Fetal Alcohol Spectrum Disorders

Washington State History

1968 through 2004

Introduction

In 2004, a population-based surveillance study was published documenting the following outcomes in Washington State [1];

1. A significant decline in maternal drinking during pregnancy from 1993 to 1998 across Washington State.

2. A significant decline in the prevalence of FAS among children in King County foster care, born in those same years (1993 to 1998).

These data provide compelling evidence that Fetal Alcohol Spectrum Disorders (FASD) prevention efforts in Washington State were working.

So what did Washington State do over the years that may have contributed to these positive outcomes? While the 2004 study, cited above, was not designed to determine which prevention efforts were most effective, the prevention literature strongly supports that a comprehensive approach that utilizes the entire spectrum of effort from public health education to targeted intervention has the greatest impact.

To review the comprehensive approach taken by Washington State, we have compiled an annotated historical record of programs and policies broadly related to FASD implemented in Washington State from 1968 (when FASD was first discovered in Washington State) to 2004 [2,3]. We provide a brief description of each listing and references to *key* publications and/or websites where you can obtain more detailed information. Please note, this document does not provide a complete list of *all* published biomedical FASD articles originating from Washington State. There are far too many to list. We recommend you use an online service such as PubMed from the National Library of Medicine (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&itool=toolbar) to obtain a more comprehensive list of citations.

This document is a work in progress and represents our best effort, to date, to record the history of FASD-related activities in Washington State. This document was compiled by Susan Astley, Ph.D. with the help of individuals across Washington State who played a role in this history. Susan Astley is a Professor of Epidemiology at University of Washington in Seattle WA and is the Director of the Washington State FAS Diagnostic & Prevention Network. This document will be updated periodically as additional information is obtained. The date of last update is printed in the header of this document. Updates will be posted on the Washington State FASD (www.fasdwa.org) and FAS DPN (http://depts.washington.edu/fasdpn) websites. Please contact Susan Astley, Ph.D. (astley@u.washington.edu) if you have questions/comments regarding this document.

References

1. Astley SJ, Fetal alcohol syndrome prevention in Washington State: Evidence of success. Paediatric and Perinatal Epidemiology, 2004;18:344-351.

2. Hankin JR. Fetal alcohol syndrome prevention research. Alcohol Research and Health 2002;26:58-65.

3. Hankin JR. FAS prevention strategies: passive and active measures. Alcohol Health and Research World 1994;18:62-66.

Washington State FASD History from 1968 to 2004	
1968	**Link between prenatal alcohol exposure and adverse infant outcome first discovered**. Christy Ulleland, M.D. Chief Resident at Harborview Medical Center, University of Washington first discovers the link between prenatal alcohol exposure and adverse outcomes in infants. In January 1968, Dr. Ulleland received funding to conduct an 18-month study to scientifically assess her clinical observation that infants born to alcoholic women had impaired outcomes. Upon completion of the study, Dr. Ulleland concluded "Chronic alcoholism can be appropriated added to the list of maternal factors that create an unhealthy intrauterine environment for the developing fetus; the consequences of which may be lifelong". Ulleland CN; Wennberg RP, Igo RP; Smith NJ. The Offspring of Alcoholic Mothers. American Pediatric Society and Society for Pediatric Research 1970. p. 93. *This abstract was accepted for presentation by Dr. Ulleland at the Annual Meeting of the American Pediatric Society-Society for Pediatric Research, held in Atlantic City New Jersey in 1970. This abstract was printed (not published) in the Abstract Issue distributed at the meeting, therefore it cannot be found through a Medline search. The Society for Pediatric Research furnished a copy of the Abstract from their archives. It can be viewed on the website listed below.* Ulleland CN. Offspring of Alcoholic Mothers. Annals New York Academy of Sciences, 1972;197:167-169. http://depts.washington.edu/fasdpn
1970's to present	**Statewide Training and Education.** With each successive year, an increasing number of individuals and agencies/institutions provided FASD training and education to families and professionals. By 2004, tens of thousands of individuals were trained. These training/educational efforts are described in more detail throughout this document.
1970's to present	**Public Education through News Releases:** Hundreds of press releases (newspaper, radio, TV) contributed to public education. A sample of these releases can be found on the following websites. www.fetalalcoholsyndrome.org http://depts.washington.edu/fadu

1973	**The term FAS is coined.** In 1973, Kenneth Jones, MD and David Smith, MD, from the University of Washington, Seattle Washington, coin the term FAS to describe a subset of alcohol-exposed children, obtained from Dr. Ulleland's study and their own clinical records, who shared a common pattern of abnormality. Jones KL, Smith DW, Ulleland CN, Streissguth AP. Pattern of malformation in offspring of chronic alcohol mothers. Lancet 1973;i:1267-1271. Jones KL, Smith DW. Recognition of the fetal alcohol syndrome in early infancy. Lancet 1973;Nov 3;2(7836):999-01001.
1973 to present	**Gestalt Approach to Diagnosis:** FAS is a medical diagnosis diagnosed by a medical doctor. Diagnostic services were originally provided at Children's Hospital and Regional Medical Center and the University of Washington in Seattle where FAS was first discovered. Diagnostic services were expanded statewide when the Department of Health, in collaboration with Children's Hospital and Regional Medical Center, established the Regional Genetics Clinics. Diagnostic Guidelines through 1996 (Jones & Smith, 1973; Clarren & Smith, 1978; Rosett, 1980, Sokol & Clarren, 1989; IOM, 1996) utilized a "gestalt" approach to diagnosis. A 'gestalt' approach relies more on 'clinical impression' than on objective, case-defined criteria. In 1996, the Institute of Medicine documented the necessity for making the diagnostic process more objective and explicit. In 1997 the FAS DPN created the FASD 4-Digit Diagnostic Code; a comprehensive, objective, case-defined diagnostic method designed for use by an interdisciplinary diagnostic team. The 4-Digit Code is utilized by the Washington State FAS Diagnostic & Prevention Network of clinics (described below). Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention , and Treatment. Institute of Medicine. Stratton, Howe, Battaglia (eds), National Academy Press, Washington D.C., 1996.
1974	**FAS Epidemiological Study**: Epidemiological study documenting increased mortality and morbidity at age seven years in 23 children born to alcoholic mothers relative to matched controls. Jones, K.L., Smith, D.W., Streissguth, A.P., & Myrianthopoulos, N.C. (1974). Outcome in offspring of chronic alcoholic women. Lancet, 1(866), 1076-1078

