that's probably what's wrong with him but why would you want to label him that? And, you know, you can't understand the pervasiveness of it if it's being denied.

Senator DASCHLE. Jeaneen?

Ms. GREY EAGLE. I guess one thing that I would like to share that just strikes real close to home with that question is, this summer we had a lady that went into the emergency room that was 6 months pregnant and her head was cut open. And the doctor stitched up the cut in her head and sent her home; and then 3 months later when the baby was born somebody called me from the hospital and said, can you come up and take a peek and see if this is an FAS baby.

And I went up and the baby was starting to go into withdrawals. And I asked—I was really upset because I had found out that the lady was in 3 months prior with a high blood alcohol content and only her head was stitched up. And what I was told is, we don't want to give the doctors too much responsibility in having to call people because they may leave.

And my priority is to get doctors trained so that they can begin because it's at their level that they see a lot of this prenatally afterbirth and they can do a lot to prevent. It's not taught in medical schools.

Senator DASCHLE. What happens when a baby goes into withdrawal?

Mrs. WILL. Tremors. The same as an adult.

Ms. GREY EAGLE. The same as an adult would go into with DTs.

Senator DASCHLE. I'm sorry?

Ms. GREY EAGLE. The same as an adult would go into with DTs. They have tremors very similar to seizures. Well I guess they are seizures.

Mrs. WILL. Intense agitation.

Senator DASCHLE. You're telling me that a doctor who sees that in an infant will still not diagnose a baby as having FAS?

Ms. GREY EAGLE. No, they will not. They will not. It will not even be written into the chart and they will not even pick up the phone to make a phone call when they're faced with an obvious problem. And what upsets me is that if we can't do it at that level, which level—where can we start?

But my priority would be to provide training for the doctors, to provide training at all levels so that people are trained to identify, we can get the numbers of people that are affected and then maybe this $140 million can have an impact. Because as it is now the numbers are so slow—4 out of 1,000. How can you advocate for something that appears to be so low.

And when you sit and you talk about the numbers of women who are arrested and the numbers of people who are drinking it's like you feel real out of place doing it. But I think, like I agree with Michael, a study to determine the extent and also ongoing training for all present doctors would really help a lot.

Mrs. WILL. I think the problem is that we're dealing with an invisible disability that is truly life threatening. Not life threatening the way that we have come to think of life threatening, such as cancer, any of the—AIDS—but it's quality of life threatening and until we do educate, train, inform, we will never understand the full extent of what we are dealing with.

Senator DASCHLE. Well that's an excellent statement to end this panel. We thank you.

And, Jeaneen, thank you very, very much.

To the extent that your schedules will allow, I would like to try a discussion at the end of the hearing. So I may call you back if you're able to come back.

Our third panel is comprised of Ms. Christine Lubinski, director for public safety, the National Council on Alcoholism and Drug Dependence; Ms. Kathleen Tavenner, a certified dependency counselor and regional director of the Community Outreach and Education at Mount Manor Treatment Center in Emmitsburg, MD; and Mr. Gary Kimble, executive director, Association on American Indian Affairs, accompanied by Mr. Jack Trope, the staff attorney from New York.

We thank you very much for coming and appreciate your patience while waiting to testify. Ms. Christine Lubinski first.

STATEMENT OF CHRISTINE LUBINSKI, DIRECTOR FOR PUBLIC POLICY, NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC., WASHINGTON, DC

Ms. LUBINSKI. Good morning, Senator. Thank you very much. It's good to be here. My name is Christine Lubinski and I serve as director for public policy for the National Council on Alcoholism and Drug Dependence. NCADD serves as an advocate for alcoholics, other drug dependent persons, and their families and also for the development of alcohol and drug policies in the best interests of the public health.

We have strong links with community-based organizations with 190 affiliates in 36 states. We have a long history of prevention, education, and advocacy in efforts to reduce the toll of alcohol-related birth defects.

Since 1983 NCADD has launched an annual community-based educational campaign beginning on Mother's Day. We mail 1,500 comprehensive packets to health professionals and other community leaders which include basic information about birth defects associated with alcohol and other drugs, recommendations about strategies to inform the public about the risks of alcohol and drug use during pregnancy and initiatives to encourage the expansion of alcoholism and drug treatment for pregnant women and their children.

We also support legislative and regulatory changes to increase public awareness. In partnership with the Center for Science for the Public Interest, NCADD led the coalition of over 100 organizations which successfully facilitated the adoption of warning label legislation by the Congress. As you know, that label includes a specific warning regarding the risks of drinking during pregnancy and I may add it took us ten years to get it because the influence of the alcohol industry on this body made that a very difficult task. And if any other chemical had the kind of birth defects potency that alcohol had, it wouldn't have taken us ten years.

We've also lent support and technical assistance to dozens of efforts across the country to require warning posters at points of purchase for alcoholic beverages warning consumers about the risk of drinking during pregnancy.

In May 1989 we organized the Coalition on Alcohol and Drug Dependent Women and Their Children as part of our ongoing work to increase access to quality treatment services for alcoholic and drug dependent women and to prevent alcohol and other drug-related birth defects. Our goal was to counteract the growing trend to punish rather than treat pregnant alcoholic and drug dependent women by developing a humane public health response and to unite the various organizations which share a concern about the n any dimensions of maternal and child health.

There is a crisis in maternal drug addiction in America today. In recent months the news media have been filled with articles reporting this tragic story. What has been missing from the media and from the national war on drugs in general is attention to the Nation's most serious drug problem—alcohol and alcohol-related birth defects.

At least 5,000 infants are born each year with full blown FAS and another 35,000 with lesser alcohol-related birth defects. Given, and we've heard a lot of it today, haphazard identification and reporting of FAS in many parts of the country and the absence of reliable diagnostic criteria for FAE, the number of alcohol affected children is probably much higher.

Alcohol, unlike illicit drugs, is widely available, inexpensive and heavily promoted to women. Because of the integration of drinking into American life as well as the depiction of alcohol in ads as appealing, sexy, and benign, we must be vigilant in our efforts to educate all Americans and especially pregnant women about the grave health risks associated with drinking.

If the long term consequences of in utero cocaine exposure are still unclear, the impact of alcohol exposure on human development is all too clear. Mental retardation, heart and limb abnormalities, profoundly limited analytical abilities and poor judgment

are just a few of the deficits faced by FAS children and their families over the course of a life time.

In addition, alcohol affected children are themselves at high risk for the development of alcoholism, triggering an intergenerational cycle of addiction which may haunt a family for decades.

Pregnant alcoholic women and their children are faced with a system of health care poorly suited to meet their many needs. The public alcoholism and drug treatment system is unprepared and sometimes unwilling to provide comprehensive services to pregnant women and their children. The National Association of State Alcohol and Drug Abuse Directors reports that the publicly funded treatment system is able to serve only 11 percent of an estimated 280,000 pregnant, alcoholic and drug dependent women in need of treatment.

Many treatment facilities refuse to accept pregnant women and very few provide child care for infants as well as other dependent children. There is ample evidence that treatment during the course of pregnancy can improve pregnancy outcome. Alcoholism is a treatable disease and millions of individuals and their families have successfully recovered.

In the absence of an environment which encourages alcoholic mothers to seek help and which offers high quality comprehensive treatment services, women die prematurely and children struggle through life with profound disabilities.

The current hostile environment hardly encourages alcoholic women to seek help.

Public attention to alcohol and other drug-affected children has been coupled with growing hostility towards women who use alcohol or other drugs during their pregnancy. Dozens of drug dependent women have been prosecuted for drug use during pregnancy and there has been at least one case of a pregnant alcoholic woman being charged on the basis of her drinking.

In our view these policies are inhumane, fail to recognize alcoholism and drug addiction as illnesses and discourage women from acknowledging their problem and seeking services. Given the notable absence of adequate treatment services virtually anywhere in the Nation, criminal prosecution and other punitive measures blame the victim for a system that is wholly inadequate to meet her needs.

And the consequences for children—increasing numbers of children born with birth defects who languish in actively alcoholic homes or in the Nation's overwhelmed foster care system. Alcohol related birth defects must be addressed as a public health problem with aggressive research, prevention, education and treatment measures.

There are significant steps that Congress can take to ensure that every person in the Nation is aware of the risks associated with alcohol consumption during pregnancy, that every alcoholic and drug dependent woman in the Nation has access to a comprehensive treatment system sensitive to her needs as a woman and a mother and that every child born alcohol affected receives the very best our health, educational and social service systems can provide.

We must develop and institutionalize a basic system of care for pregnant alcoholic and drug dependent women in order to inter-

vene and prevent the long-term and devastating impact of alcohol and drugs on women, their children and families. Treatment is the most important prevention strategy which we can implement to prevent low birth weight, transmission of AIDS and chronic physical and emotional disabilities associated with prenatal exposure to alcohol and other drugs.

Enact a Medicaid family care proposal to finance long-term residential treatment services for pregnant alcoholic and drug dependent women and their children, like that embodied in Senator Moynihan's S. 3002, introduced in the last session. Institutionalize a funding mechanism for quality, comprehensive treatment through Medicaid may be the single most important step Congress can take to ensure the provision of services to these families and to prevent alcohol and other drug-related birth defects.

Fund treatment initiatives for native American, pregnant and post-partum women and their children. And I must say, Senator, that I found the report from the Indian Health Service on their efforts in regard to this particular problem absolutely shameful. And to talk about one residential treatment facility for pregnant women and their children in the Nation for native American people funded by the Government is a disgrace.

Last session several provisions were introduced to address alcoholism among native American women and their children by Senator Kohl; and also a bill crafted by the Select Committee on Indian Affairs, which would support the development and expansion of alcoholism and drug treatment programs to serve this population.

Early intervention in the provision of comprehensive health and social services for mothers and children will greatly reduce the terrible toll of alcoholism and alcohol-related birth defects on the native American community.

We must provide treatment and other health care services for alcoholic and drug dependent women in prison. This is another important population of women, many of whom are mothers, many of whom are pregnant, who currently have no access to alcoholism and drug treatment services or prenatal care.

We must strengthen the accountability mechanisms in the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services Block Grant. This law requires that States spend 10 percent of their block grant funds on new and expanded treatment services for alcoholic and drug dependent women. But the commitment of States in creating women's programs has been minimal. You might want to check and see what's available for women in South Dakota.

Numerous reports document the virtual absence of treatment programs which serve women and their children generally and pregnant women specifically. Congress must ensure that set-aside funds are used to expand services to women and their families. One option is to require States to use a centralized categorical grant process for distribution of funds and report to the Government annually regarding the establishment and expansion of discrete treatment programs which provide services to pregnant women and other women with children.

We need to increase financial support for the pregnant and postpartum women and their infants demonstration projects which are

being administered by the Office for Substance Abuse Prevention. By year's end 100 of the first programs in the country to serve pregnant addicted women and their children will be in operation and these programs will really provide us with critical information about how best to provide services to this population.

In the area of prevention, we need to enact the Sensible Advertising and Family Education Act. This bill was introduced last session by Senator Gore and would require that all alcohol advertisements be accompanied by rotating health messages about alcohol risks, including a specific warning about drinking during pregnancy.

Too few women in America receive prenatal care. And as you've heard all too clearly, too many health professionals still fail to educate their clients about alcohol use during pregnancy. The Federal Government has a responsibility to ensure that the legal drug alcohol is marketed in a fashion that does not compromise the public's health. Requiring specific warnings on alcohol ads will make an enormous contribution to our collective efforts to empower women to make informed choices about their alcohol use.

We should also enact further increases in alcohol excuse taxes, especially on beer and wine. There is a significant body of research that has demonstrated a link between the price of alcohol, the amount of alcohol consumed and the extent of problems attendant on alcohol consumption. Research suggests that both young drinkers and heavy drinkers, including alcoholic people, are sensitive to the price of alcohol.

We need to increase access to services for children with alcohol and other drug-related birth defects. We must ensure that Federal programs which serve the Nation's children are responsive to the special needs of alcohol and other drug affected infants and children. Headstart and pediatric services provided under Medicaid can profoundly influence the quality of life for these children and their families.

Education for the handicapped programs can be enhanced by increasing Federal financial support for specialized instruction and related services under Part B; and by enhancing Part H by making it a permanent program. We should increase Federal financial support so that all States participate and amend the definition of Federal eligibility to include children who are at risk of being developmentally delayed, many of whom have alcohol and drug-related birth defects. And this really gets at the issue you discussed with the last panel.

I would also like to interject here that I think it's important to note that alcohol related birth defects really do exist on a continuum; and I am not convinced that every child born alcohol affected is doomed to a life devoid of independence and quality. I think many of the children, particularly those exposed to lesser amounts of alcohol, know the difference between right and wrong. It may take them several more years to learn how to tell time, but with specialized, individualized instruction, they can lead full and independent lives.

And I think that it is important that we not deal with this population or for that matter the population of so-called crack babies as if they are a throw away population of people.

Real movement in these policy directions will require a fundamental change in the rhetoric and policies now associated with the war on drugs and maybe with Bennett's departure we can begin that movement.

We must recognize alcohol's role as the Nation's favorite drug and the drug which is associated with more mortality and morbidity than all illicit drugs combined and we must approach alcohol and drug problems from a public health perspective. A public health perspective challenges us to change the environment which fosters alcohol and other drug problems—alcohol promotion, poverty, housing shortages, fundamental gaps in our health care system, violence and hopelessness.

NCADD is grateful for this hearing and your interest in this subject. We encourage you to review some of the policy initiatives outlined here and consider taking a role in facilitating their enactment. Alcohol has been sorely neglected in the policy discussions about perinatal addiction and the omission has serious implications for any concerted effort to reduce the numbers of drug affected children.

The very quality of life for thousands of women and their children is at stake.

Thank you very much.

Senator DASCHLE. Ms. Lubinski, thank you very much. You've made a very significant contribution to our hearing and I must tell you this is powerful testimony.

Ms. LUBINSKI. Thank you.

Senator DASCHLE. I intend in every way I can to see that my colleagues have an opportunity to read it and to consider very carefully many of the suggestions you've made. Excellent.

(The prepared statement of Ms. Lubinski appears in the appendix.]

Senator DASCHLE. Ms. Tavenner?

STATEMENT OF KATHLEEN TAVENNER, CERTIFIED CHEMICAL DEPENDENCY COUNSELOR AND REGIONAL DIRECTOR, COMMUNITY OUTREACH AND EDUCATION, MOUNT MANOR TREATMENT CENTER, EMMITSBURG, MD

Ms. TAVENNER. Yes, hi. I'm Kathleen Tavenner. I'm regional director for Mount Manor Treatment Center and I am happy to report that we do have a program for pregnant women and women with small infants and children and I'm really proud to be a part of that. I'd like to thank you for asking me to share my recovery story today. I consider it a privilege and an honor.

I believe to understand the problem of FAS and FAE. We need to begin to understand the problem of alcoholism or chemical dependency to be a little more broad. We need to understand first of all that when someone is suffering from this disease they are in denial. They more or less walk around with blinders on and don't see what's really happening in their lives.

Along with that the families learn denial and along with that the society remains in denial, which is part of the problem. Also remembering that this is a progressive illness. It gets progressively worse.

We've got to learn to pay attention to the solutions. Once we understand what the problem is we need to learn to look at the solution and it's my belief that people living in the solution, people that like myself, are recovering from alcoholism, have a lot of the answers to the solutions of the problems that we're facing.

I sort of like to refer to my disease as a predisposition with a social permission. I think that says it all. It was always okay for me to drink alcohol. I grew up in an alcoholic home. Therefore, the taking in of alcoholic beverages was very familiar to me and very normal, what I considered to be normal.

I also would like to add that I do understand this to be a disease and I believe that my father who has this disease of alcoholism was a sick person and my mother who was co-dependent on my father was also very sick. What happens in alcoholism is that the family's system is also affected as we certainly can see with FAS children. This is a disease that affects the entire family system, whether they drink or not. And they too develop a series of symptoms that are now diagnosable.

My mother became so preoccupied with my father's alcoholism that she wasn't really able to nurture us the way that we needed to be nurtured and supported. And again, my mother's a wonderful person. You know, we went to church every Sunday and I went to parochial schools. But it was her disease, her disease of co- dependency. I bring that up today because I hope that my story may shed a little light on the problem and how it all developed.

How do we get from a kid like myself that was a straight A student, went to church, was involved, the good little girl that wore a little plaid uniform from point A to point B of being a homeless mother, giving birth to an FAS child, a sudden infant death child, many, many tragedies, many—several marriages and just ending up just devastated, with my life devastated.

Anyway what basically happened was I left home very early on. And I bring that up because to understand again a child growing up in that family system I believe is drawn to a life style of drugs and alcohol because they don't have the self-esteem and the social ability just to care about themselves, so they're drawn to that type of life style.

I started using drugs and alcohol very young. I ended up pregnant by the time I was sixteen and because of my Catholic background I was married. The father of the baby was also an alcoholic. We both engaged in a lot of drugs and alcohol and gain, alcohol was my first drug of choice.

What would happen was, back then—let's see, I had my first one in 1971. And my mind set was that of if I don't use illegal drugs it's okay to drink. And back then we really didn't know what we know today about fetal alcohol syndrome and I drank; and I did not drink every day. My disease had not progressed to the point where I was into third stage. I guess I was more of a first-stage alcoholic then.

And my first son was born apparently not affected. My second child was born in 1973. The same mind set. If I wasn't using illegal drugs it was okay for me to drink a little bit of white wine. I did not drink every day. I did not get drunk every day. My drinking

was somewhat sporadic, although much more than a non-alcoholic individual.

I had my child in 1973. She was born with fetal alcohol syndrome; however, I didn't know that. She was born as far as I knew just a normal baby. She was diagnosed with no problems whatsoever as far as I knew. However, I began to notice a lot of developmental delays as Karli began to grow. I compared her to my other son and she was much slower developmentally than he was. I had a third child. That child was the same story and she was not born FAS or FAE. She apparently was not affected by my alcoholism.

The story goes on. I ended up in another marriage and had two more children with that marriage. One of the things we need to look at to understand the disease of alcoholism and why people do some of the things that they do again is to understand the codependency that goes on. In my thinking I was really believing that I wanted to fix my life. And I thought if I have another child I knew that it would force me to get my life together. I knew that my life was out of order, but I didn't know it was because of the drugs and alcohol, especially after Karli was born because she had so many problems.

I really believed I had to drink because I had so many problems in my life. That's part of what goes on. I had two more children, plus to have someone in my mind, someone to love me and to care about me unconditionally was part of the answer for me.

My fourth child was born prematurely and I believe due to my addiction, died within the first 48 hours of his life. My fifth child was born. She appeared to be a healthy baby. However, by then I was on a methadone maintenance program, which is part of one of the programs that $140 million is poured into; and she appeared to be healthy. They didn't give her any drugs to detoxify her. They kept her for the period of—I think it was ten to twelve days which medical assistance will pay for—and released her.

However, she died of sudden infant death syndrome when she was 3 months old. Today I believe the fourth and the fifth child died of alcoholism. FAS, FAE, they were affected by alcohol and drugs.

I also would hope that people here within that message today that there is recovery and there's hope for change. I certainly hope that we hear that the need for intervention. I work a lot today going out and trying to educate individuals about this disease and I have a lot of stories I could share with you about that, about the ignorance associated with this disease.

As long as this disease is looked at a moral issue, as long as we talk about women being prosecuted because they have a disease women are going to go into hiding and families are going to support the hiding and the lying that goes on. I can remember with my fifth child going into this doctor. I found a wonderful, wonderful man who agreed to take care of me and I was scared to death to have this baby. And he would ask me if I was drinking and I would deny it, because I knew that I shouldn't be, yet I didn't know how to stop.

There's a great stigma involved with having this disease. There's a stigma involved just with me getting up today. I went through quite a lot deciding whether this was the right thing for me to do.

Because of the stigmas involved, well she, look what she did to her child. And I can tell you that in sobriety the person I am today I am an advocate for children. I am a very soft and loving and nurturing mother.

I never meant harm to any of my children. It was ignorance and the disease that harmed my child. One of the things I really strive for is early intervention. It's appalling that so many individuals—Think about my story alone. I was on social services for over 15 years. I was on all the programs they had. There's wonderful programs they have.

They had WIC (Women, Infants and Children). They'd bring food to my house. I was a client on HOC (Housing Opportunities Commission). I had five full-term pregnancies. My fourth one was almost full term. And yet no one ever intervened, no one said, Mrs.—my name was Morris—Mrs. Morris, are you having a problem with drugs or alcohol?

Now I did mention with my fifth child the doctor had asked. But see I was on the legal drug methadone. And under a clinic so it was okay for me to admit to that. He did ask me about the drinking and I did deny it. However, I felt that I had to at that time because I—I just—I didn't know what it would mean if I had admitted to that.

And I guess what my point is, we need to get a little bit better at intervention followed up with, you know, what's available and having resources available.

Certainly the objective here is abstinence. What happened for me was I did go through Mountain Manor 7 years ago. I went in there and I truly believed that I was a bad person. I believed I was insane, negligent and pretty hopeless. And they taught me about my disease and that relieved a lot of the stigma for me. I could see it clearly in my family history. There's a lot of alcoholism in my family.

So I began to believe I wasn't such a bad person after all. However, the treatment center was only a 30-day treatment center and I'm talking about a person—here I was I had dropped out of high school. I had no high school education. I had been on welfare for most of my life and I had no job skills. Plus, the only relationships that I had were very co-dependent and drug and alcohol abusive.

So I left there and did not have the skills to stay sober. one of the things that we're lacking today is not only enough treatment centers for pregnant women or women with children, but the other resources as well. And I have to agree with one of the statements I heard here today. I really believe that what has happened is that there are many programs set up that have been in place for a period of years and money still gets poured into them. However, there is no recovery.

And this certainly is my own opinion. You know, where are the results. Are these programs accountable for the results? And this is a general statement certainly. And I really do believe in the competitive bid process as far as solving this problem so that we can pull agencies together.

This is an interagency problem. We're talking about housing, job skills, schooling, day care, testing for the infants and the children, and certainly therapy for the mothers to deal with this. One of the

things we see up at Mountain Manor are women that are pregnant. Most of them we haven't gotten a hold of until they're in their sixth or seventh month with no prenatal care, give birth to drug exposed infants with a whole series of problems, and they need time to process what has happened and the therapy to cope. And they need almost to be walked through the system.

The system is very difficult to work through for those types of individuals, to figure out how do you access services and how do you qualify for them. I had a woman call me Friday afternoon. She was from an upper middle class home and her child had just been diagnosed at 3 years of age with fetal alcohol syndrome and she was devastated and still drinking.

I met with her and she told me that when she was pregnant her doctor told her that as long as she drank under six drinks a day there wasn't any likelihood of fetal alcohol syndrome. She also told me that last year her child was tested at another hospital, a very well-known hospital here in Washington and was diagnosed with something completely different.

She knew in her heart that her child was fetal alcohol syndrome because she was a bright, intelligent woman who had done the research and diagnosed it herself. Her biggest dilemma, however, was how am I going to tell my family, you know, because of the stigmas involved and the ignorance around this disease.

My daughter Karli will be eighteen in February. She will then qualify for SSI. I guess the saddest thing that I have to deal with as her parent is that I have to look at this child and know that the only reason that she's handicapped and retarded today is because I used alcohol during pregnancy.

She goes to a school for special ed children in Montgomery County, Maryland. And I can tell you after doing research on fetal alcohol, knowing what I'm looking for, the school is full of kids with fetal alcohol syndrome, but they're not diagnosed as such.

I can also tell you that raising Karli is now a blessing for me and I do have to disagree with a little bit of what I've heard. I guess this is individual as any disease or handicapped that we're dealing with. I also agree that fetal alcohol effect can be anything from hyperactivity to learning disabilities and the severities. We still don't know—We still don't know what we're dealing with because we've got so much polydrug abuse.

Also, I would like to add that Karli today is—since she's been in a nurturing environment, since I've been sober, that child has changed and I do see that there's an impact on a nurturing home. That is not to say that she is not mentally retarded. That is not to say that she will always be dependent on someone. She will always have to live with me or in a group home. And she's certainly limited.

But I have heard statements, not so much here today, but I've heard statements before where people are afraid that these children are going to be some sort of social deviants and whatnot. And that's just not my experience with my daughter.

My experience is, just to give you an idea what she's like, Karli is a victim of a disease and Karli acts like a victim. My child is very passive, soft and loving and trusting. She certainly does not know the difference between talking to a stranger appropriately or

whatnot. She sets herself up to be a victim and that's of great concern to me today.

Her IQ is about 72. She can't ride a bike. She can't hold a pen in her hand. She's got very slow fine motor skills and gross motor skills. However, she can put something back and I believe that she has put something back today. What she puts back into society is love and sort of a trust, an unknowing trust in people. And I think that's a lot to give back. She gives us a lot back.

I'm just glad that I got treatment finally and I hope that in the future that others get the message so that they don't—we can prevent a lot of these births from happening.

One of the things that I experienced, I ended up in a long-term treatment center, which I forgot to mention and I thought it was important. And it was a very punitive model of treatment. And it was very inappropriate. You know, I believe that. But I went and I needed to be there because I needed a long time. I needed to be somewhere for awhile. And there's a lot of really good people in the field of addiction that know what's needed and we need to get some money and let them do what's needed.

I thank you very much.

Senator DASCHLE. Thank you very much for sharing your experiences with us, Kathleen. We can understand how difficult it must be to talk about a very private matter so publicly. But we need opportunities like this to talk with those who have been victimized and who had the experiences you've had to better understand and we're very grateful.

Thank you.

Ms. TAVENNER. Thank you. I would hope that it would not have to be a very private matter somewhere down the road.

Senator DASCHLE. Thank you.

[The prepared statement of Ms. Tavenner appears in the appendix.]

Senator DASCHLE. Mr. Trope?

STATEMENT OF JACK TROPE, STAFF ATTORNEY, ASSOCIATION ON AMERICAN INDIAN AFFAIRS, NEW YORK, NY

Mr. TROPE. Thank you, Senator Daschle. Let me first express the deep regret of Gary Kimble, our executive director, who expected to be here this morning, but was unexpectedly detained. He has asked me to express his profound regret at not being here at the hearing. My name is Jack Trope and I work for the Association on American Indian Affairs. We are a national Indian advocacy organization and have been long interested in the problem of substance abuse on reservations.

As you may recall, we worked closely with you and your staff—when you were in the House of Representatives—on the Indian Juvenile Alcohol and Drug Abuse Prevention Act which subsequently became part of the Anti-Drug Abuse Bill in an amended form. Much of that work was done by Jerry Flute of our South Dakota field office.

We are very happy to see that this Subcommittee is taking an interest in this problem. The programs which are under your jurisdiction can help to address many of the problems present on reser-

vations specifically FAS and FAE which are the subject of the hearing today.

In some of the testimony today, I heard some things that, even after working in this field, continued to astound me. When Jeaneen Grey Eagle said that they receive only a $20,000 appropriation for prevention on the Pine Ridge Reservation, which is one of the largest reservations in the country as you know, that's just astounding. Working in this field, I know the inadequacy of the resources available. It is clear, as she said that the money is simply not reaching her on the reservation. Our experience indicates that this is true across the country.

As you have recognized the money being spent simply is not working; and that is in spite of the fact that, as the Indian Health Service representative said, we have a $1.27 billion appropriation for the Alcohol, Drug Abuse and Mental Health Block Grant. There is also a $2.7 or $2.8 billion appropriation for the Social Services Block Grant. That is $4 billion right there. There is another $325 million in the Child Welfare Title IV-B budget.

And of all that money, only about $1 million makes it to reservations. The money that makes it to reservations is——

Senator DASCHLE. How much did you say, $1 million?

Mr. TROPE. One million out of all those programs, out of over $4 billion.

Senator DASCHLE. Where did you get that figure?

Mr. TROPE. Well that figure comes from about $500,000—I'm sorry, I must correct myself. About $1 million dollars comes directly from the Federal Government, probably about another $4 to $5 million comes from some pass-through money from the States. The reason for that low figure is that these programs provide little or no money directly to tribes.

The Social Services Block Grant is not provided directly to tribes by the Federal government. Only a handful of States pass through some money—our estimate is about $3 or $4 million nationwide. The Title IV-B program, the Child Welfare Services Program, provides about half a million dollars annually to tribes. And the Alcohol, Drug Abuse and Mental Health Block Grant provides about a quarter of a million dollars or less to tribes because tribes are simply not directly funded under any of those programs for the most part. The money the tribes do receive comes from the Federal Indian Budget. And there are funds that come by way of that budget, but not enough.

We did a study about 3 years ago of all the funding for Indian social services programs anywhere in the Federal budget. The number for all types of services came out to somewhere around $100 million, which is about $60 per person for every kind of social service that you can think of.

Senator DASCHLE. That's everything?

Mr. TROPE. Correct.

Senator DASCHLE. That's not just alcohol and drugs?

Mr. TROPE. Everything.

And as you know Senator Daschle, the Senate Select Committee did a study of the Federal Indian Budget and found that even as inadequate as the domestic budget is for all purposes, over the last 15 years it had nevertheless increased 2 percent annually in real

dollars, notwithstanding its inadequacy. In contrast, the Federal Indian Budget had decreased by 2 percent annually, notwithstanding the problems on the reservation.

As Michael Dorris correctly stated, when there's a Federal budget problem it's often—as he said—it's often the health programs on reservations that are among the first that are shut down. Clinics are shut down, counselors laid off, preventive education campaigns scrapped. And that's certainly been our experience as well.

That's why we appear before you today to ask you, this Committee, to look at some of the programs under your jurisdiction—to perhaps finally provide a stable source of funding for tribes at the grassroots where the money is really needed to operate programs like the one that Jeaneen Grey Eagle is running. I think there are far too few of them.

The Indian Health Service mentioned a program on the Navajo Reservation. As Ms. Lubinski stated, it's probably the only one in the country. That's why they brought it up to you. That just shouldn't be. We advocate for and believe that tribes should get an allocation from the block grants. These block grants are staples of Federal funding for social services, for alcohol and drug abuse problems, for FAS, for FAE, for programs to address all of these sorts of problems which certainly are needed on the reservations as well.

Although they may vary slightly from year to year, the block grants are relatively consistent. They are a little bit less subject to the pressures that affect the Indian budget. We believe tribes should get an allocation from these programs so that they can rely on Federal funding year after year after year.

We have advocated an allocation of 1.5 to 3 percent from these basic programs that would generate enough money to double the amount of money going into social services on reservations. Yet this would only be a small piece of the overall budget. In the last few years some of these block grants have been increased by almost $1 billion in total—the Alcohol, Drug Abuse and Mental Health Block Grant, the Social Services Block Grant and Title IV-B child welfare. And yet nothing has been done to tie tribes into that.

And again, we believe very strongly that this money can be best used at the grassroots tribal level. There was a study done a couple of years ago in the child welfare area where HHS and Interior looked at tribal programs and found that there was such a hodge podge of funding sources the tribes couldn't rely on funds from 1 year to another. And a lot of the funds came from competitive grants which they might have 1 year and lose in another year. They found notwithstanding this funding system because of the professionalism and dedication of program staff, tribes were making a dent in the problem, but just a small dent.