1974 to present	**Alcohol and Pregnancy Long-Term Follow-Up Study.** The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded FADU since 1974 to conduct the "Seattle Longitudinal Prospective Study on Alcohol and Pregnancy". This study has followed and assessed 500 individuals with prenatal alcohol exposure, from birth to adulthood. Currently, the study is analyzing data from the exams of 500 subjects collected at 25 years of age. Findings from the 25-year exam and earlier exams continue to show long-term effects from prenatal alcohol exposure. This study won a Merit Award from NIH, and in 2004 a new 5-year component was funded to interview the subjects at 30 years of age. Streissguth AP, Martin DC, Martin JC, Barr HM. The Seattle longitudinal prospective study on alcohol and pregnancy. Neurobehav Toxicol Teratol. 1981 Summer;3(2):223-33. Baer JS, Sampson PD, Barr HM, Connor PD, Streissguth AP. A 21-year longitudinal analysis of the effects of prenatal alcohol exposure on young adult drinking. Arch Gen Psychiatry. 2003 Apr;60(4):377-85. http://depts.washington.edu/fadu
1977	**First study to document impact of prenatal alcohol exposure on infant birth weight:** Maternal alcoholism during pregnancy may result in severe prenatal growth deficiency. In this prospective study, the relationship of moderate maternal alcohol consumption to infant birth weight is explored. Subjects were 263 paying members of a health maintenance organization who delivered single live children. Their alcohol consumption before pregnancy, and in early and late pregnancy, was estimated. In order to control for smoking, which is strongly related to both infant birth weight and maternal alcohol use, the sample was selected so that similar proportions of smokers were represented in both light and heavier drinkers. Multiple linear regression was employed. A regression equation was computed for each of the three periods in which drinking was estimated. Independent variables entered into the equation were maternal age, height, parity, daily cigarettes, alcohol use in the period, and gestational age and sex of child. The regression of birth weight on these variables revealed a significant relationship ($p \leq 0.01$) with alcohol consumption in two of the periods. Ingestion of an average of one ounce of absolute alcohol daily before pregnancy was associated with an average decrease in birth weight of 91 grams; the same amount ingested in late pregnancy was associated with a decrease of 160 grams. The associations were independent of the other variables entered into the equation, and in particular, of tobacco use. Little, R.E. (1977). Moderate alcohol use during pregnancy and decreased infant birth weight. Am J Public Health, 67(12),1154-1156.

1978	**Case-series publications of children and adults with FAS** Streissguth, A.P., Herman, C.S., & Smith, D.W. (1978). Intelligence, behavior, and dysmorphogenesis in the Fetal Alcohol Syndrome: A report on 20 patients. Journal of Pediatrics, 92(3), 363-367. Clarren, S.K. & Smith, D.W. (1978). The fetal alcohol syndrome. N Engl J Med, 298(19), 1063-1067.
1978 to1980	**FAS Prevention Demonstration Project targeted to pregnant women.** Investigators at the University of Washington are awarded the first 3-year demonstration grant from NIAAA to conduct a FAS Prevention Program in Seattle working with high-risk pregnant women. The Pregnancy and Health Program (PHP) was established in 1979 to develop effective methods of intervening in maternal alcohol abuse during pregnancy in a metropolitan US community. Services provided over a two-year period included public and professional education, an alcohol and pregnancy information and crisis telephone line, screening for alcohol problems in selected prenatal clinics, treatment and support for women concerned about their drinking during a pregnancy, and help for children possibly affected in utero by alcohol. Evaluation of PHP's educational programs showed significant increases in awareness and knowledge of the risks associated with drinking during pregnancy, among both the public and health professionals in the community. Information was provided by telephone to over 2400 persons, including one in every 44 pregnant women in the community. A total of 304 pregnant women were personally given information as well as treatment for alcohol problems when necessary. For women seen personally, a significant decrement in drinking was associated with program entry, which was in turn related to healthier infants at birth. This two-year program established that intervention in pregnancy drinking is essential and feasible. Screening techniques developed by PHP simplify detection of excessive drinking. Education coupled with effective screening and referral to treatment when needed make reduction of fetal alcohol effects a goal within reach for all communities Little RE, Young A, Streissguth AP, Uhl CN. Prevention fetal alcohol effects: effectiveness of a demonstration project. Ciba Foundation Symp. 1984;105:254-74
1980	**First International Conference on FAS**. Organizers: Ann Streissguth, Ph.D. and David W. Smith, M.D. Funded by NIAAA. Held in Seattle Washington.

1981 to present	**Surgeon General's Advisory on Alcohol and Pregnancy.** First country in the world to make this recommendation "ACCORDING TO THE SURGEON GENERAL, WOMEN SHOULD NOT DRINK ALCOHOLIC BEVERAGES DURING PREGNANCY BECAUSE OF THE RISK OF BIRTH DEFECTS" FDA Drug Bulletin, 1981 July:11(2):9-10.
1983 to present	**FASD training to Native American service providers.** Since 1983, the Indian Health Service has funded FADU to provide prevention, intervention, and research strategies and trainings on FASD to Native American service providers and communities. A manual on adolescents and adults with FASD with special reference to American Indians was produced and over 32,000 copies were distributed. http://depts.washington.edu/fadu
1985	**Natural history of FAS**: Publication of 10-year follow-up of original children identified with FAS in 1973. Study revealed that only half were mentally retarded. The rest were borderline IQ. Streissguth, A.P., Clarren, S.K., & Jones, K.L. (1985). Natural history of the Fetal Alcohol Syndrome: A ten-year follow-up of eleven patients. Lancet, 2, 85-91.

1986 to present	**Washington State Birth Defect Surveillance (FAS).** The Washington State Birth Defects Surveillance System was an active surveillance system from 1986 through 1991. Since then, the system has been passive, relying on hospitals to report cases of children with birth defects. Currently, an enhancement project is in progress to develop a web based, electronic reporting system to reduce the reporting burden to hospitals. Washington State has around 80,000 live births every year with an estimated 2,400 to 3,200 children diagnosed with birth defects based on annual prevalence proportion of 2-4 per 100 live births per year. According to Washington State Vital Statistics 92 of 423 deaths to children under one year of age occurred among children with birth defects in 2000. The Birth Defects Surveillance Enhancement Plan was developed to create a consistent and thorough approach to improving birth defect surveillance in Washington State. Nine structural birth defects (i.e., anencephaly, spina bifida, cleft lip with/without cleft palate, cleft palate, 2° and 3° hypospadius, limb reduction defects, gastroschisis, omphalocele, and Down Syndrome) and three complex disorders (i.e., autism, cerebral palsy, and fetal alcohol syndrome) are part of the notifiable conditions regulation. Reporting Requirements: In August 2000, the Washington State Board of Health approved a revised list of congenital abnormalities notifiable by law to public health authorities under Chapter 246-101 of the Washington Administrative Code. Among these were 9 birth defects and 3 developmental conditions. Hospitals are required to report: anencephaly, spina bifida, cleft palate, cleft lip / palate, omphalocele, gastroschisis, limb reduction defects, hypospadias, and down syndrome, on a monthly basis to the Washington State Birth Defects Surveillance Program. Autism, alcohol related birth defects, and cerebral palsy are also notifiable, but are on hold as they require different reporting procedures to be developed after the implementation of web based electronic reporting from hospitals has been completed. In 2003, the Birth Defects Surveillance program and FAS DPN will work collaboratively to report all cases of FAS, partial FAS and ARND, guided by the FASD 4-Digit Diagnostic Code. http://www.doh.wa.gov/Notify/nc/birthd.htm
1988	**FAS Education**: Over 36,000 copies distributed free by the Indian Health Service and the National Clearinghouse for Alcohol and Drug Information. Streissguth, A.P., LaDue, R.A., & Randels, S.P. (1988). A Manual on Adolescents and Adults with Fetal Alcohol Syndrome with Special Reference to American Indians (2nd ed.)

1988 to present	**Alcohol Beverage Labeling Act** warns of danger of alcohol use during pregnancy. In order to address the problem of fetal alcohol syndrome, the FDA Commissioner wrote to the BATF Director on November 15, 1977 requesting that the BATF "initiate immediately whatever procedures are necessary to require the placement on the labeling of alcoholic beverages of a warning against consumption of excessive amounts of alcohol by pregnant women...I hope that BATF, which now has exclusive responsibility for such labeling, will move promptly to address this serious health risk. On January 13, 1978, in response to this request, BATF requested comments on this proposal, by issuing an advanced notice of proposed rule making in the Federal Register. However, over one year later, the BATF issued a progress report on January 25, 1978, which rejected warning labels for a public awareness campaign to alert consumers of the possible dangers. In 1979, the Senate passed a bill requiring warning labels on all alcoholic beverages, but the House of Representatives failed to pass this bill. In 1986, a similar bill introduced into Congress failed to pass. This initial request by the FDA was finally executed when Title VIII of the Anti-Drug Abuse Act of 1988, amended the FAA Act by designating the existing sections of the FAA Act as "Title I," and by adding at the end a new title, "Title II—Alcoholic Beverage Labeling." This title, cited as the "Alcoholic Beverage Labeling Act of 1988" required that a specific health warning statement appear on the labels of all containers of alcoholic beverages and authorized the Secretary of the Treasury to implement them and enforce them. The original bill began with both the United States House and the Senate having bills, which would have required five separate warning labels to be rotated regularly on the containers of each brand of alcoholic beverage made by a manufacturer.] Under the proposed House bill, the FDA would have had the power to enforce these requirements and issue necessary regulations. However, the proposed Senate bill, which was the bill, which ultimately became the Anti-Drug Abuse Act of 1988 gave the BATF the power to enforce these requirements. Accordingly, as part of its statutory mandate, on February 14, 1990 the BATF issued a final rule. The regulations require that the following health warning statement appear on the labels of all containers of alcoholic beverages sold or distributed in the United States: GOVERNMENT WARNING: (1) ACCORDING TO THE SURGEON GENERAL, WOMEN SHOULD NOT DRINK ALCOHOLIC BEVERAGES DURING PREGNANCY BECAUSE OF THE RISK OF BIRTH DEFECTS. (2) CONSUMPTION OF ALCOHOLIC BEVERAGES IMPAIRS OUR ABILITY TO DRIVE A CAR OR OPERATE HEAVY MACHINERY, AND MAY CAUSE HEALTH PROBLEMS. For purposes of title II, the term "alcoholic beverage" included any beverage, which contained no less than one-half of one percent (0.5%) of alcohol by volume. Thus, the term included not only distilled spirits products, malt beverages, wines, but wine coolers as well. The rule's stated purpose was to promote the public health and safety and it became effective and mandatory on November 14, 1990. http://leda.law.harvard.edu/leda/data/513/Myers.html

1989 to present	**Alcohol and Drug Abuse Treatment and Support Act (ADATSA) adopted policy of fast-tracking pregnant women into treatment.** http://www.counselingseattle.com/acronyms/ADATSA.htm
1989 to present	**First Steps Program is established**. First Steps is a program that helps low-income pregnant women get the health and social services they may need. The goal of the First Steps program, authorized by the Maternity Care Access Act of 1989, was to provide "maternity care necessary to ensure healthy birth outcomes for low-income families." The legislation called for removal of unnecessary barriers to receiving prenatal care and provided for increased access to care and expanded Medicaid services for low-income pregnant women. During the late 1980s, women across Washington State faced increasing difficulty in accessing prenatal care. Increasing malpractice premiums and low Medicaid reimbursement had resulted in a shortage of obstetrical providers, and maternity care providers were increasingly reluctant to provide care to the growing number of Medicaid clients. Private practitioners, representatives of state agencies, public officials and University of Washington faculty recognized this crisis in maternity care and formed the Access to Maternity Care Committee, sponsored by the Washington Chapter of the American College of Obstetricians and Gynecologists. This committee was instrumental in identifying major causes of the maternity care crisis and in shaping the First Steps legislation. The First Steps program includes the following components: ▪ Expanded Medicaid eligibility to 185% of the federal poverty level for pregnant/postpartum women and infants less than one year old. ▪ Maternity Support Services during pregnancy and through two months postpartum. ▪ Maternity Case Management for women at high risk for poor pregnancy outcomes during pregnancy and up to one year postpartum. ▪ Increased reimbursement for maternity care providers. ▪ Designation of maternity care distressed areas to encourage community planning and enhancement of health care delivery system for pregnant women and their infants ▪ A statewide public education campaign stressing the importance of early prenatal care. http://fortress.wa.gov/dshs/maa/firststeps/