When somebody like Jeaneen Grey Eagle comes before you, that's very typical of the dedicated program people that I've run across and I know you have run across in many of your field hearings—people that are working in this field under conditions where there are so few funds and so little resources to address the problem.

So what we're proposing very specifically, let me read it so it's explicit: We're asking that this Committee require the Secretary of HHS to reserve from 1.5 percent to 3 percent of the Title XX Social Services Block Grant, Title IV-B Child Welfare Services, and Alcohol, Drug Abuse and Mental Health Block Grant appropriations for Indian Tribes. We would ask that the Secretary allocate the money to all tribes as an entitlement, based primarily upon the Indian population on or near the tribe's reservation, except in Oklahoma and Alaska—a special circumstance—with some special consideration for poorer and smaller tribes; that we apply to the tribes all rules and regulations and requirements applicable to States except that the Secretary shall alter them to reflect tribal standards and as necessary because of special tribal conditions; that the legislation provide that the money reserved to these grant programs will be supplemental to existing funds; and that the legislation allow tribes to form consortiums or contract with providers if necessary to administer these programs.

We would just mention one last thing. There are programs that currently have allocations for tribes, for example, the Clean Water Act, some of the education programs, some of the library programs and the recent child care block grant as well, through the efforts of yourself and others. And we believe that this is entirely appropriate, not only from a philosophical standpoint, the tribes as governments providing services to their people, but also because of the reasons you've heard here today.

For some reason when the money comes through the Federal bureaucracy, in inadequate amounts to start with, it doesn't make it down to the grassroots. And if we can, through these block grants make funds available directly to tribes, we think that's the way to get services down on the reservation where they are needed. If some of these programs can provide funding to American Samoa, the Virgin Islands, et cetera, we can also provide funds to tribal governments who have the responsibility to provide services to their people and do it quite effectively when they get the resources to do it.

Thank you for inviting us today.

Senator DASCHLE. Thank you very much.

[The prepared statement of Mr. Trope appears in the appendix.]

Senator DASCHLE. Let me ask you about the CDC conference in Atlanta. Are you familiar with it?

Mr. TROPE. Vaguely, but not too extensively.

Senator DASCHLE. Vaguely?

Mr. TROPE. I know about it. But——

Senator DASCHLE. Has your organization been invited?

Mr. TROPE. We have not been, no.

Senator DASCHLE. Do you expect to be?

Mr. TROPE. Possibly. I'm not sure.

Senator DASCHLE. I understand that tribes have been invited. Has there been much discussion about the response, whether they're planning to go, whether tribes have any ability at this point to become active participants in the conference? I suppose if you're vaguely familiar with it you can't answer that question.

Mr. TROPE. Yes. That would be a difficult question to answer. I think maybe Jeaneen Grey Eagle could.

Senator DASCHLE. Would you do us a favor and get back to us on that? Not necessarily for the record.

Mr. TROPE. Sure.

Senator DASCHLE. I'll tell you, I'm concerned. Because I've heard reports that there isn't going to be much of a role for tribal officials or for people at the grassroots level to participate. And for whatever it's worth, here's one Senator who's going to make darn sure that there's all kinds of involvement, that there's all kinds of participation and that people better be prepared to come back to this Committee and give us a full report as to what happened at that conference.

Whether it's this Committee or Indian Affairs we'll see to it that some follow-up is done. Because I don't want another one of these academic exercises where we talk in only theoretical concepts; and once again, not only the money, but the information never gets down to them. So we're going to follow up with that as well.

I've kept you all over the noon hour, and I apologize for that. But I would like to ask Jeaneen and Linda and Dr. Brenneman to come to the panel, and we'll finish up by having just a short discussion about some of these issues. I would also encourage everybody else to stay.

This may be a little cumbersome in that there are three microphones and many more speakers.

Without ganging up on you, Dr. Brenneman, let me just tell you you've heard a lot of skepticism here. And I must tell you I'm more frustrated now than I was when this hearing began because I see $4.5 billion being allocated by Congress. We've got an incredible debt out there. I don't know where the next million dollars is going to come from for anything around here, and we see an unbelievable need.

Jeaneen tells us that $20,000 have trickled down to Pine Ridge. Most of these people haven't seen the first dollar. You've got one program now, somewhere in New Mexico. I don't mean to minimize that, but as Ms. Lubinski said, that's kind of shameful, frankly.

What's happening? Why isn't all this money—clearly in many cases outside your jurisdiction, so I'm not criticizing you personally—but where in the world is all this money going?

Dr. BRENNEMAN. Well I cannot speak, you know to the huge amount, the $4 billion, you're referring to in the Department. In terms of Indian Health Service I can say that the $20,000, being referred to, is an amount that is earmarked as FAS prevention and it does go out to each of the Indian Health Service Areas. There is a consideration amount——

Senator DASCHLE. $20,000 goes out to each Indian Health Service area?

Dr. BRENNEMAN. $20,000 to each.

Senator DASCHLE. $20,000 per area?

Dr. BRENNEMAN. Yes.

Senator DASCHLE. How many people are in an area?

Dr. BRENNEMAN. That varies considerably. The Navajo tribe would be the largest, approximately 200,000, I believe.

Senator DASCHLE. Two hundred thousand people and you've got $20,000. I don't know what it is in New Mexico or any place else,

but you can hardly hire one person for $20,000. Doesn't that mock the whole thing? I mean really what's $20,000?

Dr. BRENNEMAN. The Indian Health Service, as you well know, is a comprehensive health program and its efforts in health care are broad and therefore many of its resources in providing health care and preventive health care extend into the prevention of FAS, the treatment of alcohol and substance abuse. The $20,000 is an amount which is earmarked to try to initiate some special activities within those areas. But the IHS has, of course, uses many of its general resources in prevention as well.

Senator DASCHLE. Well again I have no intention of finding you personally at fault here, but I must tell you that is just horrendous. I mean that is really unforgivable frankly. What is the total IHS budget?

Dr. BRENNEMAN. I believe the total budget is a little over $1 billion per year.

Senator DASCHLE. One billion. And do you—Would you challenge Mr. Trope's statement that $1 million is now being spent for treatment and prevention of alcoholism?

Dr. BRENNEMAN. Considerably more than that is being spent for the prevention and treatment of alcoholism. I'm not sure what the total alcohol, substance abuse budget is for the Indian Health Service, but it's considerably more than that.

Senator DASCHLE. Mr. Trope?

Mr. TROPE. If I may just clarify. That number referred to the various block grant and other programs under the jurisdiction of this Committee. There is an IHS budget that is larger than that. That's part of that $100 million total from all Federal sources that I quoted.

Within that $100 million are some funds that the Indian Health Service uses for alcohol and substance abuse. But that's still a pitifully small amount nationwide for all Indian social services. So the $1 million dealt with the $4 billion block grant programs under the jurisdiction of this Committee. I was not referring directly to the IHS budget. That wasn't——

Senator DASCHLE. I see. Out of the $4 billion, $1 million is allocated to tribes?

Mr. TROPE. Correct. Out of the over $4 billion in those block grants, only $1 million directly goes out to tribes from the Federal Government.

Senator DASCHLE. You wouldn't contest that, Dr. Brenneman?

Dr. BRENNEMAN. I'm not familiar with those numbers to be able to——

Senator DASCHLE. What would be your—you're in charge of this thing. What would you say is your best guess?

Dr. BRENNEMAN. Well my responsibility is as maternal and Child Health Coordinator for Indian Health Service. Therefore, I am overseeing and coordinating programs that relate to maternal and child health within the Indian Health Service.

I cannot speak to the $4 billion block grants that come through I believe the Bureau of Maternal and Child Health.

Senator DASCHLE. What is your total budget?

Dr. BRENNEMAN. Within the Maternal——

Senator DASCHLE. Yes.

Dr. BRENNEMAN. Maternal and Child Health does not have a budget line item in the Indian Health Service. This position is to coordinate services within the Indian Health Service to try and focus on the needs of mothers and children, Indian mothers and children.

Senator DASCHLE. Well how much do you coordinate then?

Dr. BRENNEMAN. You mean in terms of——

Senator DASCHLE. What is the budget of what you coordinate?

Dr. BRENNEMAN. I cannot give you that number at this time. I'm not familiar with how it's broken out in the other professional disciplines within the Indian Health Service. For example, nursing, has a very broad scope of responsibility and activity including inpatient care as well as public health nursing.

Some of those activities definitely relate to maternal and child health and others don't. The budget just isn't broken out in that way that I can give you an exact number.

Senator DASCHLE. Don't you think that's part of the problem; that we don't know what money is being spent where? I mean, number one, you can't give me a figure; number two, you can't give me an overall assessment of where the money's being spent.

What do you do?

Dr. BRENNEMAN. I think you're sensing——

Senator DASCHLE. In terms of coordinating.

Dr. BRENNEMAN. Your sensing a very important aspect of FAS, as well as some other health problems that not only Indians face, but we face in the country as a whole, and that is that it's an interagency activity and it's multi-disciplinary. It's not possible to find a quick and simple solution to an issue such as FAS and FAE.

It involves social services, it involves medical, it involves outreach with public health nursing, and it involves communities and tribal resources for the Indian Health Service. There are many aspects and it's not really possible to identify a certain amount of funds and then expect to solve the problem. It has to be more integrated and it's very complex.

Senator DASCHLE. A sense that I have, Dr. Brenneman, and I hope that I'm wrong here, because it really doesn't do the valuable services you provide justice, but I sense that HHS and IHS are like sponges. And the bureaucracy is that sponge and it just continues to grow with dollars. That sponge gets larger and larger and it keeps absorbing more and more of the dollars; and the sponge never really releases much. You squeeze the sponge and some of it finally gets down in $20,000 allotments to each area for real treatment at the level that it can do some good.

But my guess is that over 50 percent of all the money we allocate is used up in bureaucracy. I really believe that's true.

And as I say, we're going to find out. You can't provide us with this information, and it's not fair for me to again look at you and put all of this on your shoulders. But it's outrageous. It's absolutely outrageous that we have to sit and listen to the testimony I've heard today, by people whose lives have been affected, who are doing all that they can.

We get agencies of Government, well intended, I'm sure, come before us and say they are spending $4.5 billion. We still have a lot of work to do but we're spending all this money. By God, you know

what, I would almost like to take all of that money, eliminate the bureaucracy in Washington, put it at the grassroots level completely. Eliminate the bureaucracy entirely. I would be willing to subject myself to the abuse and fraud and everything else that comes with that action, but at least I would have the confidence in knowing that that money is getting into the hands of the people that need it the most.

I'm sorry, I just feel very strongly about this matter. As I say, we're going to get to the bottom of all this and you can't do it with one hearing. But we've had some very good testimony here, and we've got to work together. We've really got to work together to make sure we're getting the most out of that money. I don't want any more pointy headed philosophers in colleges somewhere telling me what a social illness is. We don't need that. We have to find out at the local level how Linda Will is going to teach and train those kids.

Is there any disagreement among those who have experience with FAS in terms of the priorities? We've talked a lot about priorities today and I'd like that to be the final subject. What ought to be my marching orders? What can you tell me that hasn't already been said? I know I'm probably asking the impossible—but if I'm going to do one, two and three, who can tell me what one, two and three are as succinctly as we can state it?

Ms. Lubinski?

Ms. LUBINSKI. I'll give it a stab.

Senator DASCHLE. Let's do this. Each person give me your one, two and three priorities and let's see how much of a consensus we've got.

Ms. LUBINSKI. Well my number one is clear for me. That's expanding access to treatment. Because if we get women treated for alcoholism and drug dependence, not just early in pregnancy, but before they're pregnant, we won't have alcohol and drug affected children to contend with.

And since I'm speaking before the Finance Committee, it's the Medicaid expansion. That's number one.

Number two I think is this, for me, is this clarification of developmentally delayed. Whatever efforts need to be made, and it's probably more than one, under the education for the Handicapped Act, under supplemental security income, to ensure that children and adults who are alcohol and drug affected receive access to benefits regardless of their IQ if they can demonstrate this functional impairment must be implemented.

And number three is, I think, just really piggybacking on some of the other efforts we've made to educate the public about the risks of using alcohol during pregnancy and that would be enactment of a bill to put health and safety warnings on alcohol advertisements. But, of course, particularly the issue at hand, a message about the risk of drinking during pregnancy.

Senator DASCHLE. Dr. Brenneman, let's go with you and then we'll just go right on down the line after that.

Dr. BRENNEMAN. The three things that I would put in priority would be to provide preconceptual counseling to all women who are of childbearing age; and to incorporate preconceptual counseling into a prenatal program.

Senator DASCHLE. That's your second one?
Dr. BRENNEMAN. No, that's preconceptual.
Senator DASCHLE. Okay.
Dr. BRENNEMAN. The second would be to, in cooperation with families and in my area, in cooperation with tribal groups, develop a program designed to identify families at risk and institute an outreach effort to those families as soon as the risk is recognized.
And the third thing which is not necessarily the third in priority is physician education. You've heard a lot about that and I certainly am supportive, as a physician, of better physician education about FAS.
Senator DASCHLE. Thank you.
Kathleen?
Ms. TAVENNER. Yes. The first being treatment. We need to be able to have the ability to—when we have a pregnant woman who identifies herself as having chemical dependency that we can get her in a protected environment, and that doesn't mean jail. Jail isn't a protected environment. But in treatment, maybe for the duration of her pregnancy.
I believe there's a lot of other options available if we're working together as an interagency cooperative with housing, et cetera, et cetera, that we wouldn't necessarily have to keep individuals for the duration of their pregnancy. But if so, it would save a lot more money to keep an individual in treatment even if mom chooses to go back and use, at least that infant maybe can be born without the affects of drug and alcohol.
Second of all, I would like to see an all out campaign for the education of our school-aged children about chemical dependency, about the genetic factors involved, and about the devastations of fetal alcohol syndrome and affects. I do a lot of educating in the schools and it's appalling to me that these kids don't even know that if they drink that their children can be affected.
And thirdly, a campaign for educations for doctors, the OB/GYNs, the pediatricians that see these infants and try to break down some of the stigma and combat some of the ignorance that still goes on with chemical dependency and maybe have a substance abuse counselor that would have to be on staff.
You know, I can think of a million ideas. But that would be it, one, two and three. Thanks.
Senator DASCHLE. Very well. Thank you.
Jeaneen?
Ms. GREY EAGLE. I guess coming from the reservation where we feel that our resources are so limited I would like to see a special needs clinic to maybe identify at a certain age. I don't know if that's 10 or 15, or whatever the cut off point is. To identify how many children we do have affected so we can start addressing it medically, socially, as to what the special needs are for these children.
We have many children who need surgery. Medical needs are just horrendous, let alone the educational on down the line.
The second would be treatment on demand. So that when I deal with a pregnant thirteen year old whose been huffing or been drinking that there's a place where she can go if she wants help.

And thirdly, prevention and education on all levels, starting from the very young all the way on up for medical doctors, social workers, and so on. That this Nation become educated. I've seen so many PSAs on alcohol and drugs and yet we don't seem to have any about drinking during pregnancy. And I believe that a nationwide campaign to prevent women from drinking during pregnancy would do a lot to help.

That would be my three.

Senator DASCHLE. Thank you very much.

Mr. Trope?

Mr. TROPE. In terms of the goals, I certainly would subscribe to the ones I've just heard. I'd just like to focus on the mechanism for a minute. I think that we cannot rely solely on the Federal Indian Budget to address the magnitude of this problem. While the Indian Health Service has a role to play, I think it's critical that the resources get to the tribes at the grassroots.

The only really stable, adequate sources of funding that we see out there are the block grants. We would like to see the Committee look at tribal allocations from those block grants so that year in and year out each tribe can rely on a certain amount of funding that it will get from the Social Services Block Grant, the Alcohol, Drug Abuse and Mental Health Block Grant, and the child welfare Title IV-B program.

Senator DASCHLE. Thank you.

Linda?

Mrs. WILL. I would like to support you first of all in your idea to take the money from the bureaucracy and pass it down to the grassroots. The network has been in operation for about 7 months now and I can—we don't even have a budget. We've had some contributions. But I can tell you what we've spent in ball park for everything, how much we've grown and where we are and so on. And I don't understand an inability to know those kinds of facts.

But to answer the question that you asked me, I guess first I would like to go with the redefinition of developmental disabilities or delays. I guess some sort of task force might be a way to go about that. The redefinition of who gets the funding, who gets Medicaid. To think that you'd have to get below 185 percent poverty level to qualify for a program—oh, okay, that's not what they said. But, you know, it's just astounding.

The third thing——

Senator DASCHLE. I'm sorry, the second thing was what? The first thing was redefine development disability.

Mrs. WILL. Yes. Redefining funding.

Senator DASCHLE. Redefining the funding for——

Mrs. WILL. Redefining the funding for medical assistance supplemental security income according to your definition of development disability.

Senator DASCHLE. Okay.

Mrs. WILL. In other words, they sort of go hand in hand.

The third thing that I would advocate is educate the professionals who could have the most impact on prevention and education. That would be doctors, social workers, psychologists, et cetera.

Thank you.

Senator DASCHLE. Well thank you very much. It's past the hour of 1:00 p.m. I think we could go on with more questions and even greater discussion, but I think for 1 day this has been a very helpful hearing and I am so pleased and grateful to each one of you for your participation, for your contribution.

Let me just put out an open invitation. I was telling Jeaneen before we started today that we don't even know the right questions to ask. I mean it's that fundamental for me. I probably missed more opportunities this morning to ask questions than I've succeeded, but you've got to start and with this start comes more education and hopefully better questions, and better hearings, and better understanding, and then better programs.

So it's with a tremendous amount of ignorance that I condemn the bureaucracy. But I must tell you, we really have to work together here. We aren't going to have that many more resources with which to work. So we've got to take those that we've got and make them work better. And we've got to understand in Congress. I mean, really, it's an amazing thing to me that to my knowledge we've only held two or three hearings on FAS and FAE in the entire Congress in all of our history.

So Congress itself is not without blame here. We've got to begin to develop a better program and we've got to require that there is better oversight to see that those dollars are being spent well. But you've got to help us. You've got to volunteer information and direction. Don't wait for the next hearing to contact us and to let us know what we're doing wrong and to let us know what we ought to know in order to make the decisions that we've got to.

Ms. Lubinski, I know I'm speaking especially to the choir when I talk to you because you make it a regular part of your program and I applaud that. But I'm one who hasn't had the benefit of a lot of the good things your organization does. We're going to change that.

I know you've got so many fires out there the last thing you've got to worry about is telling some politician how to run the Government. But we need that. We've got to have your insight and your leadership.

So with that, let me once again thank you all. The hearing is adjourned.

[Whereupon, the hearing was adjourned at 1:04 p.m.].

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF MARK BARNES

Good morning, Senator Daschle. I am Mark Barnes, Counsel to the Secretary for Drug Abuse Policy and I am pleased to be here today to discuss the problem of fetal alcohol syndrome and other effects of alcohol on pregnancy outcome. With me here at the table are Dr. Craig Vanderwagen and Dr. George Brenneman both of the Indian Health Service. You are to be congratulated for holding this hearing. The harmful effects of prenatal exposure to alcohol we now know exist on a continuum, ranging from gross morphological defects at the more severe extreme, to more subtle cognitive-behavioral dysfunctions at the other. And as you are aware, most identified cases of FAS in the United States have come from study sites where the mothers were black or American Indian and of low socioeconomic status. As the Secretary's drug counsel, I can tell you that there is no public health problem which Dr. Sullivan finds more disturbing than the effects of prenatal exposure to alcohol and other drugs on unborn babies. FAS and FAE are now costing nearly $⅓ billion a year to treat and are among the leading causes of mental retardation in the Western world. But, what Dr. Sullivan finds even more appalling is that both are totally preventable.

HHS has a wide variety of programs which address the issues related to alcoholism and/or substance abuse. My purpose here today is to give you a brief overview of those programs and activities.

RESEARCH

Research to determine the nature and extent of exposure to licit and illicit drugs; to assess the health consequences of such exposure on the mother, developing infant and child; and to develop improved prevention techniques and treatment is a critical component of the Department's multifaceted approach to dealing with maternal drug abuse.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the preeminent Federal Agency for research focused on improving the treatment and prevention of alcoholism and alcohol-related health problems and in particular the effects of maternal alcohol consumption on pregnancy outcome. Prior to the 1970's, there were virtually no treatment options for women with alcoholism and other drug addictions, but through the early efforts of NIAAA funding for women's treatment programs has increased.

Briefly, the institute supports a wide range of extramural and intramural research projects. The extramural research program awards grants to scientists in academic settings, and other independent organizations. In addition NIAAA maintains an intramural program of biological, epidemiologic and clinical research. NIAAA supports cooperative agreements and contracts for studies in areas of special need and for dissemination of scientific findings and research results. **The fiscal year 1991 appropriation for NIAAA research is approximately $140 million.**

The National Institute of Drug Abuse (NIDA) is tracking the incidence and prevalence of alcohol use through its National Household Survey, the High School Senior Survey, the Drug Abuse Warning Network, and the In-utero Drug Abuse Survey. The latter involves personal interviews with pregnant women in hospitals to collect information about their consumption of alcohol in each trimester of their pregnancy.

The Public Health Service Centers for Disease Control (CDC) monitor the rate of FAS in its national Birth Defect Monitoring System. These data were used as the

basis for the Year 2000 Prevention Objectives for FAS. Since FAS is underreported, CDC is working to improve FAS/FAE surveillance methods, in the Metropolitan Atlanta Congenital Defects Program and State and local health departments.

Effective November 1989, it became unlawful to manufacture, import, or bottle any alcohol beverage unless the container in which it was sold had a warning about the risks of drinking while pregnant. Future research will assess whether this requirement has had an impact on knowledge, attitudes, or behavior related to alcohol consumption during pregnancy.

PREVENTION

Although many people are aware of increased risks associated with heavy drag during pregnancy, there is still a need to educate young adults on the specific harmful effects of alcohol exposure on the developing fetus.

Prevention of FAS, as you would expect, is geared to women of child bearing years. In keeping with the 1981 surgeon general's advisory, which recommended abstinence during pregnancy, these activities are focused on a clear no-alcohol-use message. The Department has several programs to accomplish this.

The Office of Substance Abuse Prevention (OSAP) within the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was created by the Anti-Drug Abuse Act of 1986 to lead the Federal Government's efforts toward the prevention and intervention of alcohol and other drug abuse among the Nation's citizens, with special emphasis on youth and families living in high-risk environments.

OSAP manages the Model Project for Pregnant and Post-partum Women and Their Infants. This program offers funding for the development of community-based service demonstration projects that propose promising models or innovative approaches to prevent or minimize fetal exposure to alcohol and other drugs. This program is being done in conjunction with the Office of Maternal and Child Health. **The fiscal year 1991 funding level for the High Risk Youth and the Model Projects for Pregnant and Post Partum Women is Approximately $112 million.**

OSAP's goal is to promote the concepts of no use of any illegal drugs and no illegal or high-risk use of alcohol or other legal drugs. (High-risk alcohol use includes drinking and driving, and drinking while pregnant, drinking while recovering, drinking when using certain medications, drinking if a child of an alcoholic, and drinking to intoxication.)

The guiding principles behind OSAP's prevention work are based on the premises that: (1) the earlier prevention is started in a person's life, the more likely is its success; (2) prevention programs should be knowledge-based and incorporate state-of-the-art findings and practices drawn from scientific research and expertise from the field; (3) prevention programs should be comprehensive, including components of education, health care, social service, religion, and law enforcement, as well as family involvement; (4) programs should include process as well as outcome evaluations to ensure that knowledge derived from prevention programs is synthesized usefully and disseminated to the field; and (5) the most successful programs are likely to be those that are initiated and conducted by the community members themselves.

To that end, OSAP funds a number of additional prevention program which, although do not directly focus on maternal drug use, do provide opportunities for primary prevention. First, the Community Partnership Grant is available to stimulate the formation of local coalitions, consortiums, and partnerships for the purpose of developing comprehensive, multi-disciplinary alcohol and drug abuse prevention systems within local communities; **(fiscal year 1991 funding for this program is approximately $99 million.)**

Second, the Community Youth Activity Program also provides funding to communities and/or National organizations, with community based affiliates, to establish and evaluate innovative alcohol and drug abuse prevention services programs for youth, especially for those who are in school. **(In fiscal year 1991 $20 million will be available for this program.)**

The Centers for Disease Control (CDC) and the Indian Health Service (IHS) are exploring ways to work together to prevent FAS/FAE among Native Americans. These agencies will work this year in Alaska to evaluate current surveillance efforts and prevention programs. The agencies will also develop a plan to work together in the Aberdeen and Billings Service Areas.

In fiscal year 87-89, as part of the Office of Human Development Services' Coordinated Discretionary Program Announcement, the Administration for Native Americans funded fourteen projects which focused on developing comprehensive prevention strategies to reduce the incidence of alcohol and substance abuse among American Indians. A cultural approach aimed at traditional Native American practices

was emphasized. Additionally, ANA has entered interagency agreements with the Indian Health Service and Bureau of Indian Affairs to fund alcohol and drug abuse prevention conferences.

The Alcohol, Drug Abuse and Mental Health Block Grant which will be discussed further in the Treatment section, requires that States use 20% of their allotment on prevention activities. **(The total appropriation for the Block Grant in fiscal year 1991 is $1.27 billion.)**

Prevention of FAS also occurs through the Maternal and Child Health Block Grant which was funded at $587 million for fiscal year 1991. The focus here is on comprehensive quality prenatal care. The Office of Maternal and Child Health also supports such activities through different discretionary grant programs. The Office has been very active in, supporting "one-stop shopping" programs in local communities to improve access to prenatal care for pregnant women the total and pregnant alcohol and/or drug abusing women in particular.

TREATMENT

Again, as I stated before, treatment is focused on women of child bearing years. The primary way the Federal Government assists States in their responsibility for alcohol and drug abuse services is through the Alcohol, Drug Abuse and Mental Health Block Grant. In fiscal year 1991 over $1.2 billion was appropriated for the grant; $317.5 million will be distributed to the States for the purposes of providing prevention and treatment services on alcohol abuse.

It should be noted here, that the States are required under the provisions of the Block Grant to use at least 10 percent of their entire allotment on services for women, especially pregnant women.

The Office of Treatment Improvement (OTI) in conjunction with the National Institute on Drug Abuse (NIDA) is developing a series of treatment guidelines that will cover perinatal women and substance-exposed infants. These guidelines will focus, not only on effective treatment methodologies, but also on efficacious methods of outreach.

Other treatment programs, although not directed at maternal drug use, provide further assistance to alcohol or drug abusing individuals and were funded at approximately $60 million in fiscal year 1990. They include the Cooperative Agreements for Treatment Improvement Projects in Target Cities, Model Comprehensive Treatment Programs for Critical Populations, and Model Drug Abuse Treatment Programs for Correctional Settings.

SOCIAL SERVICES

In the Interest of time, the descriptions of the programs I am giving you are necessarily abbreviated. Needless to say, I would be happy to supply you and the committee with more detailed information upon request I will now take you through a very quick review of some of the other programs and activities within the Department which focus on some of the social welfare issues attendant to this special population.

Recent program expansions in the Medicaid program now require States to provide coverage to certain non-AFDC groups, such as pregnant and post-partum women and their children under 6 years of age in families with incomes below 133% of the Federal poverty level and children up to age 19 who were born after September 30, 1983 in families with incomes below 100% of the poverty level. Medicaid also offers alcohol treatment and other health care services. For categorically eligible individuals, States must provide, at a minimum, needed inpatient and outpatient hospital services, rural health clinic services, physician services, nurse midwife services, services in federally qualified health centers, and Early Periodic Screening, Diagnosis and Treatment (EPSDT).

The Health Care Finance Administration (HCFA) is carrying out several demonstration projects to further improve access to care for this population. Recently, Maine, Florida, and Michigan were selected to test expanding Medicaid eligibility by extending coverage to pregnant women and children under age 20 in families with incomes below 185% of the Federal poverty level. As part of this initiative, employers are encouraged to become involved in funding participant's coverage and premiums are charged on a sliding scale for families with incomes above the Federal poverty level.

HCFA has also entered into an agreement with the American College of Obstetricians and Gynecologists and the Public Health Service to assist State Medicaid agencies in improving the recruitment and retention of obstetrical providers. Jointly, they are addressing such issues as: payment levels and procedures; professional

liability; provider relations; and the development of practice guides to assist providers in Medicaid participation.

In conjunction with the Office of Maternal and Child Health, the Department of Agriculture's Women, Infants, and Children program (WIC), has initiated outreach activities to the targeted population, and will streamline eligibility, and case management services.

Through the Office of Human Development Services' (OHDS) Foster Care and Adoption Assistance, Federal subsidies for foster care and adoption services on behalf of children from low income families are provided with a special emphasis on children with special needs. **(Federal funding for these programs is approximately $2 billion for fiscal year 1991.)**

The Child Welfare formula grant reimburses States for 75% of their foster care and child welfare services. Head Start which is funded at $1.9 billion for fiscal year 1991 is a comprehensive child development program which serves approximately 450,000 low income pre-school children. Head Start estimates that approximately 20% of children 1th the program have a parent or guardian with substance abuse problems.

A new grant program. entitled the Emergency Child Protection Grant Program, will support a variety of activities to provide protective services to children of drug abusing parents. $19.5 million has been appropriated for this program in fiscal year 1991.

In closing, Senator Daschle, I want to emphasize again that the Department of Health and Human Services considers FAS and FAE a major public health problem. What the future holds is reflected in an ongoing longitudinal study being conducted in Seattle which shows that attentional deficits in children whose mothers drank heavily during pregnancy endure in children in their school-age years. How long these deficits persist and if they hamper classroom learning remains to be seen, but it is a question whose answer will have a profound impact on the quality of life for future generations.

1989 National High School Senior Drug Abuse Survey "Monitoring the Future Survey"

The 1989 survey on drug use and related attitudes of America's high school seniors is the 15th in an annual series begun in 1975. These surveys are conducted through an ongoing national research and reporting program entitled "Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth." The program is conducted by the University of Michigan's Institute for Social Research and is funded by the National institute on Drug Abuse (NIDA). The study is sometimes referred to as the High School Senior Survey, since each year approximately 16,000 high school seniors are surveyed. However, the study also includes representative samples of young adults from previous graduating classes. NIDA's annual support for the Monitoring the Future program is approximately $1.5 million.

PROCEDURES AND CONTENT

Data from high school seniors are collected during the spring of each year. Data collection takes place in approximately 130 public and private high schools selected to provide an accurate cross section of high school seniors throughout the United States, except in Alaska and Hawaii. Approximately 16,000 seniors have been surveyed each year since 1975. Although most questions, such as those concerning drug use, are asked of all participants, some questions dealing with attitudes, beliefs, and perceptions are asked of only about one-fifth of the respondents. A representative sample of 2,400 individuals is chosen from each class for ongoing follow-up via a mailed questionnaire once every two years (half the group receives a questionnaire each year).

Two major topics in the reports of these surveys are the current prevalence of drug use among American high school seniors and trends in use since 1975. Sixteen classes and subclasses of drugs are covered, including alcohol and cigarettes illicit for minors) and nonprescription stimulants as well as illicit drugs. Also included are age of first use, trends in use at earlier grade level, intensity of drug use, attitudes and beliefs among seniors concerning various types of drug use, and their perceptions of certain relevant aspects of the social environment.

1989 Survey Results

from

Monitoring the Future: A Continuing Study
of the Lifestyles and Values of Youth

Conducted by the University of Michigan
Institute for Social Research

Funded by the National Institute on Drug Abuse

TABLE 1
Sample Sizes and Response Rates

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989
Number public schools	111	108	108	111	111	107	109	116	112	117	115	113	117	113	111
Number private schools	14	15	16	20	20	20	19	21	22	17	17	16	18	19	22
Total number schools	125	123	124	131	131	127	128	137	134	134	132	129	135	132	133
Total number students	15,791	16,678	18,436	18,924	16,662	16,524	18,267	18,348	16,947	16,499	16,502	15,713	16,843	16,795	17,142
Student response rate	78%	77%	79%	83%	82%	82%	81%	83%	84%	83%	84%	83%	84%	83%	80%

TABLE 2

Lifetime Prevalence (Percent Ever Used) of Eighteen Types of Drugs: Observed Estimates and 95% Confidence Limits Class of 1989

(Approx. N = 16700)

	Lower limit	Observed estimate	Upper limit
Marijuana/Hashish	41.6	43.7	45.8
Inhalants[a]	16.5	17.6	18.7
Inhalants Adjusted[b]	*17.3*	*18.6*	*20.0*
Amyl & Butyl Nitrites[c]	2.5	3.3	4.4
Hallucinogens	8.4	9.4	10.5
Hallucinogens Adjusted[d]	*8.9*	*9.9*	*10.9*
LSD[c]	7.4	8.3	9.3
PCP[c]	3.0	3.9	5.0
Cocaine	9.3	10.3	11.4
"Crack"[e]	4.1	4.7	5.4
Other cocaine[c]	7.2	8.5	10.1
Heroin	1.0	1.3	1.6
Other opiates[f]	7.6	8.3	9.1
Stimulants Adjusted[f,g]	*17.7*	*19.1*	*20.5*
Sedatives[f]	6.5	7.4	8.4
Barbiturates[f]	5.7	6.5	7.4
Methaqualone[f]	2.2	2.7	3.3
Tranquilizers[f]	6.7	7.6	8.6
Alcohol	89.1	90.7	92.1
Cigarettes	64.0	65.7	67.4

[a] Data based on five questionnaire forms. N is five-sixths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-sixth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

[e] Data based on two questionnaire forms. N is two-sixths of N indicated.

[f] Only drug use which was not under a doctor's orders is included here.

[g] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

TABLE 4

Lifetime, Annual and Thirty-Day Frequency of Use of Seventeen Types of Drugs, Class of 1989

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRCK[b]	OtCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC
Approx. N =	16700	13900	2800	16700	16700	2800	16700	5500	2800	16700	16700	16700	16700	16700	16700	16700	16700
Lifetime Frequency																	
No occasions	56.3	82.4	96.7	90.6	91.7	96.1	89.7	95.3	91.5	98.7	91.7	80.9	92.6	93.5	97.3	92.4	9.3
1-2 occasions	12.0	10.0	1.7	3.7	3.6	1.9	4.3	2.3	3.7	0.8	3.9	7.7	3.2	3.1	1.4	4.2	8.6
3-5 occasions	6.7	3.3	0.7	2.1	1.6	0.4	1.7	0.7	1.6	0.2	1.9	3.8	1.7	1.3	0.4	1.4	9.8
6-9 occasions	4.5	1.5	0.4	1.1	1.0	0.6	1.1	0.7	1.0	0.1	0.8	2.3	0.7	0.8	0.2	0.8	9.4
10-19 occasions	5.3	1.2	0.1	1.2	0.9	0.2	1.0	0.3	0.7	0.1	0.6	1.9	0.6	0.5	0.3	0.5	13.2
20-39 occasions	4.5	0.6	–	0.5	0.5	0.1	0.7	0.2	0.9	0.1	0.4	1.4	0.4	0.4	0.2	0.3	13.5
40 or more	10.8	1.1	0.5	0.9	0.6	0.7	1.4	0.6	0.8	0.2	0.6	2.0	0.7	0.5	0.2	0.4	36.3
Annual Frequency																	
No occasions	70.4	94.1	98.3	94.4	95.1	97.6	93.5	96.9	94.8	99.4	95.6	89.2	96.3	96.7	98.7	96.2	17.3
1-2 occasions	10.0	3.3	0.9	2.9	2.9	1.2	2.8	1.6	2.3	0.3	2.4	5.3	1.7	1.7	0.7	2.2	16.9
3-5 occasions	5.1	1.1	0.2	1.3	0.9	0.3	1.3	0.6	1.1	0.1	0.9	2.0	0.9	0.7	0.2	0.6	14.1
6-9 occasions	3.3	0.5	0.2	0.5	0.5	0.2	0.6	0.2	0.6	*	0.4	1.3	0.4	0.3	0.2	0.4	10.9
10-19 occasions	3.6	0.4	0.1	0.4	0.4	0.3	0.8	0.3	0.6	0.1	0.4	1.1	0.4	0.3	0.1	0.3	14.1
20-39 occasions	2.5	0.2	–	0.2	0.1	0.1	0.5	0.1	0.3	*	0.1	0.7	0.2	0.1	0.1	0.1	11.5
40 or more	5.1	0.4	0.3	0.2	0.1	0.3	0.5	0.3	0.3	0.1	0.2	0.5	0.2	0.1	0.1	0.1	15.2
Thirty-Day Frequency																	
No occasions	83.3	97.7	99.4	97.8	98.2	98.6	97.2	98.6	98.1	99.7	98.4	95.8	98.4	98.6	99.4	98.7	40.0
1-2 occasions	7.1	1.4	0.2	1.4	1.3	0.9	1.4	0.7	1.2	0.1	0.9	2.2	0.8	0.8	0.3	0.8	23.3
3-5 occasions	2.7	0.3	0.1	0.4	0.3	0.2	0.6	0.2	0.2	0.1	0.2	0.9	0.4	0.3	0.1	0.2	15.2
6-9 occasions	2.0	0.2	*	0.1	0.1	*	0.4	0.1	0.2	*	0.2	0.5	0.1	0.1	0.1	0.1	9.8
10-19 occasions	2.1	0.1	*	0.1	0.1	0.1	0.2	0.1	*	*	0.1	0.3	0.1	0.1	0.1	0.1	7.5
20-39 occasions	1.5	0.1	*	*	*		0.2	0.2	0.1	*	0.1	0.2	0.1	*	*	*	2.4
40 or more	1.4	0.2	0.2	*	*	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	*	*	*	1.8

NOTE: * indicates less than .05 percent. – indicates no cases in category.

[a] Unadjusted for known underreporting of certain drugs. See text for details.

[b] Cocaine data based on six questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

[c] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

TABLE 5

Frequency of Cigarette Use and Occasions of Heavy Drinking
Class of 1989

(Entries are percentages)

	Percent who used
Q. Have you ever smoked cigarettes?	
Never	34.3
Once or twice	28.2
Occasionally but not regularly	15.9
Regularly in the past	6.9
Regularly now	14.7
Approx. N =	(16800)
Q. How frequently have you smoked cigarettes during the past 30 days?	
Not at all (includes "never" category from question above)	71.4
Less than one cigarette per day	9.7
One to five cigarettes per day	7.7
About one-half pack per day	5.4
About one pack per day	4.4
About one and one-half packs per day	1.1
Two packs or more per day	0.3
Approx. N =	(16700)
Q. Think back over the LAST TWO WEEKS. How many times have you had five or more drinks in a row?	
None	67.0
Once	11.1
Twice	8.3
3 to 5 times	9.0
6 to 9 times	2.7
10 or more times	1.9
Approx. N =	(16100)

TABLE 6

Lifetime Prevalence of Use of Eighteen Types of Drugs by Subgroups, Class of 1989

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRCK[b]	OtCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC	CIG
All Seniors	43.7	17.6	3.3	9.4	8.3	3.9	10.3	4.7	8.5	1.3	8.3	19.1	7.4	6.5	2.7	7.6	90.7	67.7
Sex:																		
Male	46.6	21.8	5.4	11.6	10.5	6.2	12.1	6.2	9.7	1.9	9.2	18.7	8.0	6.9	3.6	7.5	91.4	64.3
Female	40.4	13.4	1.6	7.0	6.0	1.9	8.4	3.2	7.3	0.8	7.4	19.4	6.5	6.0	1.7	7.6	90.0	69.8
College Plans:																		
None or under 4 yrs	51.5	20.7	3.7	11.9	10.7	5.6	14.6	6.7	12.2	2.0	10.1	26.0	10.7	9.6	4.4	9.9	91.2	73.5
Complete 4 yrs	39.7	16.2	3.1	8.1	7.1	3.2	8.3	3.7	6.8	1.0	7.4	16.0	5.6	4.9	1.9	6.7	90.4	61.9
Region:																		
Northeast	45.4	15.5	1.7	9.7	8.3	3.3	11.9	4.5	9.1	1.7	8.3	16.4	6.9	6.1	2.7	7.5	93.6	66.1
North Central	46.8	19.3	4.6	10.3	9.3	5.1	8.5	3.2	7.7	1.2	9.6	23.4	7.2	6.3	2.8	8.7	92.8	69.3
South	38.2	17.6	3.7	7.8	6.9	3.4	8.8	4.6	6.5	1.1	6.6	16.9	8.0	7.2	2.7	8.6	87.6	64.1
West	48.4	17.1	2.3	10.9	9.8	3.4	14.7	7.6	13.3	1.5	9.8	20.4	6.9	5.7	2.5	7.4	90.4	64.3
Population Density:																		
Large SMSA	41.4	14.8	3.1	8.7	7.3	5.3	9.9	4.9	8.9	1.0	7.2	13.8	5.7	5.1	2.0	6.5	89.8	62.5
Other SMSA	45.0	17.1	3.3	10.1	9.2	3.6	11.1	5.1	9.3	1.3	8.9	20.4	7.3	6.3	2.9	7.5	91.9	68.4
Non-SMSA	43.2	21.4	3.6	8.6	7.3	3.2	8.9	3.7	6.5	1.5	8.0	21.9	9.3	8.5	3.0	9.1	90.7	69.5
Parental Education:[d]																		
1.0-2.0 (Low)	39.5	18.6	1.8	7.6	6.4	4.6	10.4	4.7	5.4	1.8	6.9	18.8	8.7	8.1	2.7	8.7	84.6	66.8
2.5-3.0	45.5	17.4	3.6	8.4	7.4	4.1	10.1	4.5	7.5	1.3	8.0	21.0	8.2	7.5	2.7	8.2	90.9	68.9
3.5-4.0	45.6	17.8	4.1	9.7	9.0	5.0	10.8	5.0	9.3	1.5	8.6	21.2	7.3	6.1	2.9	7.6	93.1	68.5
4.5-5.0	42.2	17.9	2.2	10.3	9.4	1.8	10.5	4.2	9.0	1.1	8.1	17.1	6.1	5.1	2.5	7.0	91.1	64.4
5.5-6.0 (High)	40.7	16.7	3.8	11.2	9.2	4.3	9.0	4.3	10.9	0.9	10.4	14.3	6.6	6.1	2.6	9.2	91.0	62.0

NOTE: See Table 9 for sample sizes.

[a]Unadjusted for known underreporting of certain drugs. See text for details.

[b]Cocaine data based on six questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

[c]Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[d]Parental education is an average score of mother's education and father's education reported on the following scale: (1) Completed grade school or less, (2) Some high school, (3) Completed high school, (4) Some college, (5) Completed college, (6) Graduate or professional school after college. Missing data was allowed on one of the two variables.

TABLE . .

Annual Prevalence of Use of Eighteen Types of Drugs by Subgroups, Class of 1989

(Entries are percentages)

	MJ	INH[a]	NIT	HAL[a]	LSD	PCP	COKE[b]	CRK[b]	OCCo[b]	HER	OP	STM[c]	SED	BARB	QUA	TRN	ALC	CIG[d]
All Seniors	29.6	5.9	1.7	5.6	4.9	2.4	6.5	3.1	5.2	0.6	4.4	10.8	3.7	3.3	1.3	3.8	82.7	–
Sex:																		
Male	32.8	7.8	3.1	7.4	6.5	4.3	8.1	4.3	6.5	0.9	4.9	11.1	4.2	3.5	1.9	4.9	83.9	–
Female	26.3	4.0	0.6	3.6	3.2	0.8	4.9	1.8	4.0	0.4	3.8	10.5	3.2	3.0	0.7	3.5	81.4	–
College Plans:																		
None or under 4 yrs	34.4	7.1	1.8	7.1	6.5	3.4	9.3	3.8	7.3	0.9	5.3	15.1	5.4	4.8	2.1	4.8	82.9	–
Complete 4 yrs	27.3	5.4	1.7	4.8	4.2	2.0	5.3	2.7	4.2	0.5	3.9	9.1	2.9	2.5	0.9	3.3	82.5	–
Region:																		
Northeast	31.3	6.3	0.8	5.6	5.1	2.7	7.3	3.3	4.9	0.9	4.7	9.0	3.7	3.2	1.4	3.7	86.9	–
North Central	33.0	6.7	2.9	6.6	6.0	3.3	5.3	2.2	4.8	0.6	5.7	13.3	3.5	3.2	1.4	3.1	86.4	–
South	25.0	5.5	1.7	4.9	4.2	2.0	6.0	3.3	4.6	0.6	3.2	9.9	4.2	3.7	1.3	4.4	77.9	–
West	32.3	4.8	1.1	5.5	4.4	1.9	8.5	3.8	7.5	0.7	4.9	11.1	3.2	2.7	1.1	3.4	81.9	–
Population Density:																		
Large SMSA	27.8	5.1	1.6	5.4	4.6	3.0	6.4	3.4	5.6	0.5	4.1	7.1	3.0	2.6	0.9	3.1	81.5	–
Other SMSA	30.3	5.8	2.1	5.9	5.3	2.8	7.1	3.3	5.4	0.7	4.9	11.4	3.7	3.1	1.4	3.5	83.2	–
Non-SMSA	30.0	6.8	0.9	5.0	4.3	1.2	5.4	2.2	4.4	0.8	3.8	13.3	4.7	4.4	1.5	4.9	82.8	–
Parental Education:[e]																		
1.0-2.0 (Low)	23.3	5.9	0.9	4.2	3.6	2.4	6.7	3.1	3.3	0.9	3.6	10.4	4.5	4.1	1.3	3.6	74.1	–
2.5-3.0	29.6	5.5	1.8	4.9	4.3	2.1	6.4	3.1	4.6	0.7	4.0	11.7	3.9	3.4	1.5	3.9	81.9	–
3.5-4.0	31.4	6.1	2.4	5.6	5.1	4.3	6.4	2.8	5.1	0.6	4.6	12.3	3.6	3.2	1.2	3.4	86.0	–
4.5-5.0	29.7	5.7	0.8	6.6	5.9	0.5	7.1	2.6	6.1	0.6	4.2	9.4	3.3	2.8	1.2	3.8	84.1	–
5.5-6.0 (High)	30.7	6.8	2.5	7.0	5.5	2.1	5.8	3.7	6.5	0.4	6.4	9.1	3.8	3.4	1.5	4.9	84.4	–

NOTE: See Table 9 for sample sizes.

[a] Unadjusted for known underreporting of certain drugs. See text for details.

[b] Cocaine data based on six questionnaire forms, "crack" data based on two questionnaire forms, and other cocaine data based on one questionnaire form.

[c] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non prescription stimulants.

[d] Annual prevalence is not available.

[e] Parental education is an average score of mother's education and father's education reported on the following scale: (1) Completed grade [illegible] or less, (2) Some high school, (3) Completed high school, (4) Some college, (5) Completed college, (6) Graduate or professional school after college. Missing data was allowed on one of the two variables.

TABLE 9

Thirty-Day Prevalence of Daily Use of Marijuana, Alcohol, and Cigarettes by Subgroups, Class of 1989

		Percent who used daily in last thirty days				
			Alcohol		Cigarettes	
	N (Approx.)	Marijuana	Daily	5+ drinks[b]	One or more	Half-pack or more
All Seniors	16700	2.9	4.2	33.0	18.9	11.2
Sex:						
Male	8000	4.1	6.0	41.2	17.9	11.2
Female	8300	1.5	2.2	24.9	19.4	10.7
College Plans:						
None or under 4 yrs	4800	4.6	6.1	38.2	27.9	18.6
Complete 4 yrs	11000	2.0	3.2	30.5	14.6	7.5
Region:						
Northeast	3200	3.3	4.3	33.3	21.3	13.6
North Central	4500	3.2	5.1	40.4	23.0	14.2
South	6100	2.6	4.0	28.5	17.1	9.7
West	2900	2.5	3.5	30.8	13.8	6.9
Population Density:						
Large SMSA	4000	2.3	4.0	28.6	16.7	10.1
Other SMSA	8800	3.0	3.9	33.7	19.0	11.2
Non-SMSA	3900	3.3	5.2	35.8	20.9	12.1
Parental Education[a]						
1.0-2.0 (Low)	1700	2.4	3.9	25.4	17.1	11.5
2.5-3.0	4600	2.6	5.0	34.0	21.5	13.5
3.5-4.0	4500	2.6	4.0	34.3	19.0	10.7
4.5-5.0	3500	3.3	3.8	34.2	17.2	9.2
5.5-6.0 (High)	1700	2.7	3.0	31.8	15.8	8.4

[a]Parental education is an average score of mother's education and father's education reported on the following scale: (1) Completed grade school or less, (2) Some high school, (3) Completed high school, (4) Some college, (5) Completed college, (6) Graduate or professional school after college. Missing data was allowed on one of the two variables.

[b]This measure refers to use of five or more drinks in a row in the past two weeks.

TABLE 10
Trends in Lifetime Prevalence of Eighteen Types of Drugs

	Percent ever used														
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	(16700)	
Any Illicit Drug Use[a]	55.2	58.3	*61.6*	*64.1*	*65.1*	*65.4*	*65.6*	*65.8*	*64.1*	–	–	–	–	–	–	
Adjusted Version[b]	–	–	–			–	–	*64.4*	*62.9*	*61.6*	*60.6*	*57.6*	*56.6*	*53.9*	*50.9*	*–3.0ss*
Any Illicit Drug Other Than Marijuana[c]	36.2	35.4	35.8	36.5	37.4	38.7	42.8	*45.0*	*44.4*	–	–	–	–	–	–	
Adjusted Version[b]	..	–	–					*41.1*	*40.4*	*40.3*	*39.7*	*37.7*	*36.8*	*32.6*	*31.4*	*–1.1*
Marijuana/Hashish	47.3	52.8	56.4	59.2	60.4	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2	47.2	43.7	–3.5ss
Inhalants[d]	NA	10.3	11.1	12.0	12.7	11.9	12.3	12.8	13.6	14.4	15.4	15.9	17.0	16.7	17.6	+0.9
Inhalants Adjusted[e]	*NA*	*NA*	*NA*	*NA*	*18.2*	*17.3*	*17.2*	*17.7*	*18.2*	*18.0*	*18.1*	*20.1*	*18.6*	*17.5*	*18.6*	*+1.1*
Amyl & Butyl Nitrites[f,g]	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7	3.2	3.3	+0.1
Hallucinogens	16.3	15.1	13.9	14.3	14.1	13.3	13.3	12.5	11.9	10.7	10.3	9.7	10.3	8.9	9.4	+0.5
Hallucinogens Adjusted[h]	*NA*	*NA*	*NA*	*NA*	*17.7*	*15.6*	*15.3*	*14.3*	*13.6*	*12.3*	*12.1*	*11.9*	*10.6*	*9.2*	*9.9*	*+0.7*
LSD	11.3	11.0	9.8	9.7	9.5	9.3	9.8	9.6	8.9	8.0	7.5	7.2	8.4	7.7	8.3	+0.6
PCP[f,g]	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0	2.9	3.9	+1.0
Cocaine	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2	12.1	10.3	–1.8ss
"Crack"[i]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.4	4.8	4.7	–0.1
Other cocaine[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0	12.1	8.5	–3.6ss
Heroin	2.2	1.8	1.8	1.6	1.1	1.1	1.1	1.2	1.2	1.3	1.2	1.1	1.2	1.1	1.3	+0.2
Other opiates[j]	9.0	9.6	10.3	9.9	10.1	9.8	10.1	9.6	9.4	9.7	10.2	9.0	9.2	8.6	8.3	–0.3
Stimulants[j]	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[h,j]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	27.9	*26.9*	*27.9*	*26.2*	*23.4*	*21.6*	*19.8*	*19.1*	*–0.7*
Sedatives[j]	18.2	17.7	17.4	16.0	14.6	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7	7.8	7.4	–0.4
Barbiturates[j]	16.9	16.2	15.6	13.7	11.8	11.0	11.3	10.3	9.9	9.9	9.2	8.4	7.4	6.7	6.5	–0.2
Methaqualone[j]	8.1	7.8	8.5	7.9	8.3	9.5	10.6	10.7	10.1	8.3	6.7	5.2	4.0	3.3	2.7	–0.6
Tranquilizers[j]	17.0	16.8	18.0	17.0	16.3	15.2	14.7	14.0	13.3	12.4	11.9	10.9	10.9	9.4	7.8	–1.6ss
Alcohol	90.4	91.9	92.5	93.1	93.0	93.2	92.6	92.8	92.6	92.6	92.2	91.3	92.2	92.0	90.7	–1.3
Cigarettes	73.6	75.4	75.7	75.3	74.0	71.0	71.0	70.1	70.8	69.7	68.8	67.8	67.2	66.4	65.7	–0.7

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Use of "any illicit drugs" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[b] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[c] Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[d] Data based on four questionnaire forms in 1976–1988; N is four-fifths of N indicated. Data based on five questionnaire forms in 1989; N is five-sixths of N indicated.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[f] Data based on a single questionnaire form; N is one-fifth of N indicated in 1979–1988 and one-sixth of N indicated in 1989.

[g] Question text changed slightly in 1987.

[h] Adjusted for underreporting of PCP. See text for details.

[i] Data based on two questionnaire forms; N is two-fifths of N indicated in 1987–1988 and two-sixths of N indicated in 1989.

[j] Only drug use which was not under a doctor's orders is included here.

TABLE 1
Trends in Annual Prevalence of Eighteen Types of Drugs

Percent who used in last twelve months

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	(16700)	
Any Illicit Drug Use[a]	*45.0*	*48.1*	*51.1*	*53.8*	*54.2*	*53.1*	*52.1*	*50.8*	*49.1*	—	—	—	—	—	—	
Adjusted Version[b]								*49.4*	*47.4*	*45.8*	*46.3*	*44.3*	*41.7*	*38.5*	*38.4*	*–0.1sss*
Any Illicit Drug Other Than Marijuana[c]	*26.2*	*25.4*	*26.0*	*27.1*	*28.2*	*30.4*	*34.0*	*33.8*	*32.5*	—	—	—	—	—	—	
Adjusted Version[b]								*30.1*	*28.4*	*28.0*	*27.4*	*25.9*	*24.1*	*21.1*	*20.0*	*–1.1*
Marijuana/Hashish	40.0	44.5	47.6	50.2	50.8	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3	33.1	29.6	–3.5sss
Inhalants[d]	NA	3.0	3.7	4.1	5.4	4.6	4.1	4.5	4.3	5.1	5.7	6.1	6.9	6.5	5.9	–0.6
Inhalants Adjusted[e]	*NA*	*NA*	*NA*	*NA*	*8.9*	*7.9*	*6.1*	*6.6*	*6.2*	*7.2*	*7.5*	*8.9*	*8.1*	*7.1*	*6.9*	*–0.2*
Amyl & Butyl Nitrites[f,g]	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6	1.7	1.7	0.0
Hallucinogens	11.2	9.4	8.8	9.6	9.9	9.3	9.0	8.1	7.3	6.5	6.3	6.0	6.4	5.5	5.8	+0.1
Hallucinogens Adjusted[h]	*NA*	*NA*	*NA*	*NA*	*11.8*	*10.4*	*10.1*	*9.0*	*8.3*	*7.3*	*7.6*	*7.2*	*6.7*	*5.8*	*6.2*	*+0.4*
LSD	7.2	6.4	5.5	6.3	6.6	6.5	6.5	6.1	5.4	4.7	4.4	4.5	5.2	4.8	4.9	+0.1
PCP[f,g]	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	1.2	2.4	+1.2ss
Cocaine	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3	7.9	6.5	–1.4ss
"Crack"[i]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	3.9	3.1	3.1	0.0
Other cocaine[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8	7.4	5.2	–2.2ss
Heroin	1.0	0.8	0.8	0.8	0.5	0.5	0.5	0.6	0.6	0.5	0.6	0.5	0.5	0.5	0.6	+0.1
Other opiates[j]	5.7	5.7	6.4	6.0	6.2	6.3	5.9	5.3	5.1	5.2	5.9	5.2	5.3	4.6	4.4	–0.2
Stimulants[j]	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[k,j]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*20.3*	*17.9*	*17.7*	*15.8*	*13.4*	*12.2*	*10.9*	*10.8*	*–0.1*
Sedatives[j]	11.7	10.7	10.8	9.9	9.9	10.3	10.5	9.1	7.9	6.6	5.8	5.2	4.1	3.7	3.7	0.0
Barbiturates[j]	10.7	9.6	9.3	8.1	7.5	6.8	6.6	5.5	5.2	4.9	4.6	4.2	3.6	3.2	3.3	+0.1
Methaqualone[j]	5.1	4.7	5.2	4.9	5.9	7.2	7.6	6.8	5.4	3.8	2.8	2.1	1.5	1.3	1.3	0.0
Tranquilizers[j]	10.6	10.3	10.8	9.9	9.6	8.7	8.0	7.0	6.9	6.1	6.1	5.8	5.5	4.8	3.8	–1.0ss
Alcohol	84.8	85.7	87.0	87.7	88.1	87.9	87.0	86.8	87.3	86.0	85.6	84.5	85.7	85.3	82.7	–2.6ss
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Use of "any illicit drugs" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[b] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[c] Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[d] Data based on four questionnaire forms in 1976–1988; N is four-fifths of N indicated. Data based on five questionnaire forms in 1989; N is five-sixths of N indicated.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[f] Data based on a single questionnaire form; N is one-fifth of N indicated in 1979–1988 and one-sixth of N indicated in 1989.

[g] Question text changed slightly in 1987.

[h] Adjusted for underreporting of PCP. See text for details.

[i] Data based on a single questionnaire form in 1986; N is one-fifth of N indicated. Data based on two questionnaire forms in 1987–1989; N is two-fifths of N indicated in 1987–1988 and two-sixths of N indicated in 1989.

[j] Only drug use which was not under a doctor's orders is included here.

TABLE 2
Trends in Thirty-Day Prevalence of Eighteen Types of Drugs

	Percent who used in last thirty days															
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	(16300)	(16700)	
Any Illicit Drug Use[a,b]	30.7	34.2	37.6	38.9	38.9	37.2	36.9	33.5	32.4							
Adjusted Version[b]	-	-	-	-	-	-	-	32.5	30.5	29.2	29.7	27.1	24.7	21.3	19.7	−1.6ss
Any Illicit Drug Other Than Marijuana[c]	15.4	13.9	15.2	15.1	16.8	18.4	21.7	19.2	18.4							
Adjusted Version[b]		-						17.0	15.4	15.1	14.9	13.2	11.6	10.0	9.1	−0.9
Marijuana/Hashish	27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0	18.0	16.7	−1.3
Inhalants[d]	NA	0.9	1.3	1.5	1.7	1.4	1.5	1.5	1.7	1.9	2.2	2.5	2.8	2.6	2.3	−0.3
Inhalants Adjusted[e]	*NA*	*NA*	*NA*	*NA*	*1.2*	*2.7*	*2.5*	*2.5*	*2.5*	*2.6*	*3.0*	*3.2*	*3.5*	*3.0*	*2.7*	*−0.3*
Amyl & Butyl Nitrites[f,g]	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3	0.6	0.8	0.0
Hallucinogens	4.7	3.4	4.1	3.9	4.0	3.7	3.7	3.4	2.8	2.6	2.5	2.5	2.5	2.2	2.2	0.0
Hallucinogens Adjusted[h]	*NA*	*NA*	*NA*	*NA*	*5.1*	*4.4*	*4.5*	*4.1*	*3.5*	*3.2*	*3.8*	*3.5*	*2.8*	*2.3*	*2.9*	*+0.6*
LSD[f,g]	2.3	1.9	2.1	2.1	2.4	2.3	2.5	2.4	1.9	1.5	1.8	1.7	1.8	1.8	1.8	0.0
PCP[f,g]	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6	0.3	1.4	+1.1sss
Cocaine[i]	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3	3.4	2.8	−0.6s
"Crack"[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.3	1.0	1.4	−0.3
Other cocaine[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	3.2	1.9	−1.3s
Heroin	0.4	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.3	+0.1
Other opiates[j]	2.1	2.0	2.8	2.1	2.4	2.4	2.1	1.8	1.8	1.8	2.3	2.0	1.8	1.6	1.8	0.0
Stimulants[j]	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[h,j]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*10.7*	*8.9*	*8.3*	*6.8*	*5.5*	*5.2*	*4.6*	*4.2*	*−0.4*
Sedatives[j]	5.4	4.5	5.1	4.2	4.4	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7	1.4	1.8	+0.3
Barbiturates[j]	4.7	3.9	4.3	3.2	3.2	2.0	2.6	2.0	2.1	1.7	2.0	1.8	1.4	1.2	1.4	+0.3
Methaqualone[j]	2.1	1.6	2.3	1.9	2.3	3.3	3.1	2.4	1.8	1.1	1.0	0.8	0.6	0.5	0.8	+0.1
Tranquilizers[j]	4.1	4.0	4.6	3.4	3.7	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0	1.5	1.3	−0.3
Alcohol	68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2	65.9	65.3	66.4	63.9	60.0	−3.9sss
Cigarettes	36.7	38.8	38.4	36.7	34.4	30.5	29.4	30.0	30.3	29.3	30.1	29.6	29.4	28.7	28.6	−0.1

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Use of "any illicit drugs" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[b] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[c] Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, sedatives, or tranquilizers not under a doctor's orders.

[d] Data based on four questionnaire forms in 1976–1988; N is four-fifths of N indicated. Data based on five questionnaire forms in 1989; N is five-sixths of N indicated.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[f] Data based on a single questionnaire form; N is one-fifth of N indicated in 1979–1988 and one sixth of N indicated in 1989.

[g] Question text changed slightly in 1987.

[h] Adjusted for underreporting of PCP. See text for details.

[i] Data based on two questionnaire forms; N is two-fifths of N indicated in 1987–1988 and two sixths of N indicated in 1989.

[j] Only drug use which was not under a doctor's orders is included here.