1990 to present	**The FAS Family Resource Institute (FAS*FRI)** is a non-profit educational organization, which began in 1990, when Program Managers for the state Adoption Support Program helped frustrated parents organize and gather the "Collective Family Experience" on behaviors observed in children and adolescents with FASD. Counselors and therapists, who were trying to help preserve these families, had read the scientific literature on FASD. But they still could not understand the core behavior traits of the disability, especially when the IQ of the affected individual was normal. So FAS*FRI developed their mission to help others identify, understand and care for individuals with FASD and their families and to prevent future generations from having to live with this disability. The situation in the early 1990's was critical as adoptions failed and children were returned to foster care and/or families were being forced to relinquish custody of their children to access residential treatment. Consequently, the foundational activity of the organization was to gather information from parents through personal interviews, surveys and formal retreats. This information was analyzed and organized into educational materials and seminars to fill the experience-based void in the field. At their educational seminars, FAS*FRI frequently includes one researcher and always involves a birth mother as a presenter, along with foster or adoptive parents. No one can understand FASD prevention and intervention until they see the situation from the perspective of families, especially birth families. Since their origin in the early 1990's, FAS*FRI has trained approximately 17,567 professionals and parents and handled over 26,682 contacts for FASD information, referral and mentoring (through June 2004). In addition, Vicky McKinney and other parent presenters she trained have educated over 30,000 high school students with her prevention program. Today FAS*FRI is an educational resource for people around the world who want and need information to compassionately keep affected individuals and their communities safe and to facilitate prevention within the community and the family. The Institute has remained an educational organization based on the Collective Family Experience with FASD. Their products and programs include: • *FAS Times* (quarterly educational newsletter) • Books and educational brochures • Professional development seminars • Mentoring for affected individuals, families and professionals who serve them • Public advocacy (representing affected individuals and their families) • Individual advocacy and representation to access appropriate services in all relevant systems of care • A Birth Mom Mentor Program • Toll-free phone line • Website: www.fetalalcoholsyndrome.org www.fetalalcoholsyndrome.org

1991 to 1993	**FAS Family Resource Institute (FAS*FRI) Policies and Programs:** FAS*FRI's public awareness plan was patterned after the one used by Michael Dorris who galvanized parents by defining a previously unrecognized disability (FASD) through behavioral traits. The following types of activities during this period were based on parental experience and advocacy training: • Reaching out to other families raising children medically diagnosed with FAS. • Gathering and documenting the Collective Family Experience on FAS/E from hundreds of families. • Producing information packets and brochures to educate others about the core behavioral traits of adolescents with FAS/E (documented in *Addiction Biology*, June 2004) • Cooperating with the radio, TV and print media to increase public awareness about the potentially tragic results of alcohol use during pregnancy. • Developing and holding educational seminars to increase public awareness on the Core Disability Traits of FAS/E through the Eyes of Parents. • Cultivating relationships with the media and policy makers, so that when a news event involving FAS surfaced, FAS*FRI was the organization they contacted for further information and a balanced perspective, illustrated by human-interest stories. Activity Summary: Activities during these years included working in the state capitol to motivate the Washington State Legislature to conduct joint hearings (both the House of Representatives and the Senate) on FAS/E to determine the state of the field regarding affected adolescents and adults. Another major activity was to educate community leaders such as county prosecutors, police and judges and the Secretary of DSHS on how youth with FASD are impacting the families, schools and courts in Washington State. FAS*FRI also partnered with the Secretary of DSHS in the State Policy Design Team to educate psychiatrists and the mental health workforce about adolescents and adults who had organic brain damage. FAS*FRI families participated in 4 national TV broadcast interviews and 23 local and regional newspaper articles. www.fetalalcoholsyndrome.org

1991 to 1994	**Washington State MOMS Project: NIDA Perinatal Research and Demonstration Project**. This NIDA-funded research-demonstration project is described in full in the monograph cited below. This project was one of 21 perinatal projects funded nationally in the early to mid-90's. The principal investigators included representatives from the UW Department of Obstetrics and Gynecology, Adolescent Medicine, and DASA. This was a joint effort of: NIDA; The Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse; the University of Washington (multiple departments, listed in the monograph, including Obstetrics & Gynecology, Adolescent Medicine, Department of Psychiatry and Behavioral Sciences), the Seattle-King County Department of Health, Maternal and Child Health Services; Parents Anonymous (now called Parent Trust); the Program for Early Parent Support; the Center for Health Economics Research; and the Washington state Department of Social and Health Services Research and Data Analysis section. The demonstration components of the MOMs Project were designed to incorporate existing community services into a comprehensive service delivery model that focused on recovery for pregnant, chemically dependent women and their families. The MOMS Project was a major impetus behind the increase in beds for women in the state of Washington, and the impetus behind creating more therapeutic childcares onsite at chemical dependency centers, and creating more woman-oriented services in the state. There was an effort to survey for FAS among the women at the treatment center and to educate the staff and patients on FAS. The MOMS Project facility eventually became the non-profit Perinatal Treatment Service, which now has locations in Seattle (the original facility, which moved to Shoreline) and in Tacoma. Washington State MOMS Project: Perinatal Research and Demonstration Project—Final Report. (1999). Department of Social and Health Services, Division of Alcohol and Substance Abuse. Olympia: WA.
1991 to 2003	**Inpatient Treatment Capacity Increased for Women.** DASA tripled the number of gender-specific inpatient residential treatment beds (55 to 148) for pregnant/postpartum women between 1991 and 2003. http://www1.dshs.wa.gov/dasa/default.shtml
1991 to present	**Fetal Alcohol Information Services of Washington State (FASIS)** organized and incorporated under a non-profit charter. **Iceberg Newsletter:** FASIS prints quarterly, international educational newsletter on FASD; a parent/professional partnership. Parent support group held in response to article in Iceberg asking all interested parents to attend. http://www.fasiceberg.org

1991 to present	**FASD Primary Prevention through Birth-to-3 and PCAP.** In 1991, FADU was funded by the Center for Substance Abuse Prevention to conduct a research demonstration project to enable communities to respond, through long-term advocacy, to the problems of mothers who abuse alcohol and drugs during pregnancy. In 1996, the successful program continued through a combination of private funding and state legislative appropriation through DASA, and was expanded to two sites, Seattle and Tacoma. In 1999, legislative funds were appropriated to expand the Parent-Child Assistance Program (PCAP) to sites in Yakima, Moses Lake, and Spokane (including one advocate housed on the Spokane Reservation), increasing statewide capacity to 360 families. Since its inception, PCAP has successfully served over 750 families in Washington State, and the model has been replicated at 14 sites in Minnesota, Texas, Alaska, North Carolina, as well as Alberta, and Manitoba, Canada. Grant TM, Ernst CC, Streissguth AP. Intervention with high-risk alcohol and drug-abusing mothers: I. Administrative strategies of the Seattle model of paraprofessional advocacy. J Community Psychology 1999;27(1):1-18. Ernst CC, Grant TM, Streissguth AP, Sampson PD. Intervention with high-risk and drug-abusing mothers: II. 3-year findings from the Seattle model of paraprofessional advocacy. J Community Psychology 1999;27(1):19-38. http://depts.washington.edu/fadu
1992	**Survey of Gender-Specific Treatment for Women**. In 1992, a survey was conducted of 79 Seattle and King County non-profit and for-profit alcohol and drug treatment agencies to assess the availability of gender specific treatment for women (*Seattle-King County Task Force for Chemically Dependent Women, 1993*). The agencies reported 33% of their clientele were women, and 73% were between 21 and 40 years of age. 84% did not provide on-site child-care, 54% did not offer medical or mental health services at the agency site and 44% did not offer on-site recovery support groups like Alcoholics Anonymous. These are troubling statistics in light of the data collected by Astley et al., *(Astley et al., 2000).* from 80 women in Washington State who gave birth to a child with FAS. Ninety-six percent of the 80 women had one to ten mental health disorders and the women who received mental health treatment were significantly more likely to achieve abstinence than women with mental health disorders who did not receive treatment. Sixty to 70% of the 80 women reported they were taking care of one or more children during their reported abstinence attempts. Women who achieved abstinence were significantly more likely to participate in an aftercare program like Alcoholic Anonymous. Astley SJ, Bailey D, Talbot T, Clarren SK. Fetal alcohol syndrome (FAS) primary prevention through FAS diagnosis: II. A comprehensive profile of 80 birth mothers of children with FAS. Alcohol & Alcoholism, 2000; (35)5:509-519. Seattle-King County Task Force for Chemically Dependent Women, 1993. Chemical dependency treatment for women in Seattle and King County Washington. pp.39 http://depts.washington.edu/fasdpn