TABLE 13
Trends in Thirty-Day Prevalence of Daily Use of Eighteen Types of Drugs

	Percent who used daily in last thirty days														
Approx. N =	Class of 1975 (9400)	Class of 1976 (15400)	Class of 1977 (17100)	Class of 1978 (17800)	Class of 1979 (15500)	Class of 1980 (15900)	Class of 1981 (17500)	Class of 1982 (17700)	Class of 1983 (16300)	Class of 1984 (15900)	Class of 1985 (16000)	Class of 1986 (15200)	Class of 1987 (16300)	Class of 1988 (16300)	Class of 1989 (16700)	'88 - '89 change
Marijuana/Hashish	6.0	8.2	9.1	10.7	10.3	9.1	7.0	6.3	5.5	5.0	4.9	4.0	3.3	2.7	2.9	+0.2
Inhalants[a]	NA	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.3	0.0
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*0.1*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.4*	*0.4*	*0.4*	*0.3*	*0.3*	*0.0*
Amyl & Butyl Nitrites[c,d]	NA	NA	NA	NA	0.0	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3	0.1	0.3	+0.2
Hallucinogens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.0[j]
Hallucinogens Adjusted[e]	*NA*	*NA*	*NA*	*NA*	*0.2*	*0.2*	*0.1*	*0.2*	*0.2*	*0.2*	*0.3*	*0.3*	*0.2*	*0.0*	*0.3*	*+0.2*[j]
LSD	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0	0.0	0.0
PCP[c,d]	NA	NA	NA	NA	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.1	0.2	+0.1
Cocaine	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.4	0.4	0.3	0.2	0.3	+0.1
"Crack"[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.1	0.1	0.2	+0.1
Other cocaine[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	0.2	0.1	−0.1
Heroin	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	+0.1
Other opiates[g]	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.0[j]
Stimulants[g]	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1	1.1	NA	NA	NA	NA	NA	NA	NA
Stimulants Adjusted[g,h]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*0.7*	*0.8*	*0.6*	*0.4*	*0.3*	*0.3*	*0.3*	*0.5*	*0.0*
Sedatives[g]	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	+0.1[j]
Barbiturates[g]	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0[j]
Methaqualone[g]	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0[j]
Tranquilizers[g]	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.0[j]
Alcohol																
Daily	5.7	5.6	6.1	5.7	6.0	6.0	6.0	5.7	5.5	4.8	5.0	4.8	4.8	4.2	4.2	0.0
5+ drinks in a row/ last 2 weeks	36.8	37.1	39.4	40.3	41.2	41.2	41.4	40.5	40.8	38.7	36.7	36.8	37.5	34.7	33.0	−1.7
Cigarettes																
Daily	28.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1	21.2	18.7	19.5	18.7	18.7	18.1	18.9	+0.8
Half-pack or more per day	17.9	19.2	19.4	18.8	16.5	14.3	13.5	14.2	13.8	12.3	12.5	11.4	11.4	10.6	11.2	+0.6

NOTES: Level of significance of difference between the two most recent classes: * = .05, ** = .01, *** = .001. NA indicates data not available.

[a] Data based on four questionnaire forms in 1976-1988; N is four-fifths of N indicated. Data based on five questionnaire forms in 1989; N is five-sixths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form; N is one-fifth of N indicated in 1979-1988 and one-sixth of N indicated in 1989.

[d] Question text changed slightly in 1987.

[e] Adjusted for underreporting of PCP. See text for details.

[f] Data based on two questionnaire forms; N is two-fifths of N indicated in 1987-1988 and two-sixths of N indicated in 1989.

[g] Only drug use which was not under a doctor's orders is included here.

[h] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[j] Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding error.

TABLE 19
Trends in Proportions of Seniors Disapproving of Drug Use

Q. Do you disapprove of people (who are 18 or older) doing each of the following?[b]	Percentage "disapproving"[a]															
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Try marijuana once or twice	47.0	38.4	33.4	33.4	34.2	39.0	40.0	45.5	46.3	49.3	51.4	54.6	56.6	60.8	64.6	+3.8ss
Smoke marijuana occasionally	54.8	47.8	44.3	43.5	45.3	49.7	52.6	59.1	60.7	63.5	65.8	69.0	71.6	74.0	77.2	+3.2ss
Smoke marijuana regularly	71.9	69.5	65.5	67.5	69.2	74.6	77.4	80.6	82.5	84.7	85.5	86.6	89.2	89.3	89.8	+0.5
Try LSD once or twice	82.8	84.6	83.9	85.4	86.6	87.3	86.4	88.8	89.1	88.9	89.5	89.2	91.6	89.8	89.7	−0.1
Take LSD regularly	94.1	95.3	95.8	96.4	96.9	96.7	96.8	96.7	97.0	96.8	97.0	96.6	97.8	96.4	96.4	0.0
Try cocaine once or twice	81.3	82.4	79.1	77.0	74.7	76.3	74.6	76.6	77.0	79.7	79.3	80.2	87.3	89.1	90.5	+1.4
Take cocaine regularly	93.3	93.9	92.1	91.9	90.8	91.1	90.7	91.5	93.2	94.5	93.8	94.3	96.7	96.2	96.4	+0.2
Try heroin once or twice	91.5	92.6	92.5	92.0	93.4	93.5	93.5	94.6	94.3	94.0	94.0	93.3	96.2	95.0	95.4	+0.4
Take heroin occasionally	94.8	96.0	96.0	96.4	96.8	96.7	97.2	96.9	96.9	97.1	96.8	96.6	97.9	96.9	97.2	+0.3
Take heroin regularly	96.7	97.5	97.2	97.8	97.9	97.6	97.8	97.5	97.7	98.0	97.6	97.6	98.1	97.2	97.4	+0.2
Try amphetamines once or twice	74.8	75.1	74.2	74.8	75.1	75.4	71.1	72.6	72.3	72.8	74.9	76.5	80.7	82.5	83.3	+0.8
Take amphetamines regularly	92.1	92.8	92.5	93.5	94.4	93.0	91.7	92.0	92.6	93.6	93.3	93.5	95.4	94.2	94.2	0.0
Try barbiturates once or twice	77.7	81.3	81.1	82.4	84.0	83.9	82.4	84.4	83.1	84.1	84.9	86.8	89.6	89.4	89.3	−0.1
Take barbiturates regularly	93.3	93.6	93.0	94.3	95.2	95.4	94.2	94.4	95.1	95.1	95.5	94.9	96.4	95.3	95.3	0.0
Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	21.6	18.2	15.6	15.6	15.8	16.0	17.2	18.2	18.4	17.4	20.3	20.9	21.4	22.6	27.3	+4.7ss
Take one or two drinks nearly every day	67.6	68.9	66.8	67.7	68.3	69.0	69.1	69.9	68.9	72.9	70.9	72.8	74.2	75.0	76.5	+1.5
Take four or five drinks nearly every day	88.7	90.7	88.4	90.2	91.7	90.8	91.8	90.9	90.0	91.0	92.0	91.4	92.2	92.6	91.6	−1.2
Have five or more drinks once or twice each weekend	60.3	58.6	57.4	56.2	56.7	55.6	55.5	58.8	56.6	59.6	60.4	62.4	62.0	65.3	66.5	+1.2
Smoke one or more packs of cigarettes per day	67.5	65.9	66.4	67.0	70.3	70.8	69.9	69.4	70.8	73.0	72.3	75.4	74.3	73.1	72.4	−0.7
Approx. N =	(2677)	(2957)	(3085)	(3686)	(3221)	(3261)	(3610)	(3651)	(3341)	(3254)	(3265)	(3113)	(3302)	(3311)	(2799)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.
[a]Answer alternatives were: (1) Don't disapprove, (2) Disapprove, and (3) Strongly disapprove. Percentages are shown for categories (2) and (3) combined.
[b]The 1975 question asked about people who are "20 or older."

TABLE 20

Trends in Seniors' Attitudes Regarding Legality of Drug Use

Q. Do you think that people (who are 18 or older) should be prohibited by law from doing each of the following?[b]	Percentage saying "yes"[a]															
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Smoke marijuana in private	32.8	27.5	26.8	25.4	28.0	28.9	35.4	36.6	37.8	41.6	44.7	43.8	47.6	51.8	51.5	−0.3
Smoke marijuana in public places	63.1	59.1	58.7	59.5	61.8	66.1	67.4	72.8	73.6	75.2	78.2	78.9	79.7	81.3	80.0	−1.3
Take LSD in private	67.2	65.1	63.3	62.7	62.4	65.8	62.6	67.1	66.7	67.9	70.6	69.0	70.8	71.5	71.6	+0.1
Take LSD in public places	85.8	81.9	79.3	80.7	81.5	82.8	80.7	82.1	82.8	82.4	84.8	84.9	85.2	86.0	84.4	−1.6
Take heroin in private	76.3	72.4	69.2	68.8	68.5	70.3	68.8	69.3	69.7	69.8	73.3	71.7	75.0	74.2	74.4	+0.2
Take heroin in public places	90.1	84.8	81.0	82.5	84.0	83.8	82.4	82.5	83.7	83.4	85.8	85.0	86.2	86.6	85.2	−1.4
Take amphetamines or barbiturates in private	57.2	53.5	52.8	52.2	53.4	54.1	52.0	53.5	52.8	54.4	56.3	56.8	59.1	60.2	61.1	+0.9
Take amphetamines or barbiturates in public places	79.6	76.1	73.7	75.8	77.3	76.1	74.2	75.5	76.7	76.8	78.3	79.1	79.8	80.2	79.2	−1.0
Get drunk in private	14.1	15.6	18.6	17.4	16.8	16.7	19.6	19.4	19.0	19.7	19.8	18.5	18.6	19.2	20.2	+1.0
Get drunk in public places	55.7	50.7	49.0	50.3	50.4	48.3	49.1	50.7	52.2	51.1	53.1	52.2	53.2	53.8	52.6	−1.2
Smoke cigarettes in certain specified public places	NA	NA	42.0	42.2	43.1	42.8	43.0	42.0	40.5	39.2	42.8	45.1	44.4	48.4	44.5	−3.9a
Approx. N =	(2620)	(2959)	(3113)	(3783)	(3288)	(3224)	(3611)	(3627)	(3315)	(3236)	(3254)	(3074)	(3332)	(3288)	(2813)	

NOTE: Level of significance of difference between the two most recent classes: a = .05, aa = .01, aaa = .001. NA indicates data not available.

[a]Answer alternatives were: (1) No, (2) Not sure, and (3) Yes.

[b]The 1975 question asked about people who are "20 or older."

TABLE 21

Trends in Seniors' Attitudes Regarding Marijuana Laws

(Entries are percentages)

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989
Q. There has been a great deal of public debate about whether marijuana use should be legal. Which of the following policies would you favor?															
Using marijuana should be entirely legal	27.3	32.6	33.6	32.9	32.1	26.3	23.1	20.0	18.9	18.6	16.6	14.9	15.4	15.1	16.6
It should be a minor violation like a parking ticket but not a crime	25.3	29.0	31.4	30.2	30.1	30.9	29.3	28.2	26.3	23.6	25.7	25.9	24.6	21.9	18.9
It should be a crime	30.5	25.4	21.7	22.2	24.0	26.4	32.1	34.7	36.7	40.6	40.8	42.5	45.3	49.2	50.9
Don't know	16.8	13.0	13.4	14.6	13.8	16.4	15.4	17.1	18.1	17.2	16.9	16.7	14.8	13.9	14.6
Q. If it were legal for people to USE marijuana, should it also be legal to SELL marijuana?															
No	27.8	23.0	22.5	21.8	22.9	25.0	27.7	29.3	27.4	30.9	32.6	33.0	36.0	36.8	38.8
Yes, but only to adults	37.1	49.8	52.1	53.6	53.2	51.8	48.6	46.2	47.6	45.8	43.2	42.2	41.2	39.9	37.9
Yes, to anyone	16.2	13.3	12.7	12.0	11.3	9.6	10.5	10.7	10.5	10.6	11.2	10.4	9.2	10.5	9.2
Don't know	18.9	13.9	12.7	12.6	12.6	13.6	13.2	13.8	14.6	12.8	13.1	14.4	13.6	12.8	14.1
Q. If marijuana were legal to use and legally available, which of the following would you be most likely to do?															
Not use it, even if it were legal and available	53.2	50.4	50.6	46.4	50.2	53.3	55.2	60.0	60.1	62.0	63.0	62.4	64.9	69.0	70.1
Try it	8.2	8.1	7.0	7.1	6.1	6.8	6.0	6.3	7.2	6.6	7.5	7.6	7.3	7.1	6.7
Use it about as often as I do now	22.7	24.7	26.8	30.9	29.1	27.3	24.8	21.7	19.8	19.1	17.7	16.8	16.2	13.1	13.0
Use it more often than I do now	6.0	7.1	7.4	6.3	6.0	4.2	4.7	3.8	4.9	4.7	3.7	5.0	4.1	4.3	2.4
Use it less than I do now	1.3	1.5	1.5	2.7	2.5	2.6	2.5	2.2	1.5	1.6	1.6	2.0	1.3	1.5	2.1
Don't know	8.5	8.1	6.6	6.7	6.1	5.9	6.9	6.0	6.4	6.0	6.5	6.1	6.3	5.0	5.7
Approx. N =	(2600)	(2970)	(3110)	(3710)	(3280)	(3210)	(3600)	(3620)	(3300)	(3220)	(3230)	(3080)	(3330)	(3277)	(2812)

TABLE 22

Trends in Proportion of Friends Disapproving of Drug Use

All Seniors

Q. How do you think your close friends feel (or would feel) about you . . .	Adjustment Factor	Percentage saying friends disapprove[a]														
		Class of 1975[b]	Class of 1976	Class of 1977[b]	Class of 1978	Class of 1979[b]	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88 – '89 change
Trying marijuana once or twice	*(−0.5)*	*44.3*	NA	*41.8*	NA	*40.9*	42.6	46.4	50.3	52.0	54.1	54.7	56.7	58.0	62.9	63.7	+0.8
Smoking marijuana occasionally	*(+0.8)*	*54.8*	NA	*49.0*	NA	*48.2*	50.6	55.9	57.4	59.9	62.9	64.2	64.4	67.0	72.1	71.1	−1.0
Smoking marijuana regularly	*(+4.6)*	*75.0*	NA	*69.1*	NA	*70.2*	72.0	75.0	74.7	77.6	79.2	81.0	82.3	82.9	85.5	84.9	−0.6
Trying LSD once or twice	*(+2.0)*	*85.6*	NA	*86.6*	NA	*87.6*	87.4	86.5	87.8	87.8	87.6	88.6	89.0	87.9	89.5	88.4	−1.1
Trying cocaine once or twice		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	79.6	83.9	88.1	88.9	+0.8
Taking cocaine occasionally		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	87.3	89.7	92.1	92.1	0.0
Trying an amphetamine once or twice	*(+2.2)*	*78.8*	NA	*80.3*	NA	*81.0*	78.9	74.4	75.7	76.8	77.0	77.0	79.4	80.0	82.3	84.1	+1.8
Taking one or two drinks nearly every day	*(+7.8)*	*67.2*	NA	*71.0*	NA	*71.0*	70.5	69.5	71.9	71.7	73.6	75.4	75.9	71.8	74.9	76.4	+1.5
Taking four or five drinks every day	*(+9.3)*	*89.2*	NA	*88.1*	NA	*88.5*	87.9	86.4	86.6	86.0	86.1	88.2	87.4	85.6	87.1	87.2	+0.1
Having five or more drinks once or twice every weekend	*(+4.7)*	*55.0*	NA	*53.4*	NA	*51.3*	50.6	50.3	51.2	50.6	51.3	55.9	54.9	52.4	54.0	56.4	+2.4
Smoking one or more packs of cigarettes per day	*(+8.3)*	*63.6*	NA	*68.3*	NA	*73.4*	74.4	73.8	70.3	72.2	73.9	73.7	76.2	74.2	76.4	74.4	−2.0
Approx. N =		(2488)	(NA)	(2615)	(NA)	(2716)	(2766)	(3120)	(3024)	(2722)	(2721)	(2688)	(2639)	(2815)	(2778)	(2460)	

NOTE: Level of significance of difference between the two most recent classes: ^{a} = .05, ^{aa} = .01, ^{aaa} = .001. NA indicates data not available.

[a] Answer alternatives were: (1) Don't disapprove, (2) Disapprove, and (3) Strongly disapprove. Percentages are shown for categories (2) and (3) combined.

[b] These figures have been adjusted by the factors reported in the first column to correct for a lack of comparability of question-context among administrations. (See text for discussion.)

TABLE 23

Trends in Proportion of Friends Using Drugs as Estimated by Seniors

(Entries are percentages)

Q. *How many of your friends would you estimate . . .*	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88 – '89 change
Take any illicit drug[a]																
% saying none	14.2	15.4	13.1	12.5	11.0	12.5	14.6	13.7	17.4	19.0	17.6	17.8	18.3	20.9	23.1	+2.2
% saying most or all	31.9	31.7	33.2	36.3	37.0	32.5	29.8	26.5	23.8	20.9	22.7	21.5	18.6	15.8	15.7	−0.1
Take any illicit drug[a] other than marijuana																
% saying none	33.3	44.5	42.5	43.6	38.7	37.6	36.7	35.3	38.8	38.7	36.2	36.7	37.6	43.5	43.8	+0.3
% saying most or all	10.6	8.9	7.7	8.5	10.4	11.1	11.9	10.9	11.0	10.3	10.4	10.3	9.2	6.9	7.7	+0.8
Smoke marijuana																
% saying none	17.0	17.1	14.1	13.9	12.4	13.6	17.0	15.6	19.7	22.3	20.5	20.8	21.6	24.7	27.5	+2.8
% saying most or all	30.3	30.6	32.3	35.3	35.5	31.3	27.7	23.8	21.7	18.3	19.8	18.2	15.8	13.6	13.4	−0.2
Use inhalants																
% saying none	75.7	81.4	81.1	80.0	80.9	82.2	83.5	81.6	83.9	80.7	78.8	77.6	75.3	79.2	77.9	−1.3
% saying most or all	1.1	1.1	1.0	1.1	1.1	1.2	0.9	1.3	1.1	1.1	1.5	2.0	1.9	1.2	1.9	+0.7
Use nitrites																
% saying none	NA	NA	NA	NA	78.4	81.0	82.6	82.5	85.5	85.0	84.4	82.0	81.7	86.4	86.7	+0.3
% saying most or all	NA	NA	NA	NA	1.9	1.3	1.2	0.9	0.7	1.2	1.0	1.2	1.3	0.7	0.9	+0.2
Take LSD																
% saying none	63.5	69.4	68.1	70.1	71.1	71.9	71.5	72.2	76.0	76.1	75.6	75.5	74.7	75.9	74.8	−1.1
% saying most or all	2.7	2.8	3.0	2.0	1.9	1.8	2.2	2.4	1.4	2.0	1.5	1.8	1.6	1.5	2.4	+0.9[b]
Take other psychedelics																
% saying none	58.8	69.7	68.6	70.8	71.8	71.8	73.7	74.4	77.9	78.7	78.0	77.7	78.3	82.2	81.9	−0.3
% saying most or all	4.7	3.0	2.8	2.0	2.2	2.2	2.1	1.9	1.6	1.9	1.4	1.3	1.2	0.9	1.4	+0.5
Take PCP																
% saying none	NA	NA	NA	NA	72.2	77.8	82.8	82.7	85.8	85.8	84.1	83.9	84.5	86.5	85.3	−1.2
% saying most or all	NA	NA	NA	NA	1.7	1.6	0.9	0.9	1.1	1.1	1.2	1.2	1.1	0.9	1.2	+0.4
Take cocaine																
% saying none	66.4	71.2	69.9	66.8	61.1	58.4	59.9	59.3	62.4	61.1	58.2	54.4	58.3	62.3	62.6	+0.3
% saying most or all	3.4	3.2	3.6	4.0	6.0	6.1	6.3	4.9	5.1	5.1	5.8	6.2	5.1	3.4	3.7	+0.3
Take "crack"																
% saying none	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	72.6	74.6	73.9	−0.7
% saying most or all	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.2	1.1	2.1	+1.0[b]

(Table continued on next page)

TABLE 23 (cont.)

Trends in Proportion of Friends Using Drugs as Estimated by Seniors

(Entries are percentages)

Q. *How many of your friends would you estimate . . .*	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88 – '89 change
Take heroin																
% saying none	84.8	86.4	87.1	85.7	87.1	87.0	87.5	86.8	88.0	87.0	85.5	84.7	86.1	87.6	86.9	−1.8
% saying most or all	0.7	0.8	0.7	0.9	0.5	1.0	0.5	0.7	0.8	0.8	0.9	1.1	0.9	0.7	1.1	+0.4
Take other narcotics																
% saying none	71.2	75.9	76.3	76.8	76.9	77.6	76.9	76.1	79.2	78.6	77.2	78.2	78.8	80.6	80.8	0.2
% saying most or all	2.1	2.2	1.7	1.4	1.5	1.7	1.5	1.4	1.4	1.6	1.4	1.8	1.4	1.2	1.4	+0.2
Take amphetamines																
% saying none	49.0	57.8	58.7	59.3	59.3	58.1	51.2	49.4	53.0	54.9	56.7	58.2	60.5	66.6	66.5	−0.1
% saying most or all	5.9	5.6	4.1	4.7	4.3	4.8	6.4	5.4	5.1	4.5	3.4	3.4	2.6	1.9	2.6	+0.7
Take barbiturates																
% saying none	55.0	63.7	65.3	67.5	69.3	69.5	68.9	68.7	71.7	73.4	72.9	74.4	75.7	80.3	79.7	−0.6
% saying most or all	4.3	3.5	3.0	2.3	2.1	2.6	2.1	1.8	1.7	1.7	1.6	1.4	1.1	1.1	1.4	+0.3
Take quaaludes																
% saying none	68.3	73.0	71.7	73.0	72.3	67.5	65.0	64.5	70.3	73.9	74.0	76.5	78.0	82.9	83.4	+0.5
% saying most or all	3.0	1.8	2.9	2.2	2.8	3.6	3.6	2.6	2.6	1.7	1.3	1.6	1.0	1.0	1.3	+0.3
Take tranquilizers																
% saying none	54.4	63.7	62.2	65.2	68.0	70.3	70.5	70.1	73.3	73.4	74.2	75.3	76.7	80.1	82.0	+1.9
% saying most or all	3.5	3.1	2.7	1.8	2.0	1.9	1.4	1.1	1.2	1.5	1.2	1.3	1.0	0.7	1.5	+0.8
Drink alcoholic beverages																
% saying none	3.3	4.9	5.6	5.1	4.6	3.9	5.3	4.3	4.5	5.4	5.4	4.4	4.6	4.3	4.9	+0.6
% saying most or all	68.4	64.7	66.2	68.9	68.5	68.9	67.7	69.7	69.0	66.6	66.0	68.0	71.8	68.1	67.1	−1.0
Get drunk at least once a week																
% saying none	17.6	19.3	19.0	18.0	16.7	16.9	18.2	16.9	16.1	18.5	17.5	15.3	14.4	15.6	17.2	+1.6
% saying most or all	30.1	26.6	27.6	30.2	32.0	30.1	29.4	29.9	31.0	29.6	29.9	31.8	31.3	29.6	31.1	+1.5
Smoke cigarettes																
% saying none	4.8	6.3	6.3	6.9	7.9	9.4	11.5	11.7	13.0	14.0	13.0	12.2	11.7	12.3	13.5	+1.2
% saying most or all	41.5	36.7	33.9	32.2	28.6	23.3	22.4	24.1	22.4	19.2	22.8	21.5	21.0	20.2	23.1	+2.9
Approx. N =	(2640)	(2697)	(2788)	(3247)	(2933)	(2987)	(3307)	(3303)	(3095)	(2945)	(2971)	(2798)	(2948)	(2961)	(2587)	

NOTE: Level of significance of difference between the two most recent classes: ^{a} = .05, ^{aa} = .01, ^{aaa} = .001. NA indicates data not available.

[a]These estimates were derived from responses to the questions listed above. "Any illicit drug" includes all of the drugs listed except cigarettes and alcohol. PCP and the nitrites were not included in 1975 through 1978. "Crack" was not included in 1975 through 1986.

TABLE 24
Trends in Seniors' Exposure to Drug Use
(Entries are percentages)

Q. *During the LAST 12 MONTHS how often have you been around people who were taking each of the following to get high or for "kicks"?*	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Any illicit drug[a]																
% saying not at all	NA	17.4	16.5	15.1	15.0	15.7	17.3	18.6	20.6	22.1	22.3	24.5	26.1	28.7	31.4	+2.7
% saying often	NA	34.8	39.0	40.7	40.4	36.3	36.1	31.4	29.8	28.3	27.2	26.3	23.3	20.8	22.0	+1.2
Any illicit drug[a] other than marijuana																
% saying not at all	NA	44.9	44.2	44.7	41.7	41.5	37.4	37.5	40.6	40.2	40.7	44.7	48.3	52.2	52.9	+0.7
% saying often	NA	11.8	13.5	12.1	13.7	14.1	17.1	16.6	14.2	14.6	12.9	12.1	10.2	9.6	10.7	+1.1
Marijuana																
% saying not at all	NA	20.5	19.0	17.3	17.0	18.0	19.8	22.1	23.8	25.6	26.5	28.0	29.6	33.0	35.2	+2.2
% saying often	NA	32.5	37.0	39.0	38.9	33.8	33.1	28.0	26.1	24.8	24.2	24.0	20.6	17.9	19.5	+1.6
LSD																
% saying not at all	NA	78.8	80.0	81.9	81.9	82.8	82.6	83.9	86.2	87.5	86.8	86.9	87.1	86.6	85.0	−1.6
% saying often	NA	2.2	2.0	1.8	2.0	1.4	2.0	1.9	1.4	1.5	1.3	1.6	1.8	1.6	2.2	+0.6
Other psychedelics																
% saying not at all	NA	76.5	76.7	76.7	77.0	79.6	82.4	83.2	86.9	87.3	87.5	88.2	90.0	91.0	91.2	+0.2
% saying often	NA	3.1	3.2	2.9	2.2	2.2	2.0	2.6	1.1	1.7	1.4	1.5	1.2	1.1	1.3	+0.2
Cocaine																
% saying not at all	NA	77.0	73.4	69.8	64.0	62.3	63.7	65.1	66.7	64.4	61.7	62.6	65.1	69.8	69.8	0.0
% saying often	NA	3.0	3.7	4.6	6.8	5.0	6.6	6.6	5.2	6.7	7.1	7.8	5.9	5.1	5.4	+0.3
Heroin																
% saying not at all	NA	91.4	90.3	91.8	92.4	92.6	93.4	92.9	94.9	94.0	94.5	94.0	94.2	94.3	93.5	−0.8
% saying often	NA	0.8	1.1	0.9	0.7	0.4	0.6	1.0	0.7	1.1	0.5	1.0	0.9	0.8	1.0	+0.2
Other narcotics																
% saying not at all	NA	81.9	81.3	81.8	82.0	80.4	82.5	81.5	82.7	82.0	81.6	84.4	85.6	85.2	86.2	+1.0
% saying often	NA	1.8	2.4	2.0	1.7	1.7	1.7	2.4	2.2	2.0	1.8	2.1	1.7	1.7	1.7	0.0
Amphetamines																
% saying not at all	NA	59.6	60.3	60.9	58.1	59.2	50.5	49.8	53.9	55.0	59.0	63.5	68.3	72.1	72.6	+0.5
% saying often	NA	6.8	7.9	6.7	7.4	8.3	12.1	12.3	10.1	9.0	6.5	5.8	4.5	4.1	4.7	+0.6
Barbiturates																
% saying not at all	NA	69.0	70.0	73.5	73.6	74.8	74.1	74.3	77.5	78.8	81.1	84.2	86.9	87.6	88.2	+0.6
% saying often	NA	4.5	5.0	3.4	3.3	3.4	4.0	4.3	3.0	2.7	1.7	2.1	1.5	1.4	1.7	+0.3
Tranquilizers																
% saying not at all	NA	67.7	66.0	67.5	67.5	70.9	71.0	73.4	76.5	76.9	78.6	80.4	81.6	81.8	84.9	+3.1**
% saying often	NA	5.5	6.3	4.9	4.3	3.2	4.2	3.5	2.9	2.9	2.2	2.5	2.6	2.2	2.1	−0.1
Alcoholic beverages																
% saying not at all	NA	6.0	5.6	5.5	5.2	5.3	6.0	6.0	6.0	6.0	6.0	5.8	6.1	6.9	7.7	+0.8
% saying often	NA	57.1	60.8	60.8	61.2	60.2	61.0	59.3	60.2	58.7	59.5	58.0	58.7	56.4	55.5	−0.9
Approx. N =	(NA)	(2950)	(3075)	(3682)	(3253)	(3259)	(3608)	(3645)	(3334)	(3238)	(3252)	(3078)	(3298)	(3300)	(2795)	

NOTES. Level of significance of difference between the two most recent classes: * = .05, ** = .01, *** = .001. NA indicates data not available.
[a] These estimates were derived from responses to the questions listed above. "Any illicit drug" includes all drugs listed except alcohol.

TABLE 25

Trends in Perceived Availability of Drugs, All Seniors

Q. How difficult do you think it would be for you to get each of the following types of drugs, if you wanted some?	Percentage saying drug would be "Fairly easy" or "Very easy" for them to get[a]														
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	'88–'89 change
Marijuana	87.8	87.4	87.9	87.8	90.1	89.0	89.2	88.5	86.2	84.6	85.5	85.2	84.8	85.0	84.3	−0.7
Amyl & Butyl Nitrites	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	23.9	25.9	26.8	+0.9
LSD	46.2	37.4	34.5	32.2	34.2	35.3	35.0	34.2	30.9	30.6	30.5	28.5	31.4	33.3	38.3	+5.0ss
PCP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	22.8	24.9	28.9	+4.0ss
Some other psychedelic	47.8	35.7	33.8	33.8	34.6	35.0	32.7	30.6	26.6	26.6	26.1	24.9	25.0	26.2	28.2	+2.0
Cocaine	37.0	34.0	33.0	37.8	45.5	47.9	47.5	47.4	43.1	45.0	48.9	51.5	54.2	55.0	58.7	+3.7s
"Crack"	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	41.1	42.1	47.0	+4.9ss
Cocaine powder	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	52.9	50.3	53.7	+3.4s
Heroin	24.2	18.4	17.9	16.4	18.9	21.2	19.2	20.8	19.3	19.9	21.0	22.0	23.7	28.0	31.4	+3.4s
Some other narcotic (including methadone)	34.5	26.9	27.8	26.1	28.7	29.4	29.6	30.4	30.0	32.1	33.1	32.2	33.0	35.8	38.3	+2.5
Amphetamines	67.8	61.8	58.1	58.5	59.9	61.3	69.5	70.8	68.5	68.2	66.4	64.3	64.5	63.9	64.3	+0.4
Barbiturates	60.0	54.4	52.4	50.6	49.8	49.1	54.9	55.2	52.5	51.9	51.3	48.3	48.2	47.8	48.4	+0.6
Tranquilizers	71.8	65.5	64.9	64.3	61.4	59.1	60.8	58.9	55.3	54.5	54.7	51.2	48.6	49.1	45.3	−3.8s
Approx. N =	(2627)	(2865)	(3065)	(3598)	(3172)	(3240)	(3578)	(3602)	(3385)	(3269)	(3274)	(3077)	(3271)	(3231)	(2808)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a]Answer alternatives were: (1) Probably impossible, (2) Very difficult, (3) Fairly difficult, (4) Fairly easy, and (5) Very easy.

TABLE 30

Trends in Annual Prevalence of Fourteen Types of Drugs
Among Respondents of Modal Age 19-28

	Percent who used in last twelve months				
	1986	1987	1988	1989	'88 - '89 change
Approx. Wtd. N =	(6900)	(6800)	(6700)	(6600)	
Marijuana	36.5	34.8	31.8	29.0	-2.8sss
Inhalants[b]	1.9	2.1	1.8	1.9	+0.1
Inhalants, Adjusted[b,e]	3.0	2.6	2.4	NA	NA
Nitrites[f]	2.0	1.3	1.0	NA	NA
Hallucinogens	4.5	4.0	3.9	3.6	-0.3
Hallucinogens, Adjusted[g]	4.9	4.1	3.9	NA	NA
LSD[f]	3.0	2.9	2.9	2.7	-0.2
PCP[f]	0.8	0.4	0.4	NA	NA
Cocaine	19.7	15.7	13.8	10.8	-3.0sss
Crack[c]	3.2	3.1	3.1	2.5	-0.6
Other Cocaine[f]	NA	13.6	11.9	10.3	-1.6
Heroin	0.2	0.2	0.2	0.2	0.0
Other Opiates[a]	3.1	3.1	2.7	2.8	+0.1
Stimulants, Adjusted[a,d]	10.6	9.1	7.3	5.8	-1.5sss
Sedatives[a]	3.0	2.5	2.1	1.8	-0.3
Barbiturates[a]	2.3	2.1	1.8	1.7	-0.1
Methaqualone[a]	1.3	0.9	0.5	0.3	-0.2
Tranquilizers[a]	5.4	5.1	4.2	3.7	-0.5
Alcohol	88.6	89.4	88.6	88.1	-0.5
Cigarettes	40.1	40.3	37.7	38.0	+0.3

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001
NA indicates data not available

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

[c] This drug was asked about in one of the five questionnaire forms in 1986 (N is one-fifth of N indicated), and in two of the five questionnaire forms thereafter (N is two-fifths of N indicated).

[d] Based on the data from the revised question which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text.

[f] This drug was asked about in one questionnaire form. N is one-fifth of N indicated.

[g] Adjusted for underreporting of PCP. See text.

TABLE 31

Trends in Thirty-Day Prevalence of Fourteen Types of Drugs
Among Respondents of Modal Age 19-28

	Percent who used in last thirty days				
	1986	1987	1988	1989	'88 - '89 change
Approx. Wtd. N =	(6900)	(6800)	(6700)	(6600)	
Marijuana	22.0	20.7	17.9	15.5	-2.4sss
Inhalants[b]	0.4	0.6	0.6	0.5	-0.1
Inhalants, Adjusted[b,e]	0.7	0.9	0.9	NA	NA
Nitrites[f]	0.5	0.5	0.4	NA	NA
Hallucinogens	1.3	1.2	1.1	1.1	0.0
Hallucinogens, Adjusted[g]	1.4	1.2	1.1	NA	NA
LSD[f]	0.9	0.8	0.8	0.8	0.0
PCP[f]	0.2	0.1	0.3	NA	NA
Cocaine	8.2	6.0	5.7	3.8	-1.9sss
Crack[c]	NA	1.0	1.2	0.7	-0.5
Other Cocaine[f]	NA	4.8	4.8	3.4	-1.4
Heroin	0.1	0.1	0.1	0.1	0.0
Other Opiates[a]	0.9	0.9	0.7	0.7	0.0
Stimulants, Adjusted[a,d]	4.0	3.2	2.7	2.1	-0.6s
Sedatives[a]	0.9	0.8	0.7	0.5	-0.2
Barbiturates[a]	0.7	0.7	0.7	0.5	-0.2
Methaqualone[a]	0.3	0.2	0.1	0.0	-0.1
Tranquilizers[a]	1.8	1.6	1.4	1.2	-0.2
Alcohol	75.1	75.4	74.0	72.4	-1.6s
Cigarettes	31.1	30.9	28.9	28.6	-0.3

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = 001
NA indicates data not available

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

[c] This drug was asked about in two of the five questionnaire forms. N is two-fifths of N indicated.

[d] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text.

[f] This drug was asked about in one questionnaire form. N is one-fifth of N indicated.

[g] Adjusted for underreporting of PCP. See text.

TABLE 32

Trends in Thirty-Day Prevalence of Daily Use of Fourteen Types of Drugs

Among Respondents of Modal Age 19-28

	Percent using daily in last thirty days				
	1986	1987	1988	1989	'88 - '89 change[h]
Approx. Wtd. N =	(6900)	(6800)	(6700)	(6600)	
Marijuana	4.1	4.2	3.3	3.2	-0.1
Inhalants[b]	0.0	0.0	0.0	0.1	0.0
Inhalants, Adjusted[b,e]	0.0	0.0	0.0	NA	NA
Nitrites[f]	0.0	0.0	0.1	NA	NA
Hallucinogens	0.0	0.0	0.0	0.0	0.0
Hallucinogens, Adjusted[g]	0.0	0.0	0.0	NA	NA
LSD	0.0	0.0	0.0	0.0	0.0
PCP	0.0	0.0	0.1	NA	NA
Cocaine	0.2	0.1	0.2	0.1	-0.1
Crack[c]	NA	0.0	0.1	0.0	0.0
Other Cocaine[f]	NA	0.1	0.1	0.0	-0.1
Heroin	0.0	0.0	0.0	0.0	0 0
Other Opiates[a]	0.0	0.0	0.0	0.0	0.0
Stimulants, Adjusted[a,d]	0.2	0.2	0.1	0.1	0.0
Sedatives[a]	0.0	0.0	0.1	0.0	-0.1
Barbiturates[a]	0.0	0.0	0.1	0.0	-0.1
Methaqualone[a]	0.0	0.0	0.0	0.0	0.0
Tranquilizers[a]	0.0	0.0	0.0	0.0	0.0
Alcohol					
Daily	6.1	6.6	6.1	5.5	-0.6
5+ drinks in a row in last 2 weeks	36.1	36.2	35.2	34.8	-0.4
Cigarettes					
Daily	25.2	24.8	22.7	22.4	-0.3
Half-pack or more per day	20.2	19.8	17.7	17.3	-0.4

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = 001
NA indicates data not available.

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

[c] This drug was asked about in two of the five questionnaire forms. N is two-fifths of N indicated.

[d] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[e] Adjusted for underreporting of amyl and butyl nitrites. See text.

[f] This drug was asked about in one questionnaire form. N is one-fifth of N indicated.

[g] Adjusted for underreporting of PCP. See text.

[h] Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding.

TABLE 45

Trends in Lifetime[e] Prevalence of Fourteen Types of Drugs
Among College Students 1-4 Years Beyond High School

	Percent who used in lifetime										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	'88-'89 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	
Marijuana	65.0	63.3	60.5	63.1	59.0	60.6	57.9	55.8	54.3	51.3	-3.0
Inhalants[b]	10.2	8.6	10.6	11.0	10.4	10.6	11.0	13.2	12.6	15.0	+2.4
Hallucinogens	15.0	12.0	15.0	12.2	12.9	11.4	11.2	10.9	10.2	10.7	+0.5
LSD	10.3	8.5	11.5	8.8	9.4	7.4	7.7	8.0	7.5	7.8	+0.3
Cocaine	22.0	21.5	22.4	23.1	21.7	22.9	23.3	20.6	15.8	14.6	-1.2
Crack[c]	NA	NA	NA	NA	NA	NA	NA	3.3	3.4	2.4	-1.0
Heroin	0.9	0.6	0.5	0.3	0.5	0.4	0.4	0.6	0.3	0.7	+0.4
Other Opiates[a]	8.9	8.3	8.1	8.4	8.9	6.3	8.8	7.8	6.3	7.6	+1.3
Stimulants[a]	29.5	29.4	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted[a,d]	NA	NA	30.1	27.8	27.6	25.4	22.3	19.8	17.7	14.6	-3.1s
Sedatives[a]	13.7	14.2	14.1	12.2	10.8	9.3	8.0	6.1	4.7	4.1	-0.6
Barbiturates[a]	8.1	7.8	8.2	6.6	6.4	4.9	5.4	3.5	3.6	3.2	-0.4
Methaqualone[a]	10.3	10.4	11.1	9.2	9.0	7.2	5.8	4.1	2.2	2.4	+0.2
Tranquilizers[a]	15.2	11.4	11.7	10.8	10.8	9.8	10.7	8.7	8.0	8.0	0.0
Alcohol	94.3	95.2	95.2	95.0	94.2	95.3	94.9	94.1	94.9	93.7	-1.2

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a]Only drug use which was not under a doctor's orders is included here.

[b]This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

[c]This drug was asked about in two of the five questionnaire forms. N is two-fifths of N indicated.

[d]Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[e]Data are uncorrected for cross-time inconsistencies in the answers.

TABLE 46

Trends in Annual Prevalence of Fourteen Types of Drugs

Among College Students 1–4 Years Beyond High School

	Percent who used in last twelve months										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	'88 – '89 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	
Marijuana	51.2	51.5	44.7	45.2	40.7	41.7	40.9	37.0	34.6	33.6	−1.0
Inhalants[b]	3.0	2.5	2.5	2.8	2.4	3.1	3.9	3.7	4.1	3.7	−0.4
Hallucinogens	8.5	7.0	8.7	6.5	6.2	5.0	6.0	5.9	5.3	5.1	−0.2
LSD	6.0	4.6	6.3	4.3	3.7	2.2	3.9	4.0	3.6	3.4	−0.2
Cocaine	16.8	16.0	17.2	17.3	16.3	17.3	17.1	13.7	10.0	8.2	−1.8
Crack[c]	NA	NA	NA	NA	NA	NA	1.3	2.0	1.4	1.5	+0.1
Heroin	0.4	0.2	0.1	0.0	0.1	0.2	0.1	0.2	0.2	0.1	−0.1
Other Opiates[a]	5.1	4.3	3.8	3.8	3.8	2.4	4.0	3.1	3.1	3.2	+0.1
Stimulants[a]	22.4	22.2	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted[a,d]	NA	NA	21.1	17.3	15.7	11.9	10.3	7.2	6.2	4.6	−1.6
Sedatives[a]	8.3	8.0	8.0	4.5	3.5	2.5	2.6	1.7	1.5	1.0	−0.5
Barbiturates[a]	2.9	2.8	3.2	2.2	1.9	1.3	2.0	1.2	1.1	1.0	−0.1
Methaqualone[a]	7.2	6.5	6.6	3.1	2.5	1.4	1.2	0.8	0.5	0.2	−0.3
Tranquilizers[a]	6.9	4.8	4.7	4.6	3.5	3.6	4.4	3.8	3.1	2.6	−0.5
Alcohol	90.5	92.5	92.2	91.6	90.0	92.0	91.5	90.9	89.6	89.6	0.0
Cigarettes	36.2	37.6	34.3	36.1	33.2	35.0	35.3	38.0	36.6	34.2	−2.4

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in four of the five questionnaire forms. N is four-fifths of N indicated.

[c] This drug was asked about in one of the five questionnaire forms in 1986 (N is one-fifth of N indicated), and in two of the five questionnaire forms thereafter (N is two-fifths of N indicated).

[d] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

TABLE 47

Trends in Thirty-Day Prevalence of Fourteen Types of Drugs
Among College Students 1-4 Years Beyond High School

	Percent who used in last thirty days										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	'88 - '89 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	
Marijuana	34.0	33.2	26.8	26.2	23.0	23.6	22.3	20.3	16.8	16.3	−0.5
Inhalants[b]	1.5	0.9	0.8	0.7	0.7	1.0	1.1	0.9	1.3	0.8	−0.5
Hallucinogens	2.7	2.3	2.6	1.8	1.8	1.3	2.2	2.0	1.7	2.3	+0.6
LSD	1.4	1.4	1.7	0.9	0.8	0.7	1.4	1.4	1.1	1.4	+0.3
Cocaine	6.9	7.3	7.9	6.5	7.6	6.9	7.0	4.6	4.2	2.8	−1.4s
Crack[c]	NA	NA	NA	NA	NA	NA	NA	0.4	0.5	0.2	−0.3
Heroin	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0
Other Opiates[a]	1.8	1.1	0.9	1.1	1.4	0.7	0.6	0.8	0.8	0.7	−0.1
Stimulants[a]	13.4	12.3	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted[a,d]	NA	NA	9.9	7.0	5.5	4.2	3.7	2.3	1.8	1.3	−0.5
Sedatives[a]	3.8	3.4	2.5	1.1	1.0	0.7	0.6	0.6	0.6	0.2	−0.4
Barbiturates[a]	0.9	0.8	1.0	0.5	0.7	0.4	0.6	0.5	0.5	0.2	−0.3
Methaqualone[a]	3.1	3.0	1.9	0.7	0.5	0.3	0.1	0.2	0.1	0.0	−0.1
Tranquilizers[a]	2.0	1.4	1.4	1.2	1.1	1.4	1.9	1.0	1.1	0.8	−0.3
Alcohol	81.8	81.9	82.8	80.3	79.1	80.3	79.7	78.4	77.0	76.2	−0.8
Cigarettes	25.8	25.9	24.4	24.7	21.5	22.4	22.4	24.0	22.6	21.1	−1.5

NOTES: Level of significance of difference between the two most recent years:
s = .05. ss = .01, sss = .001.
NA indicates data not available.

[a]Only drug use which was not under a doctor's orders is included here

[b]This question was asked in four of the five questionnaire forms. N is four-fifths of N indicated.

[c]This question was asked in two of the five questionnaire forms. N is two-fifths of N indicated.

[d]Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

TABLE 48

Trends in Thirty-Day Prevalence of Daily Use for Marijuana, Cocaine, Stimulants, Alcohol, and Cigarettes

Among College Students 1–4 Years Beyond High School

	Percent who used daily in last thirty days										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	'88–'89 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	
Marijuana	7.2	5.6	4.2	3.8	3.6	3.1	2.1	2.3	1.8	2.6	+0.8
Cocaine	0.2	0.0	0.3	0.1	0.4	0.1	0.1	0.1	0.1	0.0	−0.1
Stimulants[a]	0.5	0.4	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted[a,b]	NA	NA	0.3	0.2	0.2	0.0	0.1	0.1	0.0	0.0	0.0
Alcohol											
Daily	6.5	5.5	6.1	6.1	6.6	5.0	4.6	6.0	4.8	4.0	−0.9
5+ drinks in a row in last 2 weeks	43.9	43.6	44.0	43.1	45.4	44.6	45.0	42.8	43.2	41.7	−1.5
Cigarettes											
Daily	18.3	17.1	16.2	15.3	14.7	14.2	12.7	13.9	12.4	12.2	−0.2
Half-pack or more per day	12.7	11.9	10.5	9.6	10.2	9.4	8.3	8.2	7.3	6.7	−0.6

NOTES: For all drugs not included here, daily use is below 0.5% in all years. Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a]Only drug use which was not under a doctor's orders is included here.

[b]Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

PREPARED STATEMENT OF SENATOR TOM DASCHLE

Chairman Moynihan is not able to be here today, but I want to thank him for scheduling this important hearing and acknowledge his leadership in this area. An earlier hearing of this subcommittee focused on the children of crack cocaine-abusing mothers. That hearing was the impetus for this follow-up hearing on the consequences of alcohol-abusing mothers—fetal alcohol syndrome and effect.

I also want to thank all our witnesses. Some of them have traveled long distances to tell their difficult, but important stories.

Too many Americans are unaware of the devastating consequences of alcohol use and abuse during pregnancy. Because alcohol is a legal drug, few people realize that alcohol, if used during pregnancy, can be just as harmful as crack cocaine or heroin. It's legal, so people think it's okay.

That's what Kathleen Tavenner thought. Kathleen has shown a great deal of courage by appearing today to tell her story. She is a recovering alcoholic who has turned her life around completely and is now helping other women do the same thing for themselves and their children. When Kathleen was pregnant, she abstained from other drugs to which she was addicted and replaced them with alcohol—the legal, "acceptable" drug.

But when a woman is pregnant, it is not okay. Its use can result in permanent damage to the fetus—damage with which the child and his or her family will live for the rest of their lives. Kathleen will speak to those consequences later this morning.

Fetal alcohol syndrome, or FAS, affects all races and nationalities and crosses all social and economic boundaries.

It is the leading cause of mental retardation in the Western world.

The costs associated with it are astronomical. Every year, more than $1.25 billion is spent in this country on medical, residential, and support services for FAS victims.

Yet very few people understand what a tragic impact FAS and fetal alcohol effect, a less severe form of FAS, are having on this country's children and their families.

I first began to understand the enormity of the FAS problem after reading Michael Dorris' *The Broken Cord,* which tells the story of his relationship with his adopted child, Adam Michael's story was particularly moving to me, as Adam was born on the Pine Ridge Indian Reservation, which I represent. In his book Michael tells of returning to South Dakota to develop a better understanding of his FAS child. I am pleased that Michael is also here today to tell his story.

Although FAS has no boundaries, its effects are especially felt in Indian country. The rate of FAS on some reservations is seven times the national average. On Pine

Ridge, one of every four Indian children is born with fetal alcohol syndrome or fetal alcohol effect.

Jeaneen Grey Eagle comes from Indian country. She lives with these statistics along with the statistics that reflect the many social ills associated with poverty, like unemployment rates as high as 50-85%.

But I will let Jeaneen tell her story. She does it movingly.

Finally, I am troubled by the fact that the American public has not faced up to alcohol's impact on the quality of the lives of our children—that a pregnant woman can permanently impair the young life she carries, and that that damage, though irreversible, is 100% preventable. I am troubled by this fact, because it doesn't have to be this way.

I am convinced the American public is well aware of the consequences of smoking. I am convinced the American public knows what can happen when they drink and drive. I am not convinced, however, that the American public is as informed as they should be on the consequences of drinking during pregnancy.

This hearing is intended to focus public attention on a preventable problem of tragic proportions, to assess the Federal response to that problem, and to begin to look in the direction of solving it.

PREPARED STATEMENT OF MICHAEL DORRIS

Unlike so many good people, scientists and social workers and politicians, who have chosen out of the kindness of their hearts and the dictates of their social consciences to become knowledgeable about fetal alcohol syndrome and effect, to work with its victims, to demand its prevention, I was dragged to the subject blind-folded, kicking and screaming. I'm the worst kind of expert, a grudging, reluctant witness, an embittered amateur, above all else: a failure. A parent.

I'm a living, breathing encyclopedia of what hasn't worked in curing or reversing the damage to one child prenatally exposed to too much alcohol. Certain drugs temporarily curbed his seizures and hyperactivity, but their dampening effects on his learning ability and personality development are unknown quantities. Fifteen years of special education isolation in a classroom, repetitive instruction, hands-on learning maximized his potential but they didn't add up to a normal I.Q. Psychological counselling introspective techniques, group therapy—had no positive results, and may even have encouraged his ongoing confusion between what is real and what's imagined.

Brain surgery hasn't worked.

Anger hasn't worked.

Patience hasn't worked.

Love hasn't worked.

When you're the parent of a FAS or FAE child, your goals change with the passing years. At first you start with seeking solutions: ideas and regimens to penetrate the fog that blocks your son's or daughter's ability to comprehend rules, retain information, or even be curious. You firmly believe—because it *has* to be true—that the answers are "out there." It's just a matter of locating them. You go through teachers and their various learning theories like so many Christmas catalogues received in the mail, determined to find the perfect gift, the right combination of toughness and compassion, optimism and realism, training and intuition. Once you find a likely prospect, you badger her (and most LD teachers seem to be women), demand results, attempt/to coerce with praise or threat. You become first an ally, then increasingly a pain in the neck, a judgmental critic, an occasionally hysterical, ever-persistent nuisance. When the teacher, worn out and frustrated, eventually gives up on your child, decides he's beyond her ability or resources to help, she's as glad to see you go as she is relieved that your son won't be back to remind her of her limitations. "With a crazy, irrational parent like that," you imagine her saying to her colleagues, "no wonder the kid has problems."

Do I sound paranoid, cynical? I didn't used to be this way, but I'm the product of a combined total of fifty years of dealing with alcohol-damaged children—for not only does the son I wrote about in The BROKEN CORD suffer from fetal alcohol syndrome, but his adopted brother and sister are, to a lesser and greater extent, victims of fetal alcohol effect.

My wife and I and our extended families have had no choice but to become a kind of full-time social service agency specializing in referrals, the admissions policies of various expensive institutions, the penalties meted out under the juvenile justice system, the nightmares of dealing with uninformed, often smug, bureaucrats given by default responsibility for people who can't make it on their own in contemporary

America. We were forced to progress from attending increasingly sour PTA meetings to learning the intricacies of intelligence testing—hoping that the score will come in below 70 and thus qualify for legal disability. We've had to become acquainted with the admissions policies and maximum length of stays at institutions like Covenant House, Boystown, and the Salvation Army. We've paid out well over a hundred and fifty thousand dollars, not counting what our insurance has covered, for our children's primary and secondary special school tuitions, counselling, doctors of every sort, experimental medical procedures, Outward Bound for Troubled Youth, and private camps for the learning disabled. We have managed to try every single avenue that's been suggested to us by well-meaning people who should know what might benefit our sons and daughter, and nothing—*nothing*—has consistently worked for more than a few months.

Our older children, now all adults or nearly so, cannot function independently, cannot hold jobs, tell the truth, manage money, plan a future. They have all at one time or another been arrested or otherwise detained for shop-lifting, inappropriate sexual conduct, and violent behavior. Despite all our efforts to protect them, they have periodically come under the influence of people who, for instance, worship Satan, or who take advantage of them physically, mentally, and/or financially. They maintain no enduring friendships, set for themselves no realistic goals, can call upon no bedrock inner voice to distinguish right from wrong, safe from dangerous.

Okay: maybe it's us. Maybe we're incredibly dysfunctional parents. Believe me, we've spent years feeling guilty and inadequate, holding on to the belief that if only we could become better, more resourceful, more sympathetic, more enlightened in our expectations and requirements, we could alter the bleak future that seems to lie in store or have already arrived for them. Like every self-reflective father and mother, we can recall our failures, our lapses, our losses of temper, and time after time we have added up these short-comings to see if they balance the devastating total of our children's current situations. THE BROKEN CORD was written, at least in part, to further this process, to assign guilt—if not wholly to us, then to *somebody, something*—to make not just sense of a senseless waste, but a difference. If every stone were overturned maybe something would be discovered that could reverse the fate of not just any anonymous afflicted fetus, child or adult, hut of *our* children.

But what the book yielded was worse than the least I had expected. Not only was there no magic trick, no scientific break-through that could "cure" our sons and daughter, but from the thousands of letters that have come from around the country it is clear that our family's private sorrow is far from unusual. In the year and a half since THE BROKEN CORD was published, we have heard from parents rich and poor, religious and agnostic, of all ethnic groups and every economic strata. Some live in cities, some in small towns, some on reservations. Some are adoptive parents like us, some are biological. All love their children, and almost none have given up hope. But none of them knows what the hell to do next.

The hardest group to answer are the parents of very young children, children who seem from the symptoms described to be clearly fetal alcohol effected. I recognize these parents: in the early stages of denial, full of the surety that answers exist. They want practical advice, experts to consult, books to read, effective doctors to visit. They want to head off the unpleasant disappointments described in my book, to save their child—and themselves from such a miserable chain of events. If THE BROKEN CORD had been written by somebody else, *I* would have written just such a letter to its author. I would have been skeptical of his pessimism, sure that I could do better, last longer, be smarter, succeed where he had failed, so when I answer those letters, I root for those parents, applaud their confidence, ask them to write back and tell me when things improve. So far, there have been no replies.

Alnnost equally difficult to absorb is the mail I receive from parents whose FAS or FAE children are older than ours. They write with the weary echo of experience, the products of many cycles of raised expectations followed by dejection. They tell of their "fifty-two year old" child, their FAE adult daughter who's just given birth to her third FAS baby and is pregnant again and still drinking. They tell of children serving twenty year prison terms or, in one case, of a "sweet" son sentenced to the death penalty for an impulsive murder for which he has never shown the slightest remorse. They tell of children raised in privilege who are now lost among the homeless on a distant city's streets, of children once so loving and gentle who have been maimed from drug use or knife fights, or, as is so often the case, who have been raped. They tell of innocents become prostitutes, of inexplicable suicide attempts, and always, always, of chemical dependency. They tell of children whose where-

abouts are unknown, or who are dead at twenty-five. This is not the way it was supposed to happen, these parents cry. It's not fair. It's not right.

We read these letters and wonder: is *this* in store?

I've even heard from adults diagnosed with fetal alcohol effect—one of them with a Ph.D. from Harvard and several others with masters degrees. These are highly intelligent people, the Jackie Robinsons of FAE, who have had to become specialists on themselves. Through years of observing their own trials and errors, of watching how "normal" people behave in a given context and analyzing how that contrasts with their own uncertain reactions, some of them have worked out complicated formula to simulate a greater connection of the world than they in fact possess. One woman carries in her purse a card on which is typed a series of questions she explicitly asks herself in attempt to gage the consequences of her possible responses to an unprecedented situation: What would so-and-so do in this instance? What will people probably think if I do x, y, or z? She's compensating for life in a universe that's slightly, almost imperceptibly alien, and speaks a language whose idiom and nuance are forever just beyond her automatic reach.

The correspondence we've received from around this country, and lately from around the world, has magnified exponentially our particular family experience, but hasn't contradicted it. The letter I've waited for but which has yet to arrive is the one that begins, "I've read your book and you're dead wrong," or "my child was diagnosed as having FAS but we fixed it by doing the following things and now, five years later, he's perfectly fine."

To what extent does this preventable scourge affect American Indian people? The answer, like so much about FAS, is ambiguous. On the one hand, prenatal exposure to ethanol impairs the individual fetus in exactly the same ways whether its mother is a member of a country club in Greenwich, Connecticut, or an ADC mom on White Earth. Every human being during development is vulnerable, fragile, easy to poison; ethnicity acts as neither a shield nor a magnet. Yes, "drinking age" matters, diet counts, smoking or other drug use will exacerbate the damage done by alcohol, but all things considered, physically *no* woman needs to give birth to an FAS baby.

The factors that really make a difference have to do with ephemeral things: strong family and community support for abstinence, access to good prenatal care and chemical dependency treatment, clear and widespread information on the dangers of drinking during pregnancy. And it's here that Native American women are at a severe disadvantage. Health programs on reservations have been among the first things cut when the Federal budget gets tight; clinics are shut down, counselors laid off, preventive educational campaigns scrapped. Access to organizations like planned parenthood is, in many tribal communities, impossible. Poverty, unemployment, despair—familiar elements in the daily lives of too many Indian people—lead to alcohol and other drug abuse. The long range roots of the problem, and their solution, are so much bigger and more complex than just saying no.

When you factor in to the statistics on FAS and FAE those having to do with prenatal exposure to crack cocaine—which seems to produce in children many of the same learning disabilities as too much alcohol—we are looking at something like 300,000 impaired babies born in this country annually. In ten years that's three million people. By the time the first generation counted is twenty, it's six million, and that's assuming a stable rate—not the current geometrically accelerating one. How does our society handle this onslaught, either on a local or a national level? How do we make laws that equally apply to those of us who can understand the rules and to a significant minority who, through no fault of their own, can't? How do we preserve individual liberty, free choice, safe streets, mutual trust, when some members of society have only a glancing grasp of moral responsibility? How do we cope with the growing crime rate among young people, with "wilding," with trying to teach the unteachable?

The thorny ethical issue that has troubled me most in thinking about the social impact of FAS and other such lifelong but preventable afflictions, concerns responsibility. When, if ever, are we, one-on-one or collectively, obliged to intervene? It's becoming increasingly clear FAS victims beget more FAS victims: a pregnant woman who can't calculate the longterm consequences of her decisions is a hard case for prenatal counselling. It is difficult if not impossible to convince her to defer an immediate gratification because nine months or nine years later her hypothetical child might suffer from it. That child is an abstraction, a hazy shadow at best, and its argument is a great deal less compelling than the draw of another drink or fix.

Some studies have suggested that compared to the "average" woman, female FAS and FAE victims start having children younger, continuing having them longer, and ultimately conceive and bring to term more offspring. They are less likely to seek prenatal care, to abstain from dangerous activities during their pregnancies, or to

keep custody of their babies. Statistically a woman who's given birth to an FAS baby has almost an eight out of ten chance to do so again, if she continues drinking, and subsequent siblings are likely to be even more impaired than the first.

These often abandoned or removed children, whether adopted or institutionalized, are ultimately our culture's victims and therefore are its responsibility. How to cope? At the absolute minimum, how do we—especially in a recession economy pay the medical bills, build the prisons, construct the homeless shelters? How do we train special education teachers how to function indefinitely with no hope of success, or ordinary citizens how to forgive behaviors that are irritating at best, threatening or dangerous at worst? How do we teach compassion for a growing class of people who are likely to exhibit neither pity nor gratitude, who take everything society has to offer and have almost nothing constructive to give back? How do we maintain the universal franchise to vote, the cornerstone of our political system? How do we redefine "not guilty by reason of insanity" to apply to heartless acts committed by people who are fundamentally incapable of comprehending the law?

To me these questions boil down to a simple analogy: imagine we saw a blind woman holding a child by the hand attempt to cross a busy street. The traffic was fast, she guessed wrong, and before our eyes her child was struck by a truck and killed. A tragedy we would never forget. Then a year later we come by the same intersection again, and again there's the woman, but with a new child. The light is against her but she doesn't see and tries to cross to the other side. The child is hit, terribly injured, as we stand by helplessly and watch. The next year it happens again, and the next, and the next. How many times must it happen before we become involved? Before we take the woman's arm or hold up our hand to stop the cars or carry her child or at least tell her when the signal is green? How many children are too many? When do their rights to safe passage assert themselves? And how long before the mother herself is killed?—for remember, she's a victim and at grave risk, too. It does no good to blame her, to punish her in retrospect for her blindness. Once the street is crossed the child is dead. She needs help and we need to find a decent way to provide it. If we turn our backs and walk away, we stop being innocent by-standers and become complicit in the inevitable accident, accessories after the fact.

Let us make no mistake about one point: we're not *facing* a crisis, we're *in* one, though official statistics can be deceiving. A couple of years ago South Dakota, a State with at that time no resident dysmorphologist, reported a grand total of two FAS births during the same period in which my friend Jeaneen Grey Eagle, Director of Project Recovery in Pine Ridge, estimated that somewhere between one-third and one-half of the infants born in certain communities of her reservation were at high risk due to heavy maternal drinking. Under-diagnosis, unfortunately, does not equal small numbers.

But what can we do about it? Each person must provide his or her own answers. Some of in us—the scientists—can study the biochemistry involved in fetal damage from drugs, learn to predict which women are most at risk and when, figure out how much ethanol, if any, is tolerable. Others—advocates and politicians—can address the issue of prevention: get out the word, make pests of ourselves, speak up even when it makes our friends uncomfortable, fight for the future of a child not yet even conceived. Still others—social workers, psychologists and educators—ean tackle the needs of the here-and-now, of the tens of thousands of FAS and FAE men, women, and children who exist on the margins of society. We can devise effective curricula, learning regimens, humane models for dependent care.