1992 to 1997	**CDC-Sponsored FAS DPN Primary Prevention Demonstration Project.** From 1992 to 1997, the CDC funded the FAS DPN at the University of Washington to open the first interdisciplinary FASD Diagnostic Clinic and conduct an FAS primary prevention project in Washington State. The following was accomplished. 1. The study documented the feasibility of using a FASD Diagnostic and Prevention Clinic as a center for identifying and targeting primary intervention to high-risk women (namely, women who had given birth to a child with FAS). 2. The study generated a comprehensive, lifetime profile of 80 women who gave birth to a child with FAS in Washington State as a first step in development of intervention programs to meet their needs. 3. The study identified factors that enhanced and hindered their ability to achieve abstinence and practice effective family planning. Astley SJ, Bailey D, Talbot T, Clarren SK. Fetal alcohol syndrome (FAS) primary prevention through FAS diagnosis: I. Identification of high-risk birth mothers through the diagnosis of their children. Alcohol & Alcoholism, 2000; (35)5:499-508. Astley SJ, Bailey D, Talbot T, Clarren SK. Fetal alcohol syndrome (FAS) primary prevention through FAS diagnosis: II. A comprehensive profile of 80 birth mothers of children with FAS. Alcohol & Alcoholism, 2000; (35)5:509-519. http://depts.washington.edu/fasdpn
1992 to 1997	**CDC-Sponsored FADU FASD Secondary Disabilities Study.** From 1992 to 1997, the CDC funded FADU to study secondary disabilities associated with FASD, to determine risk and protective factors and to make recommendations for prevention and treatment. The four-year study culminated in an international conference in Seattle WA in September1996 and over 25,000 copies of the final report have been distributed. Study findings continue to inform public policy on prevention and treatment. In August 2004, the Journal of Developmental & Behavioral Pediatrics published an article describing two significant protective factors against the adverse life outcomes the study documented. These protective factors are: 1) being raised in a stable, good quality home, and 2) having an early diagnosis of FAS or FAE. Streissguth AP, Bookstein FL, Barr HM, Sampson PD, O'Malley K, Young JK. Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. J Dev Behav Pediatr. 2004 Aug;25(4):228-38. The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities. (1997) Streissguth and Kanter (eds), pp 256. http://depts.washington.edu/fadu

1992 to 1997	**FAS State Coordinator:** This position was funded through the Washington State Department of Health.
1992 to 1997	**CDC-sponsored FAS Prevention through DOH.** From 1992 to 1997, the CDC funded the WA State Department of Health to conduct a number of activities related to FASD prevention. These included: a FASD Needs Assessment, Statewide FASD education, FAS screening in two Native American Tribes and a King County FAS Task Force.
1992 to present	**FASD Interdisciplinary Diagnostic Clinic opens at the University of Washington FAS DPN.** The first CDC-sponsored University of Washington FAS Diagnostic & Prevention Network (FAS DPN) Clinic opens in Seattle. The interdisciplinary diagnostic team includes a pediatrician, psychologist, speech-language pathologist, occupational therapist, social worker, family advocate and public health professional. These professionals work together to provide FASD diagnostic evaluations and intervention plans for individuals of all ages. This interdisciplinary FASD diagnostic program has expanded across the U.S. and Canada. Over 70 multidisciplinary clinical teams have been trained by 2004. Clarren SK, Carmichael Olson H, Clarren SGB, Astley SJ. A Child with Fetal Alcohol Syndrome. In Guralnick MJ (ed.), Interdisciplinary Clinical Assessment of Young Children with Developmental Disabilities Baltimore, Maryland: Paul H. Brookes Publishing Co., 2000; 307-326. http://depts.washington.edu/fasdpn
1992 to present	**FAS DPN Training of Professionals and Students Statewide.** The FAS DPN interdisciplinary team provides weekly FASD training of Washington State professionals and students in the fields of medicine, mental health, social and health services, education, and corrections. Community professionals learn their role in the community in the identification, intervention and prevention of FASD through direct observation of the diagnostic process. Approximately 300 professionals are trained annually. http://depts.washington.edu/fasdpn

1993 to present	**WA State Pregnancy Risk Assessment Monitoring System (PRAMS)**. PRAMS is a CDC-sponsored, ongoing, population-based surveillance system designed to monitor self-reported maternal behaviors that occur before, during and after pregnancy. The Washington State Department of Health has collected PRAMS data since June 1993. Washington State is one of 31 states participating in PRAMS. Each month, 1 in 40 live births are randomly selected from the Washington State birth certificates. At two to six months postpartum, the sampled mothers (n = 2000/year) are sent an explanatory letter and a self-administered PRAMS questionnaire. The PRAMS questionnaire currently includes 66 questions (52 core questions and 14 state-specific questions). The core questions address obstetric history and risk factors, maternal feelings about timing of pregnancy, maternal economic status, birth control, prenatal care, folic acid awareness, prenatal behaviors and experiences (cigarette smoking alcohol use, psychosocial stress during the 12 months prior to deliver, and physical abuse before and during pregnancy), prenatal hospitalization, labor and delivery and infant health. Two core questions documenting alcohol use include: "During the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?" and "During the last 3 months of your pregnancy, how many alcoholic drinks did you have in an average week?" Reported use of alcohol three months prior to pregnancy is deemed the most accurate measure of early pregnancy use because women often do not know they are pregnant until the second month and typically do not change their drinking patterns until they know they are pregnant. A drink was defined as: one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor or one mixed drink. The Office of Maternal and Child Health, DOH, conducts the PRAMS survey, maintains the data files, conducts analyses of PRAMS data, and generates quarterly and yearly reports. Washington State PRAMS data documents the prevalence of maternal alcohol use three months prior to pregnancy and during the third trimester declined significantly (chi-square = 66.9, $p < 0.001$ and chi-square = 101.3, $p < 0.001$ respectively) from 1993 to 1998, exceeding the Health People 2010 objective of 6%. This decline is most striking among the women reporting the highest levels of use (>14 drinks/week) in early pregnancy (chi-square = 64.5, p-value < 0.0001). http://www.doh.was.gov/cfh/PRAMS/default.htm
1993 to present	**Emmy Award Winning FASD Educational Video for Middle School Students**. Department of Health and the Western Washington Chapter of March of Dimes developed and disseminated the "Fabulous FAS Quiz Show"-a 15-minute video and teaching curriculum about FAS aimed at middle school students. The facilitator's educational kit (video and activities) was distributed to all middle schools (grades 6-9) across the state free of charge. The program emphasized "knowledge = choice = power". It was widely used and in 1994 received an Emmy Award for outstanding program achievement – instructional special. http://www.marchofdimes.com/washington/