If we, in this room today, put our minds to it, if only *we* did our part, we might not obliterate fetal alcohol syndrome on a global level, but, in all candor, we could save many lives, many mothers, many babies. All it takes is nine months of abstinence, a bit longer if a mother breast-feeds. Three hundred thousand separate and discrete solutions, three hundred thousand miracles, and it's a clean year.

And finally some of us, the parents into whose care these children have been given, whether by birth or adoption, can try to get through another day, to survive the next unexpected catastrophe, to preserve a sense of humor. We laugh at things that really aren't funny—quite the contrary but we laugh, without malice, for relief. When our oldest son, "Adam" in THE BROKEN CORD, went with me last fall to his annual case management meeting, he was asked to list all the accomplishments in the past twelve months about which he felt especially proud. He drew a blank.

"Then, tell us what you've been doing since we met here last year," the man directed and Adam complied.

"Well, I went down the stairs and I opened the door," he began. "Then I got into the car and my father took me home. For supper we had . . . ." Adam tried to re-

member that anonymous meal he polished off some three hundred and sixty-five days before, stalled, and looked to me for help,

"Next question, " I suggested, and the social worker consulted his list.

"Tell me what things you really *don't* like to do," he invited.

Adam's eyes lit. This was an easy one. "I don't like to dig up burdocks," he stated.

I blinked in surprise. Adam hadn't dug up burdocks in three years. He was simply using a response that had worked in the past.

"Wait a minute," I said. "Adam, thousands of people all over the country have read your chapter at the end of the book about how you dug up those burdocks to help us. People liked that part so much I think that's why they gave our book that prize you have sitting on your dresser. People are very proud of you for what you did. I know it wasn't fun to dig up those plant,, but you should feel good that you did it"

Adam was having an especially polite day. He smiled at me, cocked his head, and asked: "What book would that be?"

The grind doesn't get easier and it doesn't go away. FAS victims do not learn from experience, do not get well. My wife Louise keeps a diary and a while back she glanced back over the past four years. That can be dangerous, because there are some things you don't notice until you take the long view. It turned out that as a family we hadn't had a single period longer than three consecutive days in all that time when one of our alcohol-impaired children was *not* in a crisis—health, home, school—that demanded our undivided attention. It often seems to us that their problems define *our* existence as well as their own, and in that respect perhaps we are in a small way the forecast of things to come for this country. FAS is not aproblem whose impact is restricted to its victims. It's not just a woman's issue, not just a man's. No one is exempted. These are everybody's children.

PREPARED STATEMENT OF JEANEEN GREY EAGLE

On the Pine Ridge Indian Reservation abuses take place in many different forms. We have alcohol abuse, drug abuse, spouse abuse, elderly abuse, and the most hideous abuse of all, child abuse. The abuse of a child is probably one of the most devastating things that can happen over the course of a lifetime. We all know that if one is abused as a child the probability to grow up and abuse others is very strong.

One of the saddest abuses is pre-natal child abuse. During the time before birth a child should have the right to exist, free of any harmful chemicals that cause, birth defects or mental retardation. A child's birthright should include the ability to learn, the ability to reason, and most of all a promising future. Many children born to drinking parents will never have the ability to enjoy the simplest things in life, let alone know how to reason or how to plan a future.

During the 1950's-60's a drug was prescribed to pregnant women called thalidomide. This drug caused a variety of birth defects which included children born without arms and legs, and also miscarriages. The Food & Drug Administration quickly traced the source of these birth defects and banned the use of Thalidomide by pregnant women. Fortunately, women stopped using thalidomide as it had no addictive properties. People clearly understood the direct cause and effect of use equals birth defects and possible death. Each year, across this Nation there are thousands of children born to mothers who use alcohol and drugs. Even though it has been well documented that alcohol and drugs cause birth defects and miscarriages the FDA is very slow to act against a very powerful lobbying force, the liquor industry.

As we are all aware, chemical dependency is just that, dependency. Simple warning statements on cigarette packages are never read, or if they are many people suffer from "It will never happen to me," syndrome. But maybe there would be more attention paid to this topic if agencies were to get involved and scream from every rooftop about the dangers of alcohol and drugs, much like what happened with Thalidomide. Maybe this approach would also bring much needed funding to provide treatment for pregnant women and their family members. This is not just a woman thing, this belongs to all of us, men, women, equally. We both share responsibility over what happens to our future generations.

For 1989-90 there were 10,269 arrests on my reservation, the Pine Ridge Indian Reservation. Approximately 25-30% of this total were females. One step further tells us that the Chief Judge, Pat Lee feels that 95% of all arrests can be attributed to alcohol and or drug abuse, and yet, Pine Ridge is still considered a dry reservation where the use and sale of alcohol is supposed to be prohibited. The prohibition of liquor on the reservation has led to the same scenario the United States witnessed in the 1920's. Bootlegging, manufacturing and sale of alcohol is rampant on

the reservation. The lack of regulation has often resulted in the sale of liquor to children leading to extremely high rates of juvenile delinquency and teenage pregnancy, and consequently harm to unborn children.

The infant mortality rate on the Pine Ridge Reservation and the Aberdeen Area is worse than the countries of Cuba, Bulgaria, and Peru. In this great land of plenty, many babies are born exposed to such high levels of alcohol and drugs before birth, they die, are born intoxicated and experience life threatening withdrawals shortly after birth. They are doomed to spend the rest of their life with birth defects and or mental retardation, which is all 100% preventable.

According to a 1986 study done by the Children's Defense Fund, the States infant mortality rate per 1,000 live births was 13.3 compared to a national average of 10.4%. Among non-whites in South Dakota, 90% of whom are Native American the rate was 27.5%. This number means that of 1000 babies born in the State of South Dakota 13.3% die before they reach age 1, for Native Americans in the same State of South Dakota 27.5% of our babies die before their first birthday. I have heard that number has now increased to 30+ babies per 1,000. Yet nobody is asking why?

In 1986, the Children's Defense Fund spokesperson Joseph Liu is quoted as saying "Generally a one year increase like that doesn't amount to a trend, but what it obviously does is indicate something went wrong that year. South Dakota can't wait another year for a trend to emerge. It has to look into it right away." I remind you this was said in 1986.

I am upset that 3 years later we are obviously still waiting to see if a trend has developed, and there are more babies dying.

I would like to share a story witch was told to me by a midwife in Pine Ridge who cares very much what is happening to our people. A woman came to the hospital ready to deliver and had never been in prenatal clinic before. A common story. This woman was obviously intoxicated. When the baby was finally born, a little girl she would not cry and had a very difficult time breathing. The baby was taken to another room for more medical care and when the baby started to cry the smell of cheap wine on her breath was very strong. This baby would not breath because it was technically passed out. This is child abuse.

I know we are all tired of studies, tired because we never see the results or have an understanding of why it is necessary. I advocate that we find out how many amongst us are affected, how many children have been born with less than a normal life. An on-going comprehensive study would allow us the knowledge base to demand resources to address the problem. Many children with special health and educational needs re presently unserved or underserved because the extend of their disabilities or cause has never been determined. It is also felt that if the general population is made aware of the high numbers of children that are affected then the implications for future generations could be addressed. At the present time the tribe is called into believing we don't have a problem. This problem has been created by Indian Health in their incomplete and inaccurate study which would have us believe that we only have 4-5 FAS births per 1,000.

I have 10 recommendations that I feel are very important to us as Native American people and to the Nation as a whole regarding pre-natal child abuse:

(1) We begin as concerned individuals to research a proper legal forum that will address the use of alcohol and drugs by women who are not going to have abortions. That we as a Nation provide a deterrent by placing penalties for giving births to one or more babies affected by prenatal exposure.

(2) That the Food and Drug Administration take a more aggressive approach in the labeling of all alcohol beverages with warnings and also provide an aggressive, well informed public education campaign.

(3) That all medical schools teach a wide variety of health professionals Fetal Alcohol/Drug effects on babies.

(4) that Indian Health Service take a leadership role in this field and provide ongoing FAS/FAE education to medical staff. That health educators become actively involved on every reservation to teach patients, community organizations, schools, tribal councils on the consequences of alcohol and drug use by pregnant women.

(5) Indian Health Service provide prevention, education, and treatment aimed at alleviating fetal alcohol syndrome. Treatment and detox is essential for pregnant women.

(6) IHS begin immediate Special Needs Clinics across every reservation to determine the extent of present damage to our populations. That within these clinics special needs are not only identified, but also cared for.

(7) That the Bureau of Indian Affairs address the issue by screening within the school system and identifying their affected populations. Special programs and ther-

apy should then be provided instead of the typical storage mentality for learning disabled children.

(8) That a comprehensive study take place to determine the extent of effect on all reservations. That all post studying on our reservation be rendered inaccurate or flawed because of lack of certain unique characteristics and traits.

(9) Tribal courts receive training and resources adequate to apply any such law to its fullest extent, regarding the investigation, arrest, prosecution, and judgment of prenatal alcohol drug exposure and its subsequent birth defects. Depending on the appropriateness of the situation, whether its the 2, 3, 4 offense an enforcement and bringing into compliance offenders who have willingly or by court order have submitted, themselves to an appropriate diversion/rehabilitation program.

(10) That IHS print the FAS adolescent manual which contains the 10 year study by Anne Streisgaieter—which includes a working knowledge of how to work with FAS adolescents.

My friend, Michael Dorris wishes he could be here today. Unfortunately, his son Adam, for whom the Broken Cord was written is undergoing brain surgery. He is, as we all know fetal alcohol syndrome affected and has suffered a lifetime for problems, including severe seizures. Now, today surgery is being performed to see if the seizures can be stopped if not slowed down. When you pray today, remember this brave young man and his fight to find a normal lifestyle, which is his god-given right.

PREPARED STATEMENT OF CHRISTINE LUBINSKI

Thank you for offering the National Council on Alcoholism and Drug Dependence the opportunity to testify on fetal alcohol syndrome and other alcohol-related birth defects.

My name is Christine Lubinski and I serve as NCADD's Director for Public Policy.

The National Council on Alcoholism and Drug Dependence is the Nation's ninth largest voluntary health organization and the only one dedicated solely to reducing the incidence and prevalence of alcoholism, other drug addictions and related problems. Since 1944, NCADD has been a national leader in alcohol policy, education, prevention and treatment and is dedicated to supporting innovative approaches to advance the field. NCADD serves as an advocate for alcoholics, other drug dependent persons and their families and for the development of alcohol and other drug policies in the best interests of the public health. NCADD has strong links with community-based organizations through its 190 affiliates in 36 States.

NCADD has a long history of prevention, education and advocacy in efforts to reduce the toll of alcohol-related birth defects. Since 1983, NCADD has facilitated an annual community-based educational campaign about alcohol-related birth defects beginning on Mother's Day. We mail 1500 comprehensive informational packets to health professionals and other community leaders. These packets include information ranging from basic information about birth defects associated with alcohol and other drugs to recommendations about strategies to inform the public about the risks of alcohol and drug use during pregnancy and initiatives to encourage the expansion of alcoholism and drug treatment for pregnant women and their children.

NCADD supports legislative and regulatory changes to increase public Center for Science in the Public Interest, NCADD led the coalition of over 100 organizations which successfully facilitated the adoption of warning label legislation by the Congress. The warning label, now required by Federal law, includes a specific warning regarding the risks of drinking during pregnancy. We have also lent support and technical assistance to dozens of successful efforts across the Nation to require warning posters at points of purchase for alcoholic beverages about alcohol use during pregnancy.

In May, 1989, NCADD organized the Coalition on Alcohol and Drug Dependent Women and Their Children as part of our ongoing work to increase access to quality treatment services for alcoholic and drug dependent women and to prevent alcohol and other drug related birth defects. Our goal is to counteract the growing trend to punish rather than treat pregnant alcoholic and drug dependent women by developing a humane, public health response and to unite the various organizations which share a concern about the many dimensions of maternal and child health. The Coalition provides a forum to share ideas and concerns and to receive state of the art information for the many disciplines who work with alcoholic and drug dependent women and their families. It acts as a catalyst for multi-disciplinary approaches to

address the problems associated with maternal addiction including alcohol-related birth defects.

There is a crisis in maternal drug addiction in America today. In recent months the news media has been filled with articles reporting this tragic story. What has been missing from the media, and from the national "War on Drugs" in general, is attention to the nation's most serious drug problem—alcohol and alcohol-related birth defects. Fetal Alcohol Syndrome remains one of the top three causes of mental retardation due to birth defects in America, and is the only one of these three causes that is completely preventable. At least 5,000 infants are born each year with full blown Fetal Alcohol Syndrome (FAS) and another 35,000 with lesser alcohol-related birth defects. Given haphazard identification and reporting of FAS in many parts of the country and the absence of reliable diagnostic criteria for other fetal alcohol effects, the number of alcohol-affected children is probably much higher.

While public concern about pregnant illicit drug users is certainly justified, there is little doubt that many more women who are pregnant or of child-bearing age are alcohol users. Alcohol, unlike illicit drugs, is widely available, inexpensive, and heavily promoted to women. Because of the integration of drinking into American life as well as the depiction of alcohol in ads as appealing, sexy and benign, we must be vigilant in our efforts to educate all Americans, and especially pregnant women, about the grave health risks associated with drinking. If the long-term consequences of in utero cocaine exposure are still unclear, the impact of alcohol exposure on human development is all too clear. Mental retardation, heart and limb abnormalities, profoundly limited analytical abilities and poor judgment are just a few of the deficits faced by Fetal Alcohol Syndrome children and their families over the course of a lifetime. In addition, alcohol-affected children are themselves at high risk for the development of alcoholism, triggering an intergenerational cycle of addiction which may haunt a family for decades.

Pregnant alcoholic women and their children are faced with a system of health care poorly suited to meet their many needs. The public alcoholism and drug treatment system is unprepared and sometimes unwilling to provide comprehensive services to pregnant alcoholic women and their children. The National Association of Alcohol and Drug Abuse Directors (NASADAD) reports that the publicly funded treatment system is able to serve only 11 percent of the 280,000 pregnant alcoholics and drug dependent women in need of treatment. Many treatment facilities refuse to accept pregnant women. Very few provide childcare for infants as well as other dependent children. There is ample evidence that treatment interventions during the course of pregnancy do significantly improve pregnancy outcome. But the Nation is tragically unprepared to provide a system of prenatal care and comprehensive treatment services to alcoholic women and their families. Alcoholism is a treatable illness and millions of individuals and families have successfully recovered. In the absence of an environment which encourages alcoholic mothers to seek help and which offers high-quality comprehensive treatment services, women die prematurely and children struggle through life with profound disabilities.

Not only has the Nation been slow to develop a network of treatment services for women and their children, but the current hostile environment hardly encourages alcoholic women to seek help. Public attention to alcohol and other drug-affected children has been coupled with growing hostility toward women who use alcohol or other drugs during their pregnancies. Dozens of drug dependent women have been prosecuted for their drug use during pregnancy and there has been at least one case of a pregnant alcoholic woman being charged on the basis of her drinking during pregnancy. In our view, such policies are inhumane, fail to recognize alcoholism and drug addiction as illnesses, and discourage women from acknowledging their problem and seeking services. Given the notable absence of adequate treatment services virtually anywhere in the Nation, criminal prosecution and other punitive measures blame the victim for a system that is wholly inadequate to meet her needs. And the consequences for children—increasing numbers of children born with birth defects who languish in actively alcoholic homes or in the Nation's overwhelmed foster care system.

Alcohol-related birth defects must be addressed as a public health problem, with aggressive research, prevention, education and treatment measures. There are significant steps the Congress can take to insure that every person in the Nation is aware of the risks associated with alcohol consumption during pregnancy, that every alcoholic and drug dependent woman in the Nation has access to comprehensive treatment services sensitive to her needs as a woman and a mother, and that every child born alcohol affected receives the very best our health, educational and social service systems can provide.

TREATMENT

We must develop and institutionalize a basic system of care for pregnant alcoholic and drug dependent women in order to intervene and prevent the long term and devastating impact of alcohol and drugs on women, their children and families. Alcoholism and drug dependency treatment is the most important prevention strategy which we can implement to prevent low birthweight, transmission of AIDS and chronic physical and emotional disabilities associated with prenatal exposure to alcohol and other drugs.

The single most important step which this Committee and the Congress can take is to enact a Medicaid family care proposal like that embodied in Senator Moynihan's S. 3002, introduced during this last session of the Congress. Senator Moynihan's proposal would allow, at a State's option, Medicaid to cover comprehensive services to pregnant alcoholic and drug dependent women, their children, and a caretaker parent of those children. The legislation would fund long-term residential treatment for pregnant women and their children up to 12 months after they give birth. If we are serious about preventing alcohol related birth defects, we have to get serious about treating alcoholic women and their families, because these women have lost their ability to make choices about drinking during pregnancy. Institutionalizing a funding mechanism for quality, comprehensive treatment through the Federal health insurance program for low-income Americans is timely and appropriate.

Congress should also fund treatment initiatives for Native American pregnant and post-partum women and their children. It is well known that the incidence of alcoholism in a number of Native American tribes is dramatically higher than that of the general population. Native American women between the ages of 15 and 34 are 36 times more likely than white women to have cirrhosis of the liver. Appropriate treatment resources for Native American women are scarce and the level of hostility toward Native American women who drink during pregnancy is on the rise. We must fund therapeutic interventions for Native American women and their children and end practices of forced incarceration and automatic removal of infants from the care of their mothers. During the last Congressional session, Senator Kohl introduced S. 2559, the "Comprehensive Assistance to Substance Abusing Families Act of 1990." This bill would have authorized a grant program administered by the Indian Health Service which would support the development and expansion of alcoholism and drug treatment programs to serve pregnant and post-partum Native American women and their children. The programs would establish important linkages with likely points of access for high risk women including family violence and homeless shelter programs, public housing and prison programs. Early intervention and the provision of comprehensive health and social services for mother and children will greatly reduce the terrible toll of alcoholism and alcohol-related birth defects on the Native American community.

S. 2559 addressed another key population of women--women in prison. While a substantial majority of women in prisons report some alcohol or other drug involvement, treatment programs are virtually non-existent for the female prison population. Frequently pregnant women in prison are faced with the absence of any prenatal care services. S. 2559 contained a provision entitled the "Comprehensive Prevention and Treatment Services for Women in Prison" which would establish pilot programs in at least 20 State and local jails or prisons to provide comprehensive drug and alcoholism treatment services for women, and in the event of pregnancy, prenatal and post-partum care.

In addition to enacting pending legislation in these areas, we must strengthen the accountability mechanisms in the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant. The set-aside is one example of Congressional attempts to support programs for women with alcoholism and other drug addictions. This law requires that States spend 10 percent of their ADMS block grant on new and expanded prevention and treatment services for alcoholic and drug dependent women. Since 1985, the set-aside has represented $364 million that States have been required to spend on services for women. But the commitment of the States to creating women's programs has been minimal. Numerous reports document the virtual absence of treatment programs which serve women and their children, generally, and pregnant women, specifically. Congress specifically identified the need for programs to serve these two populations in the set-aside legislation. We must strengthen mechanisms for accountability for the women's set-aside of the ADMS block grant. One option is to require States to use a centralized categorical grant process for distribution of funds and report to the Federal Government annually regarding the establishment and expansion of discrete treatment programs which provide services to pregnant women, and other women with children.

We must also increase financial support for the Pregnant and Postpartum Women and Their Infants demonstration projects administered by the Office for Substance Abuse Prevention. This demonstration represents the first national effort to establish programs specifically for pregnant women, their infants and children.

PREVENTION

Given the fact that most children born with fetal alcohol syndrome and other severe drug-related birth defects are the children of alcoholic and drug dependent mothers, treatment opportunities for mothers and their children must, be on the front line of prevention initiatives. However, we also know that any drinking during pregnancy may impair the developing fetus so that all women who drink while pregnant are at risk, whether or net they are alcoholic.

Although great strides have been made through the enactment of warning label and warning poster legislation, there is still work to be done. Unlike crack cocaine and heroin, alcohol is a heavily promoted legal drug. Advertisements for alcohol in the broadcast and print media, specifically targeted to women, offer no information about the health and safety risks associated with drinking, including the risk of drinking during pregnancy. In fact, many of these ads attempt to induce women to drink by associating alcohol with economic and sexual success. It is critical that we counter these deceptive messages by ensuring that women receive vital health and safety information about alcohol. In the last Congress, Senator Gore introduced the "Sensible Advertising and Family Education Act." This bill would have required that all alcohol advertisements be accompanied by rotating health messages about alcohol risks, including a specific warning about drinking during pregnancy. Too few women receive prenatal care and too many health professionals still fail to educate their clients about alcohol use during pregnancy. The Federal Government has a responsibility to insure that the legal drug, alcohol, is marketed in a fashion that does not compromise the public's health. Requiring specific warnings on alcohol ads make an enormous contribution to our collective efforts to empower women to make informed choices about their alcohol use.

Finally, a substantial increase in alcohol excise taxes would make a substantial contribution to primary prevention of alcohol-related problems, including alcohol-related birth defects. While the budget resolution did include an increase in alcohol excise taxes, the increases were modest, especially on the price of beer. A significant body of research has demonstrated that there is a link between the price of alcoholic beverages, the amount of alcohol consumed, and the extent of problems attendant on that alcohol consumption. Research suggests that both young drinkers and heavy drinkers—including alcoholic persons—are sensitive to the price of alcoholic beverages and will reduce their consumption subsequent to a price increase. A substantial price hike on beer, wine and distilled spirits will result in a reduction in overall consumption with an accompanying reduction in alcohol-related problems, including alcohol-related birth defects.

SERVICES FOR ALCOHOL AND OTHER DRUG AFFECTED CHILDREN

We must increase access to services for children with alcohol and other drug related birth defects. Congress should formally expand Head Start eligibility to include infants and toddlers and increase financial support for this program to ensure availability of the full range of services needed by these families. Education for the Handicapped programs can be enhanced by increasing Federal financial support for specialized instruction and related services under Part B and by enhancing Part H by making it a permanent program. We should increase Federal financial support to ensure that all States participate, and amend the definition of Federal eligibility to include children who are at risk of being developmentally delayed, many of whom have alcohol and drug related birth defects.

All of these initiatives will contribute to reducing the toll of alcohol-related birth defects and to allowing alcohol and drug affected children to realize their full potential. However, real movement in this direction will require a fundamental change in the rhetoric and policies now associated with the "War on Drugs." We must recognize alcohol's role as the Nation's favorite drug and the drug which is associated with more mortality and morbidity than all illicit drugs combined. We must approach alcohol and other drug problems from a public health perspective. A public health perspective challenges us to change the environment which fosters alcohol and other drug problems—alcohol promotion, poverty, housing shortages, fundamental gaps in our health care system, violence and hopelessness.

The National Council on Alcoholism and Drug Dependence is grateful for this hearing and your interest in this subject. We encourage you to review some of the

policy initiatives outlined here and consider taking a role in facilitating their enactment in the next session of Congress. Alcohol has been sorely neglected in the policy discussions about prenatal addiction, and the omission has serious implications for any concerted effort to reduce the numbers of drug-effected children. The very quality of life for thousands of women and their children is at stake.

PREPARED STATEMENT OF SENATOR DANIEL PATRICK MOYNIHAN

All children are not born equal. Some are born suffering from Fetal Alcohol Syndrome.

These children suffer educational, emotional and social problems throughout their lives. They are often mentally retarded, scoring an average of two standard deviations below the mean on I.Q. tests. By the time they reach adulthood, they cannot perform such basic tasks as following a television program or cashing a paycheck.

The costs to us of Fetal Alcohol Syndrome are huge. The care for some quarter-million affected children and adults cost $1.5 billion in 1980. Post-natal care can cost up to $2,500 per day; special education, $20,000 per year; and institutionalization, $100,000.

As Chairman of the Subcommittee on Social Security and Family Policy, I am particularly concerned about the impact of Fetal Alcohol Syndrome on the family.

Raising these damaged babies is enormously difficult. They often do not respond to their families. Michael Dorris, who joins us today, and who authored *The Broken Cord,* eloquently expresses the struggle of parenting afflicted children. He says: "For ten years as a single parent I convinced myself that nurturing, a stimulating environment—and love—could open life up to my little boy. It wasn't true."

Tragically, the families most likely to have afflicted children are the families least able to care for them. According to available data, women who are most likely to be alcohol abusers, and thus to bear Fetal Alcohol Syndrome children, are single, separated, or divorced; relatively poorly educated; young; lacking in self-esteem and unemployed. This is a group of women that also often ends up on welfare.

Many afflicted children have no parents at all. In one study of eleven Fetal Alcohol Syndrome children, the mothers of three of the children died from alcoholism before the children had reached age six. This is yet another example of one of the most alarming trends of the past decade—the emergence of the no-parent family. Because many families are unable or unavailable to care for affected children, the children—up to 75% of them—go into foster care, a system that is breaking down. Since 1985, the number of children entering foster care has grown steadily from 270,000, to more than 360,000 in 1990.

Families from certain groups experience the tragedy of Fetal Alcohol Syndrome more than others. Native American women are 36 times more likely than white women to give birth to afflicted children, and black women are 9 times more likely. The reasons for this higher rate of incidence will hopefully be addressed this morning by our witnesses.

Unfortunately, there are few avenues of help open to alcohol-abusing mothers-to-be. Indeed, we were shocked to discover last year that drug abuse treatment services were not covered by Federal Medicaid. I introduced a bill to make it so. And last month, the legislation was enacted.

Moreover, I introduced another bill, the "Medicaid Drug Treatment for Families Act of 1990," to specifically permit Federal Medicaid to reimburse substance abuse treatment services provided in residential settings to low-income women and other eligible family members. Comprehensive education, counseling and referral services, as well as child care and room and board would be provided. Regrettably, the Congress did not pass this bill. But I plan to reintroduce a similar measure during the next session.

The consequences of Fetal Alcohol Syndrome can be seen everywhere: in our foster care program, our schools, our health care system. Alcoholism in women, whether in the reservations, the inner city, or suburbia, requires our attention now. Today we are here to learn about Fetal Alcohol Syndrome. And, at least, we will know by the and of this hearing what the questions are that need answering.

PREPARED STATEMENT OF KATHLEEN J. TAVENNER

I am recovering from the disease of chemical dependency. My name is Kathleen. I appreciate this opportunity to place my personal testimony of recovery with this committee, and I commend the committee on its concern.

This is an issue that Congress must pay attention to, not only for obvious humane reasons, but also how the grave problem of addiction affects the American pocketbook. It is my belief that by investing more money in the forefront, by offering holistic treatment services to women, and their families, it would save millions of dollars in the longer term, as well as preserve our greatest natural resource, the family.

I would also like to remind the committee that my story is not unique. Addiction is a multigenerational, genetic disease that has devastating effects on the entire family system. There is hope for recovery. Change can and does occur with proper treatment and intervention. There are thousands of women like me, who, with the proper help have been able to put their lives back together, become productive citizens, and play an active role as "mom" to their children.

When we speak of people suffering from this disease, we must try to remember that these individuals are sick, they are not bad. We must try to employ them with empathy, rather than harsh judgment, for one of the symptoms of the disease of alcoholism is denial.

I believe that my life has been a great teacher for many that have heard it: on the tragedy of alcoholism, the lack of intervention (due to ignorance and fear) and the lack of appropriate treatment services for women.

I was raised in an upper middle class home in Montgomery County, Maryland, attended parochial school, and had an above average I.Q. My father was a "functioning alcoholic," and my mother was codependent on my father, that is her life completely revolved around his drinking, to the point that she couldn't take care of herself, and had a hard time coping with all of her children. As his disease progressed, so did hers. There were many secrets in our home.

All seven children went through emotional abuse and neglect, as neither parent was able to provide us with the emotional support and nurturing for healthy self-esteem. Today I accept that both of my parents were sick, not bad parents.

Research shows us that this disease is genetic. I was certainly pre-disposed, that is, if I used I would become addicted. As an adolescent I had no self-esteem, no self-worth, and was truly a victim of my environment.

I naturally was drawn to other youngsters, like me, who were also from alcoholic homes, and were experimenting with drugs and alcohol. I finally fit in! I became sexually active (another predictable behavior), got pregnant and left home at 16 to move in with my drug-addicted 19-year old husband.

That marriage lasted 10 years and we had three children. I would stop using "hard drugs," when I became pregnant and would substitute with the legal drug, alcohol. In my mind I would minimize alcohol use, and felt as if it were perfectly alright to drink. My 17-year old daughter is a victim of my disease today. She suffers from Fetal Alcohol Syndrome (FAS) directly secondary to my alcohol use. Her name is Karli. She will be 18 in February, She will then qualify for Social Security income. I diagnosed Karli myself just two years ago. I work in the addiction field at Mt. Manor Treatment Center where we have a women's and children's treatment program. I was exposed to a lot of current research, and took her to Georgetown Developmental Clinic for testing. Their diagnosis coincided with mine, that is, all of her deficiencies are directly secondary to alcohol consumed during pregnancy.

This was not the first time she had been tested. She was tested at two other hospital development clinics, and is tested bi-yearly in her special education learning center. She has been diagnosed with cerebral palsy, emotional delayed, mentally retarded, etc.

Karli was born three weeks early. She was small with a small head circumference. She has some recognizable FAS facial features: small fingernails, slight in build, and frail limbs. Her fine and gross coordination is dysfunctional. Karli cannot write in cursive, she cannot hold a pen for a very long length of time, she cannot ride a bike. Karli cannot tell time, nor understand the concept of mathematics or money. Karli will always need to be cared for, either at home or in a group home for retarded adults. The only reason Karli's life looks like this, is because of alcohol consumed in utero. FAS is the number one cause of mental retardation in the United States.

I can remember, especially after Karli was born, feeling that I had to drink and drug because I had so many problems in my life. I had no idea that the problems in my life were due to the drugs/alcohol. I tried everything to pull my life together. We moved often, trying to "fix" our life. By the time my son was 13-years old, he had been to 16 different schools. I decided that my husband was the problem, so I left him.

The most painful memory of my addiction is the tremendous guilt and shame that I experienced around my children. I remember feeling so confused. I loved my chil-

dren so very much. They were all that mattered, yet my behavior didn't reflect this love. I came to believe that I was immoral, insane, and a terrible mother.

I remarried another abusive man who was also addicted. Again in my chemical induced insanity, I tried to "fix" my life, and had two more pregnancies. If I have another baby, it will force me to pull my life together. In my mind, I only wanted to be a good mother. I wanted the white picket fence and a normal existence. I would wake up every morning and promise myself and the kids I wasn't going to drink/drug, only to give in to the pain and cravings of my addiction.

Neither of those two children survived; one was born prematurely, the other died of SIDS. I believe both deaths were secondary to my addiction.

I was addicted for about 15 years. During those years, I had five full term pregnancies, all delivered in community hospital clinics. I was a client of many agencies, including Social Services, Housing Opportunities Commission, WIC, etc. I was reported for neglect to Child Protective Services. It is truly a tragedy to think there were so many opportunities for intervention of treatment, yet everyone turned their heads to the obvious.

I finally did get treatment, after ending up in a detox unit, due to an overdose, and a counselor persuaded me. I went through Mt. Manor Treatment Center, a 30-day program. I walked in believing I was a bad person. I was treated with love and respect, and they educated me about my disease. That was my beginning.

I needed much more than a month. I was a high school dropout on social services, with poor communication and social skills, no job skills, and poor parenting skills. I was in distress with grief and shame, was extremely codependant, and was overwhelmed with so much fear, I dreaded even driving a car.

At that time the only long-term treatment was a punitive therapeutic community. I went despite the fact I was separated from my kids. I totally disagreed with their philosophy of punishment and shame. I knew in order to stay sober I had to obtain some life skills. I did get my G.E.D. while in treatment; however, I only saw my children twice in 10 months, so I left.

Today, I am Regional Director of Marketing for Mt. Manor Treatment Center. All three of my children live with me in my home in Montgomery County. My son is a sophomore at the University of Maryland, and my two daughters are in county schools. My children are loved and nurtured. We are no longer on welfare and we give to our community.

I have found that my daughter, Karli, can teach us all a valuable lesson. I hope that Congress will learn from her. Her message is one of love, the most powerful weapon in this war on drugs.

We need better training for our social service workers, nurses, doctors, etc, for earlier intervention to avoid future tragedies. We need longer term inpatient treatment for pregnant women and their children.

We need holistic, intraagency services to meet all the needs of these populations (schooling, job skill training, parenting, housing, cultural issues, co-dependency, day care) so that these women can become independent from drugs, alcohol, welfare, and abusive relationships. Cost effective treatment will save millions down the road in social services, foster care, handicapped and judicial monies.

If medical assistance covered long-term treatment for pregnant females and they are in a protected environment, kept drug/alcohol free for the duration of their pregnancy, isn't that a success? Don't we owe that protection to these children? Won't the government save millions on helping women birth unexposed infants?

I thank you for this opportunity to share my story today.

PREPARED STATEMENT OF JACK F. TROPE

Mr. Chairman and members of the Social Security and Family Policy Subcommittee of the Senate Finance Committee, my name is Gary Kimble. It is an honor for me to be here today to testify as Executive Director of the Association on American Indian Affairs, Inc. (AAIA). With me is Jack F. Trope, AAIA Staff Attorney. The Association is a national citizens' organization headquartered in New York City with field offices in South Dakota, Arizona and California. It is dedicated to the protection and enhancement of American Indian and Alaska Native rights. Policies and programs of the Association are formulated by a Board of Directors, the majority of whom are Native Americans.

The Association has a long-standing interest in Fetal Alcohol syndrome and Fetal Alcohol Effect and, in fact, worked with then-Representative Daschle, at his request, to develop the Indian Juvenile Alcohol and Drug Prevention Act of 1985 (ultimately enacted in altered form as the Indian Alcohol and Substance Abuse Prevention and

Treatment Act subtitle of the Anti Drug Abuse Act of 1986). AAIA testified at hearings pertaining to that bill in both Washington and Rapid City.

This subcommittee's interest in this issue is of vital importance to Indian children, families and tribes because this subcommittee has jurisdiction over many funding programs which can provide the tools needed to address this problem. As recognized by other witnesses, F. A. S. and F. A. E. visit the problem of alcohol abuse upon the most innocent victims and deprive them of the ability to fully function in their society. This inability is not only devastating to the victims but to the Indian community in general.

Our testimony today will focus upon possible (and admittedly partial) solutions to these problems—particularly solutions that are within the jurisdiction of this subcommittee. This Committee has jurisdiction over the funding programs which provide the basic funding for State and territorial programs which address critical human needs such as the prevention and treatment of alcoholism, and specifically F.A.S. and F.A.E. Unfortunately, with limited exceptions, the operative statutes for those programs do not include tribes even though tribal governments have the direct responsibility for serving their communities and in general have proven to be the most effective service providers for their people.[1] It is for this reason that the interest of this committee is so critical. We hope that this hearing is the start of a process which will include tribes in these essential grant programs:

—the Title XX Social Services Block Grant
—Title IV-B child welfare services
—Title IV-E foster home program; and
—the Alcohol, Drug Abuse and Mental Health Block Grant.

Today's reality is that social services programs for Indian communities, including programs to deal with substance abuse, are woefully inadequate. In 1988, AAIA analyzed the entire Federal budget to determine the level of funding for Indian social services programs. (Attached as Exhibit A). The total expenditure amounted to approximately $100 million from all sources, less than $60 per Indian person. Although we do not know the comparable figure for the non-Indian population, it is certainly a much greater amount per person—and this is true notwithstanding the greater need (and relative service population) in Indian communities because of their lower socio-economic status and the problems which arise from these higher poverty levels. Moreover, many of the funds included in that $100 million were "one-time only" appropriations, not ongoing funds.

Funds for existing tribal social services programs are largely based upon competitive grants and the resources available vary greatly from year to year. This seriously impedes tribal efforts to establish on-going and effective service programs. The Federal Government provides certain services, but much of the money appropriated is wasted in bureaucracy. This inadequate budget in social services is part of a large budgetary problem identified in the recent Congressional Research Service Report, "Trends in Indian Related Federal spending—fiscal year 1975-1991." In that report, CRS found that in constant dollars Federal spending for Indian programs has decreased by 2.11% annually during that time period whereas overall domestic spending has increased by 2.01% annually.

If programs to address the scourge of F.A.S. and F.A.E. and other devastating social problems are to be developed, the locus of such efforts must be the tribe. Tribal communities are best situated to provide such services to their communities:

—Tribal governments are largely independent from States. They have a direct government-to-government relationship with the Federal government.
—Tribal programs are more attuned to the special cultural needs of their communities. For example, the 1988 CSR, Inc. study, commissioned by the Departments of HHS and Interior, showed that tribal child welfare programs were, in many ways, outperforming State Systems, notwithstanding unreliable and inadequate funding sources.

In fact, the 1988 study made an observation that is applicable to many tribal social services programs:

> funding for tribal child welfare programs comes from a hodge-podge of sources that requires tribes to scramble and compete annually for small and unreliable grants. This funding pattern makes continuity in services

[1] Programs which currently provide for tribal allocations, include the Vocational Rehabilitation Act (29 U.S.C. 724, 730), Library Services and Construction Act (20 U.S.C. 351c-351e, 361-366), Clean Water Act (33 U.S.C. 1377) and the recently enacted Child Care and Development Block Grant.

nearly impossible and the delivery of the quality services observed in this study obtainable only through the professionalism and dedication of [tribal] program staff.

In order for tribes to begin a systematic counteroffensive against F.A.S. /F.A.E. on the reservation, as well as other pressing social problems, tribes must receive consistent and adequate funding. The programs under this subcommittee's jurisdiction provide perhaps the best source of such funding. Indeed, in view of the status of tribes as domestic dependent nations and their special relationship with the Federal government, it is long overdue for tribes to receive direct allocations from these programs just as do American Samoa, the Northern Mariana Islands and the Virgin Islands.

We propose the following:

1. Require the Secretary of H.H.S. to reserve from 1.5 to 3 percent of the Title XX, IV-B and Alcohol, Drug Abuse and Mental Health block grant appropriations for Indian tribes. (At present, tribes receive no direct money under Title XX, only a State pass through in a handful of States; only 30 (of 500) tribes receive Title IV-B money—a total of less than $ 500,000 annually due to a restrictive interpretation by HHS of 42 U.S.C. 628 which authorizes such funding;[2] only one tribe and one urban Indian program currently receive Alcohol, Drug Abuse and Mental Health block grant money under a special "grandfather" clause in that Title, 42 U.S.C. 300x—lb(b).[3]

2. Require the Secretary to allocate the money to all tribes as an entitlement based primarily upon the Indian population on or near the tribe's reservation (except in Oklahoma and Alaska), with some special consideration for poorer and smaller tribes.

3. Apply to tribes all rules, regulations and requirements applicable to States except where the Secretary finds that it is necessary to reasonably alter applicable requirements to reflect tribal standards.

4. Provide that money reserved to tribes under these grant programs would be supplemental to existing funds and programs.

5. Allow tribes to form consortiums or contract with qualified providers to administer these programs.

In addition we propose that States and tribes coordinate their programs, including joint tribal-State planning as part of all State plans submitted under any of the aforementioned programs.

Finally, we believe that this committee should amend Title IV-E of the Social Security Act to make it easier to obtain compensation for tribal foster homes and to permit tribes to receive funds to administer foster home programs. While prevention of F.A.S./F.A.E. is obviously the most preferable course of action, we must recognize that this is unlikely to occur instantaneously. In the meantime, there is a great need for foster homes for some of these children. Currently, placements in tribal foster homes and tribes do not receive Title IV-E money unless there is an agreement with the State. This is one of the factors that leads to a shortage of qualified Indian foster homes for these and other troubled children. This Committee can help to rectify this situation.

We have attached specific legislative proposals as Appendix C to our testimony. We thank you for this opportunity to present our ideas about solutions to this terrible problem. The interest of this subcommittee is most encouraging as this Subcommittee deals with programs that have the potential to greatly impact upon the problem of F.A.S. and F.A.E.

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[2] HHS has indicated that it will be reevaluating the formula utilized to implement 42 U.S.C. 628, although it is unclear when this review will occur (see attached Appendix B).

[3] This information is not from fiscal year 1991, although we expect that the fiscal year 1991 data would essentially be similar.

Association on American Indian Affairs, Inc.

APPENDIX A

95 Madison Avenue
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Dr. Idrian N. Resnick
Executive Director

April 6, 1988

Rima J. Cohen
Legislative Assistant to
Senator Thomas A. Daschle
317 Hart Office Building
Washington, D. C. 20510

Dear Ms. Cohen:

This letter is a partial response to the questions that you have posed to me:

(1) How much money is currently appropriated for "Indian Social Services" ?

(2) What amendments might be made to the welfare reform legislation (aside from the set-aside for tribal social services programs which we previously discussed)?

Appropriations for Indian Social Services

It has been very difficult to get exact figures to answer this question. There is no central repository for such information and even specific agencies funding Indian tribes and organizations often do not break out statistics in this manner. Thus, the following numbers are somewhat "soft"; they have been developed by analyzing various budget documents and talking with knowledgeable individuals in the relevant agencies. I have not included in the summary direct grants to individuals through programs such as General Assistance, but have otherwise defined social services broadly.

DEPARTMENT OF THE INTERIOR

BUREAU OF INDIAN AFFAIRS

A total of $28.5 million is appropriated for social services programs. The breakdown is as follows:

$ 19.7 million for general social services - According to the BIA, $2.1 million is spent on BIA supervisory personnel in the central office, area offices and field operations. $17.6 million is spent for tribe/agency operations. This includes 75 tribal social services contract programs and 182 BIA staff positions (50 clerical). The duties of those funded by the line item include processing of applications and grants and the administration of the general assistance program, as well as direct social services. (Our AAIA child welfare field representative, himself a former BIA social worker, reports that most BIA staff time is spent on administration, rather than services.)

$8.8 million for Indian child welfare services - This is a competitive grant program for tribal and urban child welfare programs. In FY 1987, 128 grants were awarded (approximately 20-25 to urban programs, the remainder to tribes).

(In addition to these amounts, $14.8 million is budgeted for child welfare assistance payments. These payments are made directly to foster homes, group homes, institutions and other custodians of out-of-home children for the direct care of specific children. A few of the recipients of this money are institutions run by the BIA or tribes; most recipients are private, state or local institutions.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICES

$4.4 million for medical social services - Medical social workers work in IHS hospitals and clinics (6 of 51 hospitals are contracted to tribes and half of the outpatient clinics). These social workers work with patients to ensure that they receive "link up with" services that they need after they leave the hospital or clinic and provide some counseling services. Only patients with medical problems can utilize these services.

$ 12.4 million for mental health programs - This program funds 202 IHS positions. Approximately $2.4 million of this amount is spent by tribally contracted programs.

$ 45.5 million for alcohol and drug abuse programs - Virtually all tribes receive money from this source. $29.3 million is provided for general alcohol and drug abuse programs. This funds 1,385 staff; approximately 1,300 work for tribes and urban Indian organizations (about $20 million is used for reservation-based services). $9 million is for community rehabilitation centers, $1.5 million for education and training, $500,000 for health promotion and disease prevention grants, $5 million for regional treatment facilities, $200,000 for a demonstration project in New Mexico. (Much of this money is a result of P.L. 99-570, the omnibus drug bill of 1986; it is uncertain what continuing funding levels will be.)

Other programs which provide a small amount of social services, in addition to "health services" which are their primary Rima J. function, include the public health nursing program (provides some social services to pregnant women - total budget $14.1 million), community health representatives (funds community-based, trained, medically-guided health workers whose duties may occasionally overlap with "social services" types of activities - total budget $27.3 million), and urban health projects ($9.0 million budget).

OFFICE OF HUMAN DEVELOPMENT SERVICES

There are a number of competitive grant programs for which tribes are eligible.

In general - $670,000 was appropriated for family violence shelters run by tribes in FY 1988. In FY 1987, 74 grants were awarded covering 84 tribes (total appropriation - $690,000). In FY 1987, tribes with either 638 social services contracts with the BIA or Title II child welfare grants were eligible. In FY 1988, only those tribes that actually received funds in FY 1987 are eligible.

Administration on Aging - $7.5 million to Indian tribes for services to the elderly under Title VI of the Older Americans Act specifically applicable to Indians. 103 tribes received funding

in FY 1987. Approximately $600,000 in additional grants under Title IV which is a general grant program. In FY 1987, 3 tribes and 2 urban organizations received grants under Title IV. Finally, $82,000 was awarded to an intertribal organization as part of OHDS's Coordinated Discretionary Funds (CDF) Program.

Administration on Native Americans - $1,013,389 to 5 Indian tribes ($374,178) and 6 urban Indian organizations as part of the CDF program. Most of these funds are used to address problems relating to alcohol and drug abuse ($556,083 - total, $234,150 - tribal), mental health ($139,998 - tribal), child welfare ($94,004) and social services delivery ($149,000).

Alcohol, Drug Abuse and Mental Health Administration - $ 216,000 was distributed pursuant to the Alcohol, Mental Health and Drug Abuse Block Grant to one tribe ($116,000) and one urban program. $1,675,133 was distributed under the Drug and Alcohol Abuse Demonstration Project to 9 tribes. (There may have been additional money awarded to urban Indian programs, but I have not obtained this information.)

Administration on Children, Youth and Families - $684,413 was appropriated to runaway and homeless youth centers for Indians, $437,928 to 8 tribes and the remainder to urban organizations. $138,000 was appropriated in child welfare training grants to 2 tribes ($79,000) and one urban Indian organization. $432,679 was appropriated to 34 tribes for child welfare programs pursuant to Title IV-B of the Social Security Act. Only tribes with 638 social services contracts with the BIA are eligible and the allocation formula results in exceedingly small payments even to tribes that are eligible.

I cannot be certain that I have covered all social services expenditures targeted to Indian people. However, I believe that I have identified most of the programs. The total expenditure is approximately $100 million, excluding some incidental services provided by programs whose primary mission is not social services. About half of the appropriation is for alcohol and drug abuse programs and some of that appropriation may not continue from year to year. This is less than 4% of the total federal budget for American Indians. It also equals only about $50 for each Indian person. Although I do not know the comparable figures for the population as a whole, I am sure that when federal and state spending is calculated, the per person expenditure is far greater -- and this is true notwithstanding the fact that because of the lower socioeconomic status of most Indian people, larger percentages of the Indian population are likely to have need for social services than is the case for the population at large.

Approximately $50 million of the $100 million goes to tribes, $15 million to urban Indian programs, $35 million pays for federal government services (and bureaucracy). Many of the programs awarding money to tribes are competitive and most award money to only a handful of tribes. Even those which award money to a large number of tribes, e. g., the Title II Child Welfare grants, still deny applications from a large number of other tribes. (Last year, 128 child welfare grants were awarded, down from 164 in FY 1983. In FY 1986, 239 grant applications were submitted to the BIA.) Thus, tribes cannot be assured from year to year as to whether they will receive funding from these various competitive grants and most tribes are fortunate if one or two grant proposals a year are approved.

This limited funding for Indian social services (and the carefully circumscribed uses to which much of the money can be used) result in inadequate services to Indian people. It is for this reason that we have proposed the Social Services block grant

set-aside to tribes. We believe that the tribe, with its knowledge of its community and its needs, is best situated to provide social services to needy tribal members. The $25+ million provided by the set-aside would substantially increase the amount of resources available for social services, target the money to the entity best situated to make good use of it and provide needed flexibility in structuring services.

In addition, as noted, the Title II child welfare grant program is competitive and inadequate to meet the need. It is also arbitrarily administered. Additional money from other competitive grants and Title IV-B adds little. For that reason, the proposal for expanded funding under Title IV-B child welfare services will help to address a funding shortfall in the very important area of child welfare.

The rationale for the Alcohol, Mental Health and Drug Abuse block grant set-aside, which is part of our proposal, is probably less compelling than is the case for the other proposals in view of the amounts currently appropriated for alcohol and drug abuse prevention and treatment. Given the severity of the problem, however, and the uncertainly of continued funding at current levels under the existing programs, additional amounts through a dependable set-aside are certainly justifiable.

Other issues that might be addressed in the "welfare reform" bill

I have talked to a number of people about issues that might be addressed in the context of a welfare reform bill. In the interest of providing this information to you in a reasonably prompt manner, I have decided to send you a list of issues identified to date, rather than explicit amendments. This is not meant to be a comprehensive list and some of the items on the list, when fully developed, may turn out to be impractical or unnecessary. I must admit that my understanding of AFDC and similar programs is limited. I presume that you and other staff people will have the resources to develop these ideas into specific legislative proposals and determine their feasibility. Please let me know if you would like AAIA to be further involved in the development of these issues.

The issues that might be addressed are as follows:

1. Improper inclusion of trust asset income in calculations of eligibility for AFDC, SSI and Food Stamp programs

25 U.S.C. 1408 provides that interests in trust or restricted lands shall not be considered a resource in determining eligibility for assistance. This reflects the notion that such trust property should be utilized fully for the benefit of Indian people (as often recognized in treaties and executive orders which set aside the land for Indian people) and that such use should be unencumbered. Both the Federal Government and a number of state governments have interpreted this provision narrowly, however. They have viewed this language as not including income from the leasing or sale of such property when determining eligibility for benefits, notwithstanding that such income is clearly protected from taxation, garnishment and Rima attachment consistent with the underlying purpose of trust land. This is wrong for several reasons:

-- It is an abridgement of rights provided by treaty and other agreements with Indian tribes.

-- It has caused substantial hardship. Many of the people affected are elderly. Frequently, they have no retirement pensions and rely upon the Supplemental Security Income (SSI) program.

-- Receipt of trust money by elders is sporadic and unreliable. Nonetheless, the Social Security Administration uses estimated trust income in determining SSI benefits. Thus, deductions are often made for payments that are ultimately never received. The system ensures that income to Indian elderly will be unstable, unreliable and often inadequate.

In addition, the SSI program has recently started to impose fines upon tribal elders for failure to report trust income. Many of the elderly assume that because the SSI program has full access to BIA information (SSI recipients must agree to this access as a precondition to receiving SSI benefits), SSI has full knowledge of moneys received. Thus, they do not report. Moreover, the system of deducting estimated future income also confuses many of the elders.

For all of these reasons, an exemption (at least partial) of trust-generated income makes sense. An exemption with a cap ($4,000 has been suggested) would ensure that the exemption is not abused. You might be interested in knowing that there is precedent for such a provision. 25 U.S.C. 1407 provides that per capita distributions to tribal members (usually in satisfaction of a land claim) do not reduce financial benefits payable to that member under the Social Security Act and, except for payments in excess of $2,000, under any other Federal or Federally assisted program.

For further information on this issue, I would suggest that you contact Helen Spencer of Evergreen Legal Services in Yakima, Washington, phone 509-575-5593.

Although I am not aware of specific instances, it may also be that similar misuse of trust assets is occurring in the administration of the Food Stamp program. An amendment to 25 U.S.C. 1408 would ensure that an exemption of trust related income applies to all relevant programs.

2. Improper seizure of trust assets, including per capita payments and judgments otherwise exempt, as part of the AFDC reimbursement program.

In the AFDC reimbursement programs, States pursue absent spouses and seek to obtain reimbursement from them for amounts expended under the AFDC program. In so doing, States have sometimes seized per capita payments and judgments which are exempt from taxation and whose use in eligibility determinations is restricted by 25 U.S.C. 1407. Such seizures are inconsistent with the underlying intent and rationale of that section and should be prohibited. Likewise, if the exclusionary features of 25 U.S.C. 1407 are extended to other trust assets as recommended above, these assets should also be protected from seizure. (This is not to say that they should be exempt in a case where one spouse would directly benefit from the seizure of the other spouse's assets; rather the notion is that the State should not use the assets to reduce the expenditures it otherwise would make -- such action diminishes the value of the assets every bit as much as taxation would and taxation of these assets is specifically prohibited.)

3. Reporting requirements

Data is frequently lacking as to the "general welfare" of Indian people and whether Indians, particularly reservation Indians, are receiving their fair share of programs for which all citizens are equally eligible. For that reason, an explicit requirement that States report services provided to Indian people

through these programs, broken down into on and off reservation categories, would be useful. Specifically, I would suggest that sections 104 (section 447 -Initial State Evaluations) and 803 (section 2006 - Social Security Act) include such provisions.

4. Tribal law

There are provision in Federal law whose interpretation is dependent upon applicable local law. For example, does a stepfather have an obligation to support his stepchild? There is no provision in the law as to what happens if there is a conflict between state law and tribal law. I would recommend that there be a clear provision in the bill that tribal law governs in the case of an Indian person domiciled or resident on the reservation.

5. Funding for tribes

There are a number of demonstration grants included in S. 1511, for example, grants pertaining to foster care, housing and child care. Tribes should be explicitly eligible to apply for these grants.

6. Contracting with tribes

The welfare reform bills include a number of job programs, such as JTPA, Community Work Experience and Job Opportunities and Basic Skills Training. Provisions allowing tribes to contract for and run some of these programs for on and near reservations Indians might be considered. (I am not sure if this is feasible or not but it is worth exploring the possibility; I know that some tribes run JTPA programs at present.)

7. The General Assistance (GA) program in the Bureau of Indian Affairs

This program provides assistance to Indian individuals and families to pay basic living expenses in states that do not have a general assistance program. It may be that "reforms" to this program could be addressed in this bill, but I would caution you not to include reforms without thorough discussions with tribes. Last year, Secretary Swimmer attempted to incorporate a "workfare" proposal into GA without prior tribal consultation and tribes were outraged. Congress repudiated the proposal but it is likely that a few tribes will host pilot projects in the coming year.

One problem that I am aware of that might be specifically addressed is the administration of the program as it relates to mixed Indian/non-Indian families. If a single Indian entitled to, as an example, $220/month, marries a non-Indian (or an Indian not eligible for membership in a federally recognized tribe), he then receives only $110/month. If they have a child and the child is not eligible for membership, he would receive only $73.33/month. In short, the BIA takes the base amount, determines the percentage of people in the family who are eligible Indians and multiplies the base amount by the percentage. As you can see by the example, this leads to some absurd results.

8. Miscellaneous

One problem repeatedly raised is that the AFDC eligibility form is unduly complicated, particularly for some Indian people who speak English as a second language. I am informed that little assistance is available to applicants in most cases and

that in some instances, benefits have been delayed or denied because of applications that were incomplete. In addition, I am told that appeal processes from denials are often lengthy because of inadequate staffing. I am not sure if this can be rectified legislatively but I pass along this information for your consideration.

I hope that this list of possible additions to the welfare reform bill is helpful. I would encourage you to reach out to other people who have more familiarity with this particular issue than I do. If I can be of any further assistance, please let me know. Also, I would appreciate if you would keep me informed as to your plans. If I have any additional thoughts or obtain any more detailed information, I will be sure to pass it along.

Thanks for your interest.

Sincerely,

Jack F. Trope
Staff Attorney

APPENDIX B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Administration for
Children, Youth and Families
Washington DC 20201

FEB 16 1990

Mr. Jack F. Trope
Staff Attorney
Association on American
Indian Affairs, Inc.
95 Madison Avenue
New York, New York 10016-7877

Dear Mr. Trope:

Thank you for your letter expressing the concerns of the Association on American Indian Affairs, Inc. (AAIA) regarding Indian child welfare issues.

The resolution of specific problems related to compliance with and integration of the Indian Child Welfare Act (ICWA) into State policy and procedures, the funding of tribal child welfare programs, and the need for title IV-E and child welfare agreements between Tribes and States are complex issues and require joint efforts by the involved parties. We share your concerns and recognize the need to review the current practices and, with your assistance, explore innovative approaches for improving services and funding for Indian Tribes.

Each of the three issues raised in your letter is discussed below.

ISSUE 1. Inclusion of Indian Child Welfare compliance in title IV-B and IV-E Federal reviews of State systems.

Inclusion of Indian Child Welfare compliance issues in Federal title IV-E and IV-B reviews would not be appropriate within the

context of current legislation. As presently structured, monitoring of the Indian Child Welfare Act (ICWA) is the responsibility of the Bureau of Indian Affairs (BIA) and, therefore, the Department of Health and Human Services has no jurisdiction to monitor this activity.

The purpose of the title IV-E reviews is to verify the eligibility of the children and providers of care for whom the States are claiming title IV-E payments. As you know, title IV-E foster care payments for otherwise eligible Indian children are reimbursable only if there is a Tribal-State agreement. Individual protections and safeguards, including compliance with the ICWA, are not linked to the title IV-E payment and, therefore, are not included in the title IV-E reviews.

Section 427 of the Social Security Act does provide, however, a financial incentive to the States to provide improved foster care protections.

In fiscal year (FY) 1990, the Administration for Children, Youth and Families (ACYF) plans to develop review procedures for State child welfare services programs and to field test these procedures in at least three States. The purpose of the proposed program reviews is to promote improved social services to children and their families through the periodic assessment of State and local programs. The review process will identify exemplary programs as well as problems and weaknesses and stimulate plans for improvements. Program reviews are a qualitative evaluation of State child welfare services programs which are assistance-oriented rather than regulatory in nature. Therefore, examination of ICWA compliance issues would be appropriate within the context of the program review. In developing and field testing the review procedures, we will ensure that these issues are addressed.

In recognition of the needs set forth in the ICWA, some States have addressed these issues in their joint planning activities as reflected by the State title IV-B plans and have appointed special Indian child welfare liaison persons. We will continue to work with States through the joint planning process to emphasize the needs of Indian children and to improve cooperation and coordination in the delivery of these services.

ISSUE 2. Reexamination of the HHS tribal funding formula under title IV-B.

As set forth in section 428 of the Social Security Act, direct title IV-B grants to Indian Tribal Organizations (ITOs) are paid from the title IV-B allotment of the State or States in which the ITOs are located. The Secretary of the Department of Health and Human Services determines the manner and the amounts which are considered appropriate. The formula for apportionment of the direct grants to eligible Tribes and ITOs has been set forth in policy. Considering the period of time since the formula was originally calculated and the changing needs in the area of child welfare services, we plan to review the funding formula to determine whether changes are appropriate.

ISSUE 3. Encouragement of Tribal-State agreements pertaining to child welfare in general and title IV-E foster care funding specifically.

We agree that such agreements should be encouraged. However, as the following citations illustrate, there is no requirement for such agreements, and States and Tribes would have to take the initiative to develop agreements.

1. Section 471(a)(4) of the Social Security Act requires that the State must have a plan which ". . . provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law."

2. Section 109(a) of the Indian Child Welfare Act states that, ". . . States and Indian tribes are authorized to enter into agreements with each other respecting care and custody of Indian children and jurisdiction over child custody proceedings . . . ."

It would be useful if AAIA would share with us any available information concerning Tribal-State agreements and make recommendations regarding ways in which we could jointly impact on this problem.

We have enclosed for your information three policy issuances (ACYF-PIQ-85-05, ACYF-PIQ-87-01 and ACYF-PIQ-88-02) relevant to Tribal-State agreements which were developed in response to questions raised by several States.

We appreciate your involvement with child welfare services and look forward to working with you.

Sincerely,

Wade F. Horn

Wade F. Horn, Ph.D.
Commissioner

APPENDIX C

LEGISLATIVE PROPOSALS

1. Title XX tribal allocation

SECTION 1. RESERVATION OF FUNDS FOR SOCIAL SERVICE GRANTS TO INDIAN TRIBES.

SECTION 2003 of the Social Security Act (42 U.S.C. 1397b) is amended by adding the end thereof the following new subsection:

"(d) The Secretary shall reserve an amount, not less than 1.5 percent and not more than 3 percent of the amount specified in subsection (c) for the direct provision of funds to the governing bodies of Indian tribes."

SECTION 2. GRANTS TO INDIAN TRIBES.

(a) In General.--Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end thereof the following new sections:

"DIRECT GRANTS TO INDIAN TRIBES"

"SEC. ____. (a) INDIAN TRIBES. -- From the funds reserved under section 2003(d), the Secretary shall, upon the application of an Indian tribe, enter into a contract with or make a grant to such Indian tribe for a period of 3 years, subject to compliance with subsection (c), to plan and carry our programs and activities that are consistent with this title. Such contract or grant shall be subject to the terms and conditions of section 102 of the Indian Self-Determination Act (25 U.S.C. 450f) and section 105(c)(1) of the Indian Self-Determination Act (25 U.S.C. 450(j)(1)) that are relevant to such programs and activities. The Secretary shall provide that of the sums reserved under section 2003(d) of this title that such sums shall be made equally available to each tribe proportionately based on the ratio of the Indian population located on or near the tribe's reservation in relation to the total Indian population, (determined by counting all Indians located on or near a reservation), except that the Secretary shall reserve not less than 10 percent nor more than 20 percent of the funds allocated pursuant to section 2003(d) for supplemental grants to tribes with a high percentage of such tribe's population below the Federal income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) or to small tribes (as defined by the Secretary).

(b) INDIAN RESERVATIONS.--The grants described in this section shall be utilized in areas primarily on or near Indian

reservations. This area restriction does not apply to Oklahoma, Alaska and California.

(c) STANDARDS.--The rules, regulations and requirements generally applicable to States under this title shall be applicable to tribes except that the Secretary shall reasonably alter such rules, regulations and requirements to reflect and accommodate tribal standards.

(d) TREATMENT OF GRANTS.--All funds and programs provided for under this section shall be considered supplemental or in addition to all other programs, grants, contracts, or funds provided by any Federal, State, county government, department, or other agency serving Indian tribes, Indian service populations, or off-reservation Indian people. No such funds or programs utilizing or receiving Federal funds may be reduced or eliminated as a result of funds or programs provided by this section except in the case where direct funds are being provided to tribes pursuant to Title XX of the Social Security Act and the continuation of those direct grants in addition to those provided by this Act would be duplicative. The Secretary of Health and Human Services shall allow States to contract with or make grants to tribes for the provision of services in addition to those otherwise offered by the tribe utilizing funds allocated under this section.