1993 to present	**First Steps is expanded** to non-citizen women. Family Planning coverage is added for all women up to one year after delivery. http://fortress.wa.gov/dshs/maa/firststeps/
1994 to 2001	**FAS Family Resource Institute (FAS*FRI) Policies and Programs**: During these years, FAS*FRI focused more in-depth on education and public awareness. Through full-day seminars, developed for the state service system workforce, they explained from the Collective Family Experience that individuals with FAS/E are not bad, throw-away kids, but youths who were innocently disabled by prenatal alcohol exposure. So FAS*FRI time during 1994 through 2001 was spent on the following: • Acquiring advocacy skills to be able to obtain a diagnosis for affected individuals and access appropriate care for them. • Honing advocacy skills until they had the knowledge to convince state social workers that an occasional exception to policy is the only way to access services for a severely disabled person with FAS/E. • Working to understand how and when to introduce the disability of FAS/E to the court–for example, in the appeal process in order to access denied state services, during criminal prosecution and sentencing, etc. • Developing and publishing educational brochures, pamphlets and books to help affected individuals understand their disability and to help their parents and interested professionals understand how to support and care for them. • Creating and presenting the professional development curriculum, "FAS: Creating Intervention Touchpoints," which teaches professionals in eight systems to identify, understand and care for affected children, adolescents and adults in a more cost effective and less restrictive manner. Activity Summary: FAS*FRI began this period by working to educate the First Lady of Washington (Mary Lowry), the Secretary of DSHS and the Washington Attorney General about the needs of children with FAS/E. The result was a dynamic partnership which proved very effective in several areas, including a statewide women's forum on FAS and the passage of FAS warning signs at all points of alcohol sales in the state. FAS*FRI also produced three books: *The Best of FAS Times*; *FAS/E: A Standard of Care* and the only book ever written by a birth mom, *Cheers! Here's to the Baby, A Birth Mom's Discovery of FAS*. FAS*FRI staff worked with Senators Tom Daschle (D) and Slade Gorton (R) to write and pass national legislation on FAS/E and a $25 million appropriation for FAS/E in federal agencies such as the Centers for Disease Control and the Substance Abuse and Mental Health Services Administration. Jocie DeVries was appointed to serve on the National Task Force on FAS/E and to represent the disability on the External Partners Group of the National Center for Birth Defects and Developmental Disabilities in the CDC. FAS*FRI families also participated in 8 major news stories on FASD. www.fetalalcoholsyndrome.org

1994 to present	**FAS Diagnostic & Prevention Network clinic (FAS DPN) expands** from Seattle to Everett and Federal Way with funding from the Western Washington Chapter of the March of Dimes Birth Defects Foundation. http://depts.washington.edu/fasdpn
1994 to present	**WA State point-of-purchase alcohol warning signs posted in restaurants, bars, and liquor stores.** (RCW 66.16.110: Birth defects from alcohol – Warning required) The board shall cause to be posted in conspicuous places, in a number determined by the board, within each state liquor store, notices in print not less than one inch high warning persons that consumption of alcohol shortly before conception or during pregnancy may cause birth defects, including fetal alcohol syndrome and fetal alcohol effects. http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=66.16.110
1995 to present	**The World Wide Web (www) becomes available** in the early 1990s. This provides an unprecedented opportunity for agencies and individuals to share information regarding FASD. http://www.w3.org/history.html
1995 to present (Senate Bill 5688)	**WA State FAS Diagnostic & Prevention Network of Clinics (FAS DPN) expands statewide** (Everett, Tacoma, Seattle, Federal Way, Spokane, Yakima, and Pullman) with funding from the Washington State Division of Alcohol and Substance Abuse. http://depts.washington.edu/fasdpn
1995 to present (Senate Bill 5688)	**FAS Interagency Work Group (FASIAWG) established.** The FASIAWG was established in 1995 through Senate Bill 5688. The IAWG is a collaborative effort between all state and community-based agencies and programs to coordinate and enhance FASD diagnostic, prevention, intervention and educational services. Participants include: DOH, DSHS, OSPI, DOC, MAA, DASA, FAS*FRI, NOFAS Washington, MOD, FASIS, FADU and FAS DPN. www.fasdwa.org

1995 to present (Senate Bill 5688)	**Division of Alcohol and Substance Abuse (DASA) Contributions.** DASA contributes considerable funding to the FAS DPN, the Fetal Alcohol and Drug Unit (FADU) at the University of Washington, FAS*FRI, and Iceberg, an educational newsletter for people concerned with FASD. DASA continues to contribute staff time to the development DOH publications responding to legislation targeted at reducing the number of drug-affected infant births in Washington State. http://www1.dshs.wa.gov/dasa/default.shtml
1995 to present	**Education in the Schools**. The Office of the Superintendent of Public Instruction (OSPI) is the state office of kindergarten-12th grade public education. The agency's association with the Fetal Alcohol Syndrome Interagency Work Group in the past has been dissemination of prevention information. Three materials are available from OSPI: ▪ *Educating Children Prenatally Exposed to Alcohol and Other Drugs* sponsored by Washington State Legislature, Fetal Alcohol and Drug Unit- University of Washington ▪ Department of Social and Health Services "The Healing Circle" a set of four CDs of stories portraying animals with FAS and their challenges o *The Little Fox* birth-5 year olds o *The Little Mask* 6-11 year olds o *Sees No Danger and Wanders Afar* 12-17 year olds o *Travels in Circles* 18-22 year olds ▪ *The Washington State Fetal Alcohol Resource Tools for Prevention and Information Guide* produced by Comprehensive Health Education Foundation The future plan for OSPI's involvement with the FAS work group is to make connections with other agencies and events that promote awareness and instructional information about children with FASD in school systems.