(e) OFF-RESERVATION INDIAN PROGRAMS.--Notwithstanding direct grants to Indian tribes pursuant to this section, States, in their allocation of money from the Social Services Block Grant under Title XX of the Social Security Act, shall not discriminate against Indian controlled, off-reservation programs serving Indian people.

(f) CONSOLIDATED FUNDING.--The Secretary shall allow an Indian tribe receiving direct grants under this section to contract with

qualified providers for the delivery of services or enter into agreements with other Indian tribes for the provision of services by a single organizational unit providing for centralized administration of services for the region served by the Indian tribes so agreeing. In case of such an agreement, the organizational unit may submit a single application of all the tribes which are a party to the agreement and, unless the organizational agreement provides otherwise, shall receive an amount equal to the amount the tribes would have been entitled had they applied separately.

(g) ELIGIBILITY FOR OTHER PROGRAMS. -- This section shall not be construed or serve as authorization--

(1) to limit the eligibility of any individual to participate in any program offered by a State or subdivision thereof; or

(2) to modify any requirement imposed on a State by any provision of Title XX of the Social Security Act.

(h) DEFINITIONS--For the purposes of this section:

(1) "Indian Tribe" shall mean "Indian tribe" as defined in section 1603(d) of Title 25 of the United States Code; and

(2) "Reservation" shall mean "Indian country" as defined in section 1151 of Title 18 of the United States Code, as well as, to the extent not included under that section, Alaska Native villages (as defined in section 1602(c) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(c)) as well as any other village or community regarded as eligible for the services provided to Indians by the Secretary because of their status as Indians) and the historic Indian areas of Oklahoma (excluding urbanized areas) consisting of all current reservations and former reservations which had legally established boundaries at any time during the period of 1900-1907."

SECTION 3. EFFECTIVE DATE.

The provisions of this Act shall become effective with respect to grants provided for fiscal year 1992 and succeeding fiscal years.

2. Alcohol, Mental Health and Drug Abuse block grant: tribal allocation

SECTION 1913(b) of the Public Health Service Act (42 U.S.C. 300x-1b(b)) is amended by striking out paragraphs (1) and (2) and inserting, in lieu thereof, the following:

"(1) The Secretary shall reserve an amount, not less than 1.5 percent and not more than 3 percent of the sums appropriated under this title for the direct provision of funds to the governing bodies of Indian tribes.

(2)(A) The sums reserved under subsection (b)(1) shall be made equally available to each tribe proportionately based on the ratio of the Indian population located on or near the tribe's reservation in relation to the total Indian population, (determined by counting all Indians located on or near a reservation), except that the Secretary shall reserve not less than 10 percent nor more than 20 percent of the funds allocated pursuant to section 2003(d) for supplemental grants to tribes with a high percentage of such tribe's population below the Federal income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) or to small tribes (as defined by the Secretary). No tribe or tribal organization shall receive less than the amount that it received during any of the fiscal years from 1982 through 1991.

(B) If any Indian tribes choose not to operate a program under this title, the sums that would be payable to those tribes shall--

(i) be utilized to make payments to those tribes that are entitled to additional amounts by reason of having received grants during any of the fiscal years from 1982 through 1991, and

(ii) be reallocated, if there are sums remaining following the distribution under clause (i), to tribes that operating programs under this title in accordance with the percent of the total allocation to which each tribe is entitled pursuant to the above formula.

If the unclaimed funds are insufficient to fully fund the tribes eligible for the extra payments provided for in clause (i), any additional sums that are needed shall be deducted from the allotments of the State in which the tribes are located.

(C) All funds and programs provided for under this section shall be considered supplemental or in addition to all other programs, grants, contracts, or funds provided by any Federal, State, county government, department, or other agency serving Indian tribes, Indian service populations, or off-reservation Indian people. No such funds or programs utilizing or receiving Federal funds may be reduced or eliminated as a result of funds or programs provided by this section except in the case where direct funds are being provided to tribes pursuant to Title XIX of the Public Health Service Act and the continuation of those direct grants in addition to those provided by this Act would be duplicative. The Secretary of Health and Human Services shall allow States to contract with or make grants to tribes for the provision of services in addition to those otherwise offered by the tribe utilizing funds allocated under this section.

(D) Notwithstanding direct grants to Indian tribes pursuant to this section, States, in their allocation of money from the Alcohol, Drug Abuse and Mental Health Block Grant shall not discriminate against Indian controlled, off-reservation programs

(E) The Secretary shall allow an Indian tribe receiving direct grants under this section to contract with qualified providers for the delivery of services or enter into agreements

with other Indian tribes for the provision of services by a single organizational unit providing for centralized administration of services for the region served by the Indian tribes so agreeing. In case of such an agreement, the organizational unit may submit a single application of all the tribes which are a party to the agreement and, unless the organizational agreement provides otherwise, shall receive an amount equal to the amount the tribes would have been entitled had they applied separately.

(F) This section shall not be construed or serve as authorization--

(1) to limit the eligibility of any individual to participate in any program offered by a State or subdivision thereof; or

(2) to modify any requirement imposed on a State by any provision of Title XIX of the Public Health Service Act.

3. Amendments to Title IV-B and IV-E

SECTION 1: RESERVATION OF FUNDS FOR GRANTS TO INDIAN TRIBES

SECTION 428 of Title IV-B of the Social Security Act (42 U.S.C. 628) is amended -

(1) by striking out in subsection (a) the phrase "may, in appropriate cases (as determined by the Secretary)" and inserting, in lieu thereof, the word "shall";

(2) by striking out in subsection (a) the phrase "approved under" and inserting, in lieu thereof, the phrase "which meets the requirements of subsection 422. In reviewing the adequacy of tribal plans, the Secretary shall waive applicable requirements where required by tribal standards or the small population of a tribe, so long as such waiver will not jeopardize the effective provision of services to Indian children."

(3) by striking out the second sentence in subsection (a) and inserting, in lieu thereof, the following: "The Secretary shall reserve an amount, not less than 1.5 percent and not more than 3 percent of the amount appropriated for the direct provision of funds to the governing bodies of Indian tribes."

(4) by rewriting subsection (b) to read as follows:

"(b)(1)(A) The Secretary shall provide that of the sums reserved under subsection (a) that such sums shall be made equally available to each tribe proportionately based on the ratio of the Indian population located on or near the tribe's reservation in relation to the total Indian population (determined by counting all Indians located on or near a reservation), except that the Secretary shall reserve not less than 10 percent nor more than 20 percent of the funds allocated pursuant to subsection (a) for supplemental grants to tribes with a high percentage of such tribe's population below the poverty level (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) or to small tribes (as defined by the Secretary).

(B) If any Indian tribes choose not to operate a program under this title, the sums that would be payable to those tribes shall be reallotted to the tribes that are operating programs under this title in accordance with the percent of the total set-aside to which each tribe is entitled pursuant to the above formula.

(C) For the purposes of this clause, the term reservation shall mean "Indian country" as defined in section 1151 of Title 18, as well as, to the extent not included under that section, Alaska Native villages (as defined in section 1602(c) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(c)) as well as any other village or community regarded as

eligible for the services provided by the Secretary because of their status as Indians) and the historic Indian areas of Oklahoma (excluding urbanized areas) consisting of all current reservations and former reservations which had legally established boundaries at any time during the period of 1900-1907.

(2) Subject to the conditions set forth in subsection (a) and (b)(1), the Secretary shall pay an amount equal to 100 per cent of the total sum expended under the plan (including the cost of administration of the plan)."

(5) by adding at the end of this section new subsections (c), (d), (e) and (f) as follows:

"(c) All funds and programs provided for under this section shall be considered supplemental or in addition to all other programs, grants, contracts of funds provided by any Federal, State, county government, department or other agency serving Indian tribes, Indian service populations, or off-reservation Indian people. No such funds or programs utilizing or receiving Federal funds may be reduced or eliminated as a result of funds or programs provided by this section except in the case where direct funds are already being provided to tribes pursuant to this title and the continuation of those direct grants provided by this Act would be duplicative. The Secretary shall allow States to contract with or make grants to tribes for the provision of services in addition to those otherwise offered by the tribe utilizing funds allocated under this section.

(d) Notwithstanding direct grants to Indian tribes pursuant to this title, States in their allocation of money allocated pursuant to this title shall not discriminate against Indian/controlled, off-reservation programs serving Indian people.

(e) The Secretary shall allow an Indian tribe receiving direct grants under this section to contract with qualified providers for the delivery of services or enter into agreements with other Indian tribes for the provision of services by a single organizational unit providing for centralized administration of services for the region served by the Indian tribes so agreeing. In case of such an agreement, the organizational unit may submit a single application of all the tribes which are a party to the agreement and, unless the organizational agreement provides otherwise, shall receive an amount equal to the amount the tribes would have been entitled had they applied separately.

(f) This section shall not be construed or serve as authorization -

(1) to limit the eligibility of any individual to participate in any program offered by a State or subdivision thereof;

(2) to modify any requirement imposed on a State by any provision of this title."

SECTION 2. TRIBAL-STATE PLANNING

SECTION 422 of Title IV-B of the Social Security Act (42 U.S.C. 622) is amended by adding at the end thereof the following new clause:

"(__) include a comprehensive plan, developed in consultation with all tribes within the State and in-State Indian organizations (with social services programs), as defined by section 4(7) of the Indian Child Welfare Act (25 U.S.C. 1903(7)), to ensure that the State coordinates its efforts with tribes and

in-state Indian organizations and fully complies with the provisions of the Indian Child Welfare Act and other applicable Federal law."

SECTION 471 of Title IV-E of the Social Security Act (42 U.S.C. 671) is amended by adding after and below clause (19) the following new clause:

'(20) provides for a comprehensive plan, developed in consultation with all tribes within the State and in-State Indian organizations (with social services programs), as defined by section 4(7) of the Indian Child Welfare Act (25 U.S.C. 1903(7)), to ensure that the State coordinates its efforts with tribes and in-state Indian organizations and fully complies with the provisions of the Indian Child Welfare Act and other applicable Federal law pertaining to foster care and adoptive placements. As part of the plan, the State shall make active efforts to recruit and license Indian foster homes and, in accordance with section 201 of the Indian Child Welfare Act (25 U.S.C. 1931 , provide for the placement and reimbursement for Indian children in tribally licensed and approved facilities.'"

SECTION 3. DEVELOPMENT OF TRIBAL FOSTER HOMES.

"SECTION 472(a)(2) of Title IV-E of the Social Security Act (42 U.S.C. 672(a)(2)) is amended--

(1) by striking out at the end of subsection (a)(2)(A) the word 'or'

(2) by adding after subsection (2)(B) the following clause 'or (C) in the case of an Indian child, as defined by subsection 4(4) of the Indian Child Welfare Act (25 U.S.C. 1903(4)), the Indian child's tribe as defined in subsections 4(5) and (8) of that Act (25 U.S.C. 1903(5) and (8));'"

SECTION 474 of Part E of Title IV of the Social Security Act (42 U.S.C. 674) is amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall make payments to an Indian tribe which undertakes to operate a program under this Part.

(2) The provisions and requirements of sections 471, 472, 473 and 476 of this Act (42 U.S.C. 671, 672, 673 and 676) shall be applicable to Indian tribes except as follows:

(A) Subsections 10, 14 and 16 of section 471 of this Act (42 U.S.C. 671 (10), (14) and (16)) shall not apply. Instead, Indian tribes shall develop systems for foster care licensing and placement, development of case plans and case plan review consistent with tribal standards and the Indian Child Welfare Act (25 U.S.C. 1901 et seq.).

(B) The Secretary may reasonably alter the requirements of other sections of this Part for the purpose of relieving any unreasonable hardships upon the Indian tribes that might result, due to their unique needs, from a strict application of a particular requirement.

(3)(A) For purposes of this Part, the term "Indian tribe" means any Indian tribe, band, nation or organized group or community of Indians, including any Alaska Native village, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(B) In Alaska, regional associations defined in section 7(a) of the Alaska Native Claims Settlement Act (43 U.S.C. 1606(a)) shall be treated as tribes for the purposes of funding under this Title except that such an association may not receive funding for any village within its region that--

(i) applies separately for direct funding under this Title; or

(ii) notifies the Secretary that it does not want its regional association to apply for social services funding on its behalf.

(4)(A) The payment of funds to Indian tribes shall be calculated by the same formula applicable to states in subsection (a) of this section except that tribes shall be entitled to 100 per centum of the expenditures necessary for the proper and efficient administration of the plan as enumerated in subsection (a)(3). Per capita income shall be calculated by including only Indians who reside on the tribe's reservation.

(B) A tribe shall be permitted to use Federal or State funds to match payments for which tribes are eligible under this section, provided that the Federal or State funds are authorized for adoption assistance, foster care maintenance payments or administration of the tribal plan developed pursuant to this part.

(C) In any case where a satisfactory plan has been submitted by an Indian tribe, the Secretary shall reduce the tribal share otherwise required under subsection (a) upon a showing by the tribe that it does not have adequate financial resources to provide the required match due to a lack of comparable Federal and State funds, inadequate tribal resources, an inadequate tax base, or any other factor giving rise to financial hardship. The Secretary shall construe this section liberally with the goal of ensuring that all tribes submitting the required plan receive the funding provided for by this Act, except that

(i) in any case where the Secretary reduces the tribal share calculated pursuant to subsection (a)(1) of this section, he shall have the authority to review and approve the tribal payment schedule for foster families and child-care institutions, except that in no case shall he disapprove any schedule which proposes payments that do not exceed the amount provided for any State wherein the reservation is located; and

(ii) in any case where the Secretary reduces the tribal share calculated pursuant to subsection (a)(2) of this section, he shall have the authority to review and approve the tribal payment schedule provided for in adoption assistance agreements, except that in no case shall he disapprove any schedule which proposes payments at a level that does not exceed the amount provided for any State wherein the reservation is located."

PREPARED STATEMENT OF CRAIG VANDERWAGEN

Mr. Chairman and Members off the Committee: My name is Dr. Craig Vanderwagen, Acting Associate Director, Office of Health Programs, of the Indian Health Service (IHS). I am accompanied by Dr. George Brenneman, Maternal and Child Health Coordinator of the IHS. It is a pleasure to appear before you this morning to discuss the IHS activities regarding fetal alcohol syndrome (FAS). I would like to begin my presentation with a brief summary concerning the recognition of this syndrome and our special concern in IHS.

In the early 1970s, a group of alert medical professionals at the University of Washington recognized and described congenitally deformed children whose mothers drank alcohol during pregnancy. These affected children had a characteristic cluster of deformities including head and facial abnormalities, growth deficiencies and central nervous system damage. The scientists concluded that the deformities were due to *in utero* exposure to alcohol and named the cluster of deformities fetal alcohol syndrome (FAS).

Following publication of these observations and results of additional studies by the Seattle investigators, national interest in FAS grew. Further scientific study also recognized subtle effects associated with *in utero* alcohol exposure. Thus, some children, exposed to alcohol *in utero,* were found to have fetal alcohol effects (FAE). Some authorities believe that the ratio of the incidence of FAE to FAS is ten to one. Longitudinal studies of children with FAS and FAE established the fact that the fetal damage due to alcohol was permanent.

As convincing information increased, various groups in the medical community began to disseminate information on the risk of fetal damage following alcohol ingestion during pregnancy. It was clear that the only effective intervention in FAS and FAE was prevention, avoidance of alcohol during pregnancy.

In the 1980s, studies by the researchers at the University of New Mexico found high rates of FAS among certain Indian groups. Considerable variability was reported among the groups studied with incidence rates from 1.3 to 10.3 cases of FAS per 1,000 live births. Similarly, data from the Center for Disease Controls (CDC) national Birth Defects Monitoring Program also suggests high rates among American Indians. These data revealed a FAS rate of 2.9 per 1,000 total births in American Indians. This rate is 30 times the rate reported for white infants, according to CDC's Birth Defects Monitoring Program. Based on their clinical observations, IHS clinicians generally concur with the higher rates documented among American Indians. In two IHS Areas, surveillance activities find that FAS occurs at a rate of approximately four per 1,000 live births.

The IHS is very concerned about the apparent high rate of FAS among American Indians and Alaska Natives. Medical treatment is an important component of a FAS program, but prevention is the only effective way to reduce the incidence of FAS. Prevention of FAS requires cooperative interagency and tribal intervention activities and coordinated community alcohol control programs that lead to decisions by mothers not to drink during pregnancy. Success of these programs needs to be evaluated by epidemiologic surveillance of FAS.

In addition to broad efforts in the reduction of alcohol and substance abuse among American Indians and Alaska Natives, the IHS has focused several efforts in FAS prevention.

We are very actively exploring ways that we may work with the CDC to prevent FAS. We have held or attended meetings in Atlanta, Washington, Albuquerque, and Alaska to discuss these issues with colleagues interested in preventing FAS among

Native Americans. There is strong interest within CDC in helping us in the Billings and Aberdeen Services Areas. We will be exploring how we can work together there. We have already begun to work with CDC in Alaska to evaluate surveillance and intervention programs.

- Every year the IHS distributes $255,000 to its Areas for a variety of local FAS prevention activities.
- For the past six years the IHS has funded ($100,000 each year) research at the University of Washington in the prevention of FAS. This activity provides considerable clinical information for IHS and tribal professionals involved in the treatment and prevention of FAS.
- In 1990 the IHS funded (approximately $500,000) a residential treatment facility for pregnant women who abuse alcohol. The Southcentral Foundation, an Alaska Native organization in Anchorage, AK, was awarded the contract for this program.
- Beginning in fiscal year 1991 the IHS is establishing a FAS Team in the Headquarters-West Office in Albuquerque. NM. This team of professionals will provide technical assistance, consultation and training for IHS, tribal professionals, and Indian communities. Through this effort, professional capacity and community awareness of FAS will be increased, leading to more effective FAS and EKE prevention and treatment efforts.
- Regarding ingestion of alcohol during pregnancy, IHS professionals routinely provide counselling to prenatal patients. Screening for alcohol and substance abuse is a routine part of prenatal care required by IHS policy.

The IHS expects to continue program development with a strong focus on prevention of the devastating effects of alcohol on fetal growth and development. Fetal alcohol syndrome and FAE through strong community partnerships and activities which increase outreach to families at-risk.

Thank you for this opportunity to present information on this serious health problem. I will be happy to answer any questions at this time.

PREPARED STATEMENT OF LINDA WILL

Honorable Chairman and Senators:

Thank you for giving us the opportunity to present testimony before this sub-committee.

We are the Will's, Hank and Linda. We are the co-founders of Fetal Alcohol Network. We are a network of parents and professionals who care for or have interest in children with Fetal Alcohol Syndrome or Fetal Alcohol Effects. We include birth parents, adoptive parents, foster parents, physicians, educators, psychologists, and social workers. We have members in over fourteen states and two Canadian provinces. We provide information and support to our members through a newsletter, the Fetal Alcohol Network News, through telephone contact including our CARELINE, and through correspondence.

We, are here to testify on behalf of the members of our network and parents and care-givers of children with Fetal alcohol Syndrome and Fetal Alcohol Effects everywhere. We are also here to advocate for those children and adults who have been damaged as a result of prenatal alcohol exposure.

As you undoubtedly know by now, Fetal Alcohol Syndrome or FAS is characterised by a cluster of conditions including growth deficiency, facial anomalies, and central nervous system dysfunction. Fetal Alcohol Effects or FAE is characterised by some of the above but not enough to make a definitive diagnosis based on physical characteristics.

Frequently the first clue to the existance of FAE is the central nervous system dysfunction. Common to both conditions is the at least moderate consumption of alcohol by the mother during pregnancy (moderate is defined by the consumption of one ounce of absolute alcohol or about two drinks a day of any alcoholic beverage or combination of alcoholic beverages).

As parents of children with FAS or FAE we are presented with a variety of frustrations. Many of us are adoptive parents (birth parents frequently have problems parenting these children because the FAS/FAE child is difficult to parent and because the parent often has difficulty coping because of her/his pattern of drinking). Most of us had the same expectations and dreams as birth parents when we adopted our children. Many of us did not know that our child had FAS/FAE and if we did know, we did not know the full implications of that fact. We did not know about the behaviors - sometimes bizarre - that these children exhibit. We did not know that they would not be able to function at a level consistent with their IQ. We did not know that our children have a very poor prognosis for being able to function independently as adults.

In addition to being disillusioned we have frustrating experiences with Doctors who cannot or will not diagnose our child with FAS/FAE; we have school psychologists who do not recognize the peculiar educational needs of the affected child; there are the teachers who are unable to recognize

the child as being FAS/FAE or if they do recognize the problem they do not know how educate the child in an effective manner; we have social service providers and law enforcement personnel who have not the foggiest notion of what to expect from the child with FAS/FAE.

The reason for our being here today is that you as legislators have the power to make a great difference in the lives of our children and ourselves. In so doing you will be greatly reducing the adverse impact of these children on the rest of society. Without appropriate intervention these children will grow up to be the jobless and the homeless of the future. They will run afoul of the law. They will be found engaging in sexual misconduct or will be victims of sexual exploitation. They will be parents of another generation of children with FAS/FAE. As usual, the ounce of prevention is worth a pound of cure.

What do we need? The first thing we need is to educate women that there is such a thing as FAS. There is no need for another child ever to be born so affected if women heed the warning of experts who state that there is no safe limit of alcohol consumption for a pregnant woman.

We need consistency in the delivery of services. The services that the parent and child are able to receive depend on what state they reside in or what community or, sometimes, what case worker they have. As adults, these children will be able to travel from community to community;

from state to state. The problem is a national one now and it will continue to be a national one. It needs, therefore, to be attacked on the Federal level.

We need access to medical care. Our parents have the same kinds of problems obtaining adequate medical coverage as the rest of the population. Our children typically come with medical problems including eye problems, cardiac problems, dental and orthodontic problems, ear problems, skeletal problems, and joint problems. Infants frequently are failure to thrive babies. They are subject to feeding problems and sleep disturbances. Additionally, our children often have psychological problems and can exhaust an entire family's psychiatric coverage in a very short time (if the family is covered by insurance at all).

Birth mothers need social services. If encountered while pregnant they need the services of drug/alcohol rehabilitation providers. This is the last chance society has of mitigating the damage to the fetus. Unfortunately, many providers of this vital service will not serve women who are pregnant.

Once the child is born it is frequently the victim of neglect, abuse, or inadequate nurturing by a parent who is still abusing alcohol. We need to intervene on behalf of the child with counseling and rehabilitation. If the parent is unable or unwilling to care for the child, then the child needs to be removed from the home.

Early intervention is important to the future of these children. To this end, physicians need to be trained to recognize FAS/FAE. They must be shown the importance of making the diagnosis. They must come to know that in order to receive vital services the parents must be able to demonstrate that the child has special needs. This is the beneficial aspect of the label, "FAS" that outweighs any burden that the label entails.

We parents need information about FAS/FAE and its consequences. We frequently need financial assistance; these are handicapped children and raising handicapped children is expensive. We need services such as SSI to be based upon functional ability rather than the results of an IQ test.

We need respite. Raising one of these children is an exhausting, full time, twenty-four hour a day job. Our children need extensive structure in their lives around the clock - day in and day out - year after year. We parents need to get away occasionally. It is heartbreaking to watch parents trying to do the best for their children while they are burning out and their marriages are disintegrating from the stress of raising one or more FAS/FAE children.

We need good case managers, especially those of us who do not know our way around the social services systems. We need knowledgable advocates to help us deal with providers

of services and education.

We need teachers and educational psychologists who are familiar with the special educational characteristics and needs of these children. Our children are not the same as other retarded children and strategies which work for the average retarded child will not work with our FAS/FAE children. We need our education professionals to be educated as to the ramifications of FAS/FAE.

We need appropriate vocational education for our high school aged children. We need the providers of this vocational education to know what kinds of careers these children are going to be able to handle. We need the children to be trained in the skills of the workplace such as being on time and being properly dressed and groomed.

Our children need to be trained in life skills. They need training in money management, in rudimentary social skills, in appropriate sexual behavior, in time management, in basic housekeeping, and in personal hygiene.

We need structured living arrangements for our children as they enter their adult years. Appropriate group homes and employers with realistic expectations would be ideal for our children. It would also be the most cost-effective way of maintaining these people through their adult years.

We wish to thank you for your concern about the problems of

persons with Fetal Alcohol Syndrome/ Fetal Alcohol Effects and their parents. We hope that you and your fellow legislators see fit to provide services which will help ensure that our FAS/FAE children will be productive members of society to the extent that they are able and that the problem of FAS/FAE is greatly reduced in the next generation.

Thank you.

Comments by Betty Taaffe with Steve Saiz, and Chris Jackson
FAS/FAE Parent Support Group, Fairbanks, Alaska

December 3, 1990

I thank Linda Wills for allowing me the opportunity to add my testimony to hers. As a parent and a professional, I hear of the many needs of families with children affected with FAS/FAE. Following is a list of some of the concerns

*Respite Care - Federal definitions need to include those afflicted with FAS/FAE

*SSI / Medicaid - The FAS/FAE disorder needs to be recognized as seriously as Mental Retardation.

*Adequate Medical Care and Psychological Care - adequate diagnoses needs to be available to all people suspected of having the FAS/FAE Syndrome..

*Training For Foster Care Parents

*Rethinking foster care placements - to allow infants and children to remain in a consistent, structured homes, as is often not the practice now.

*Providing Infant Stimulation Programs for children 0-5 yrs. - often the educational disabilities don't become apparent until the middle school years. So even children with a diagnoses are often not provided with early care.

*Change school system criteria for Special Education - to provide for a diagnosed FAS/FAE child dispite their IQ, because the syndrome can show itself in a variety of ways. The goal is to foster productive and independent living.

I offer these comments to you in the ernest hope that you will implement plans and programs for the many families with FAS/FAE children.

COMMUNICATIONS

STATEMENT OF THE AMERICAN CHIROPRACTIC ASSOCIATION

The American Chiropractic Association (ACA), representing 20,000 practicing doctors of chiropractic (D.C.s) and chiropractic students, applauds this committee for its leadership in bringing attention to the tragic consequences of fetal alcohol syndrome (FAS). As physicians concerned with the mitigation of human pain and suffering, nothing is of greater concern to this profession than the needless exposure of a fetus to the damaging properties of alcohol. It is our earnest hope that the committee is successful in elevating public awareness to a level where real solutions to this terrible problem will be found.

Let us begin by explaining why ACA is submitting this testimony. Chiropractic is a branch of the healing arts that considers the individual as an integrated being and one which concentrates on human health through the *prevention of disease.* The preventative emphasis of chiropractic health care is established through rigorous educational standards and training which prepare doctors of chiropractic (D.C.s) as specialists in musculoskeletal, biomechanical, neurological, vascular and nutritional relationships.

An underlying tenant of chiropractic is that patient care is properly conducted with due regard to environmental, nutritional, and psychotherapeutic factors designed to assist in the restoration and maintenance of good health. This theory of patient care is based on the knowledge that an impaired nervous system diminishes the body's defensive capabilities, thus contributing to its susceptibility to disease etiology.

In learning to prevent susceptibility to diseases and the disease process, D.C.s are thoroughly trained as primary care, portal-of-entry health providers expert in diagnosis and clinical analysis of a wide range of disease conditions. That training includes strict study and examination in digestion and nutritional physiology, obstetrics and gynecology, and pediatrics. These educational requirements prepare the D.C. to counsel patients on the factors for good health, a principle part of which concerns providing advice on the prevention of avoidable, and tragically devastating problems like fetal alcohol syndrome (FAS) and fetal alcohol effect (FAE).

ACA is committed to promoting the highest degree of public health and safety in this country. In furtherance of that goal, it has long warned against the deleterious effects of excessive drinking. In 1982, ACA's House of Delegates carried a resolution stating, in part:

> "Alcoholism is established as a disorder manifested by complete absorption with and loss of control over consumption of alcohol and characterized by chronicity, intoxication, and tendency toward relapse.
>
> Excessive drinking causes physical disability leading to impaired emotional, occupational, spiritual, and social adjustments.
>
> Resolved, the American Chiropractic Association continues to recognize alcoholism as an illness which should be so treated; that the alcoholic is a sick person who can be helped and is worth helping and that alcoholism is a significant public health problem."

In 1988, ACA actively lobbied for the enactment of legislation requiring the printing of conspicuous and prominent warning labels on alcoholic beverage containers describing the harmful effects of consumption of alcohol. In a victory for public awareness, that legislation, sponsored by Senator Strom Thurmond and Representative John Conyers, went into effect in November of 1989. One of the messages now required to appear on wine, liquor or beer containers warns against the risks of drinking while pregnant. (Our lobbying effort continued at the Bureau of Alcohol, Tobacco, and Firearms (BATF) which issued a proposed rule permitting manufactur-

ers to print warning label messages in tiny, barely-legible print. A coalition of public health groups prevailed upon BATF to issue revised regulations that satisfy the law's requirement that health messages be "prominent and conspicuous.")

The harmful effects of prenatal exposure to alcohol are well documented and have been described in sufficient detail by other witnesses that we will not delineate them here. However, let it suffice to assert that any preventable condition which exacts $1.25 billion annually from our health care and social services network is one which is in dire need of greater Federal, State and professional attention. Add to this the magnitude of the injuries suffered by FAS babies—it is the leading cause of mental retardation in the U.S.—and the case for concerted governmental action becomes all the more compelling.

The financial and human costs of FAS/FAE are truly appalling when one considers the fact that these conditions are totally preventable. It is well established that abstinence during pregnancy avoids the in-utero exposure to alcohol that can lead to deformities, growth deficiencies and central nervous system damage.

Knowing that prevention is the key to elimination of FAS/FAE, governments, public health, and professional organizations all need to channel educational and health care resources to the segments of society where the majority of these cases occur: among American Indians, and individuals of low socio-economic status. Since these individuals obtain their health services primarily through the Indian Health Service (IHS) and Medicaid, solutions should begin with initiatives in these programs. It is vital that these populations be educated about prevention of FAS/FAE. In our view one of the surest ways to achieve the requisite level of education is through expansion of the number of primary health care providers available to provide prenatal services and counseling. An expanded pool of primary care physicians in Medicaid and IHS will ease access to the health care expertise that can make the difference in preventing FAS/FAE cases.

Of course, greater research into FAS/FAE treatment and prevention is another essential facet in solving this problem. The chiropractic profession appreciates the value of controlled, reproducible research, and we are sure the entire profession joins with the ACA in its call for greater Federal funding of research into FAS/FAE through the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Drug Abuse, and the Centers for Disease Control.

Additionally, States need greater Federal assistance in developing alcohol abuse services. Funding for the Alcohol, Drug Abuse, and Mental Health Block Grant needs to be increased, and a specific earmark for programs of prevention of FAS/FAE should be strongly considered. We are convinced that a "front-end" investment will eventually more than pay for itself in reduced costs for treatment of FAS/FAE.

The ACA commends Chairman Moynihan, Senator Daschle and the other members of this committee for bringing public attention to the tragedy suffered by the families affected by FAS/FAE. ACA has long been an advocate of initiatives to mitigate the harmful effects that drugs, both licit and illicit, have on our society. In continuation of that advocacy, we offer the foregoing comments as a small contribution to elimination of FAS/FAE.

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