1996	**Correlation between Insurance Coverage and Unintended Pregnancies (US-CDC Study).** In the United States during 1994, approximately 49% of all pregnancies, excluding miscarriages, were unintended. Unintended pregnancy can result in adverse health outcomes that affect the mother, infant, and family. Little is known about the distribution of unintended pregnancy with respect to the payment source for health care. In the absence of data for periconceptional payment source for health care, prenatal-care payment source is used as a surrogate. To develop recommendations to reduce unintended pregnancy, CDC analyzed insurance coverage-specific prevalences of live-born infants from unintended pregnancies among women aged 20-34 years using data from the Pregnancy Risk Assessment and Monitoring System (PRAMS) for 1996 (the most recent year for which data are available). This report summarizes the results of this analysis, which indicates that the highest rates of unintended pregnancy occurred among women covered by Medicaid, with lower rates among women covered by health-maintenance organizations (HMOs) or private insurance. *MMWR*, February 12, 1999/Vol.48/No.5. http://www.cdc.gov/reproductivehealth/up_up.htm
1996 to present	**FAS Facial Photographic Analysis Software** developed by the FAS DPN to screen and diagnose the facial features of FASD. This software will be used to conduct the FAS Screening in the King County Foster Care Passport Program in 1999. A user-friendly version of the software is developed for Windows-based computers and distributed worldwide starting in 2003. Astley SJ, Clarren SK. A case definition and photographic screening tool for the facial phenotype of fetal alcohol syndrome, J Peds. 1996;129:33-41. Astley SJ, Clarren SK. Measuring the facial phenotype of individuals with prenatal alcohol exposure: Correlations with brain dysfunction. Alcohol & Alcoholism, 2001; (36)2:147-159. Astley SJ. FAS Facial Photographic Analysis Software. Version 1.0.0, 2003. University of Washington, Seattle WA. http://depts.washington.edu/fasdpn

1996 to 1997	**Pilot FAS Screening Program in Foster Care (n = 65).** All children between 4.0 and 13.9 years of age transitioning to long-term (>30 days) foster care between March 1, 1996 and June 31, 1997 in South King County, Washington were referred for FAS screening as part of their foster care Early Periodic Screening, Diagnosis and Treatment (EPSDT) health assessment. Sixty-five children were eligible to be screened during the one-year study. Four public health pediatric clinics in South King County were selected to conduct the FAS screening. Each clinic received a one-day training session administered by the Washington State FAS Diagnostic and Prevention Network (FAS DPN) core clinic at the University of Washington (Clarren & Astley, 1997). The Seattle-King County Department of Public Health (SKCDPH) identified and enrolled eligible children and referred them to one of the four participating public health clinics for screening. The public health clinics forwarded the completed one-page FAS Screening Forms and facial photographs to the University of Washington FAS DPN core clinic for review and screening-outcome classification. The screening method included the recently developed photographic screening for FAS (Astley & Clarren, 1996). Children who screened positive were referred to the SKCDPH FAS Diagnostic and Prevention Network Clinic in Federal Way for diagnostic evaluation. All children were diagnosed following the 4-Digit Diagnostic Code method developed by the WA State FAS DPN (Astley & Clarren, 1997). All children and their caregivers received referrals to appropriate follow-up services from social, educational and health care professionals. This project was a collaborative effort between the Seattle-King County Department of Public Health, the Washington State Department of Social and Health Service's (DSHS) Division of Children and Family Services (DCFS), the University of Washington FAS Diagnostic and Prevention Network (FAS DPN), the Western Washington March of Dimes Birth Defects Foundation and the Washington State Department of Health (DOH). This study demonstrated that FAS screening in a foster care population was both feasible and worthwhile. This screening effort successfully linked children and foster families to community services and forged an invaluable collaborative relationship between the State Division of Children and Family Services, the University of Washington FAS DPN and the SKCDPH. Future FAS screening efforts could be conducted more efficiently and equally effectively through the collection of just a photograph with an internal measure of scale. The collection of additional data on growth, CNS function, direct facial measurements and prenatal alcohol exposure data did not contribute to the accuracy of this FAS screening effort. The collection of this additional data did, however, contribute substantially to the logistical demands and cost of this screening effort because of the need to schedule medical appointments with medical professionals in medical facilities. In contrast, the collection of photographs does not require medical professionals or facilities and the logistics of obtaining photographs could be minimized by having the foster care system obtain the child's photograph at one of several time points when foster care personnel are routinely in contact with the child (i.e., at the time of entry into foster care, during home visits, etc.). This pilot effort lead to the implementation of the 1999 ongoing FAS Screening program in the King County Foster Care Program described below. http://depts.washington.edu/fasdpn

1996 to 1997	**Pilot FAS Screening in a Juvenile Detention Center (n = 829).** This was a collaborative effort between the FAS DPN and Washington State Juvenile Rehabilitation Administration. All residents (n = 829) in a male juvenile detention center were screened using the FAS Facial Photographic Analysis Program between 1996 and 1997. All residents who screened positive for the FAS facial features were to receive a comprehensive, interdisciplinary FASD diagnostic evaluation. Although several residents screened positive for FAS facial features, diagnostic evaluations could not be completed prior to their release because of complexities encountered in obtaining consent to perform diagnostic evaluations on incarcerated youth. This high-risk population remains an important population to screen for FASD. Future efforts will require establishment of HIPAA-compliant consent procedures that can be conducted in a timely manner. http://depts.washington.edu/fasdpn
1997	**FAS Public Health Education**: "Fetal Alcohol Syndrome: A Guide for Families and Communities" Over 10,000 copies sold. Fetal Alcohol Syndrome: A Guide for Families and Communities. (1997) Ann Streissguth, Brookes Publishing Company, Inc. http://depts.washington.edu/fadu

1997 to present	**Creation of the FASD 4-Digit Diagnostic Code.** FAS DPN creates the FASD 4-Digit Diagnostic Code (Astley & Clarren 1997, 1999; Astley 2004): a comprehensive method for diagnosing FASD using an interdisciplinary diagnostic team. The interdisciplinary team includes a pediatrician, psychologist, speech/language pathologist, occupational therapist, social worker and family advocate. This diagnostic approach is used on all patients evaluated from 1997 to present. All patients diagnosed at the FAS DPN prior to the creation of the Code (1993 to 1996) have their diagnostic classifications retrofitted to the 4-Digit Code. Over 70 multidisciplinary clinical teams have been trained to use this diagnostic method across the U.S. and Canada. Astley SJ, Clarren SK. Diagnosing the full spectrum of fetal alcohol exposed individuals: Introducing the 4-Digit Diagnostic Code. Alcohol & Alcoholism, 2000;35(4):400-410. Astley SJ and Clarren SK. (1997) Diagnostic Guide for Fetal Alcohol Syndrome and Related Conditions. University Publication Services, pp. 93. Astley SJ and Clarren SK. (1999) Diagnostic Guide for Fetal Alcohol Syndrome and Related Conditions. 2nd edition, University Publication Services, pp. 111. Astley SJ. (2004) Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code, 3rd Edition, University Publication Services, pp. 114. http://depts.washington.edu/fasdpn
1997 to present	**The Foster Care Passport Program (FCPP)** is an automated, health and education record-keeping and tracking system for children in out-of-home care for more than 90 days. The Children's Administration and local public health jurisdictions collaborate to administer the program. Public Health Nurses located in Children's Administration offices collect and input information about the child's medical history and treatment, while social workers input social, behavioral and educational data. The information is given to foster parents or relative caregivers at the time of placement and is updated every six months or whenever a child moves. All children who came into care after July 27, 1997, and have resided in out-of-home care longer than 90 consecutive days are eligible. http://www1.dshs.wa.gov/basicneeds/cgs2ppfc.html
1997 to present	**Parent-Child Assessment Program (PCAP) expands** to include Seattle and Tacoma. Funded by the Washington State Legislature through the Washington State Division of Alcohol and Substance Abuse (DASA), Department of Social and Health Services. http://depts.washington.edu/fadu

1997 to present	**Solutions Group established.**
1998	**Reproductive Health Benefits Survey**. Senn, D. (1998) A Report by the Washington State Office of the Insurance Commissioner, Olympia WA pp. 1-48. Key finding: 77% of Washington State insurance plans paid for abortion, but only 30% provided coverage for contraceptives. Four out of 5 women did not have contraceptive coverage. (See also 1996 CDC report on Insurance Coverage and Unintended Pregnancies) Senn, D. (1998) A Report by the Washington State Office of the Insurance Commissioner, Olympia WA pp. 1-48.
1998 to present	**FASD Programs/Policies within the Department of Health** *HB 3103*: An act relating to prenatal screening for exposure to drugs (including alcohol) was passed and signed into law by Governor Gary Locke in early 1998. As a result, DOH was directed to: ▪ Develop screening criteria for identifying pregnant and lactating women at risk of producing a drug affected baby; ▪ Develop training protocols for medical professionals related to the identification and screening of women at risk of producing a drug-affected baby; ▪ Investigate the feasibility of developing medical protocols for laboratory testing or other screening of newborn infants for exposure to alcohol and drugs; and, ▪ Summarize the results of these efforts as described in the HB 3103 report. The report was completed in January 1999. DOH has distributed the report, presented it to the statewide Perinatal Advisory Committee, and included it on the DOH Web Page. Hard copies are still available upon request. *RCW 13.34.803:* Required DOH and the DSHS to design a comprehensive program for Medicaid eligible women who gave birth to a drug or alcohol exposed infant. A report "A Comprehensive Program for Alcohol and Drug Abusing Mothers and their Young Children" was completed in January 1999. DOH continues to participate at the state and local level in the implementation and evaluation of Safe Babies, Safe Moms Project. (*this cell continued on next page*)

1998 to present	**FASD Programs/Policies within the Department of Health (continued)** Education: Public Health, Seattle-King County provides FAS education to health care professionals, social service professionals and other who work with children and adults affected by alcohol in utero. DOH facilitated the production of the *FAS Train the Trainers* curriculum, through a CDC cooperative agreement, which continues to be distributed, as well as posted on the Washington State Department of Health, Genetic Services Section website: DOH oversees the Maternal Substance Abuse and Screening Provider Initiative. The purpose of the project is to establish universal screening by interview, observation and self-report as the standard of prenatal/postpartum care in Washington State, improve provider screening skill and effectiveness, and increase the number of women identified and women who enter treatment. These goals are being addressed by State and Regional Perinatal Program training efforts, as well as collaboration with the Comprehensive Pilot Programs for Drug and Alcohol using Women and their Children, (Safe Babies, Safe Moms). Perinatal programs outreach and education activities: 2000-2004: The four Regional Perinatal Programs receive $170,000 annually to provide professional education. From January 2000—December 2003, 4694 providers were trained, including 1,113 physicians and midwives, approximately 61% of providers who deliver babies in Washington State. The trainings and follow-up are individualized and occur in a variety of settings from conferences and grand rounds to individual practice sites. This project ended June 30,2004. New strategies will be developed and implemented based on the physician input. DOH conducted focus groups and key informant interviews with physicians who provide obstetric care to determine effective strategies for influencing and improving screening and intervention for perinatal substance abuse and violence. This project was completed December 31, 2003. DOH intends to utilize the results to develop future screening strategies. The State Health Officer, Maxine Hayes, MD and DOH staff have presented at the Washington State Obstetrical Association (WSOA) Meeting, the Central Washington Perinatal Conference, Controversies in Neonatal-Perinatal Care Regional Conference and others. In addition, information on substance abuse prevention is exhibited in professional meetings, such as the WSOA, Fundamentals of Addiction, and Reproductive Health Update. DOH staff provides the Motivational Interviewing training for individuals providing care to pregnant high-risk women using alcohol or drugs during pregnancy. (*this cell is continued on next page*)

1998 to present	**FASD Programs/Policies within the Department of Health (continued)** DOH developed and continues to update and disseminate several professional educational materials related to substance abuse during pregnancy. These include clinician pocket cards with screening questions on the front and referral information on the back, and a best practice guide, Substance Abuse During Pregnancy: Guidelines for Screening. The new edition of the best practice guide includes additional information on skill building techniques, testing consent issues, basic prenatal management, new programs and other resources. Distribution includes dissemination to OB providers, other health care professionals at First Steps trainings and regional meetings and MCH LHJ regional meetings. Professional materials are available in hard copy or electronically from the DOH website and are included in DOH exhibits at professional meetings and conferences: WSOA, Fundamentals of Addiction, Reproductive Health Update, Primary Care Update, WAFP, and others. These materials were developed with input from DSHS, Perinatal Advisory Committee, and other community experts. Annually, DOH distributes approximately 5,000 FAS Prevention Brochures to individuals requesting information on pregnancy through *Healthy Mothers Healthy Babies.* DOH worked with Perinatal Advisory Committee to develop changes to the uniform prenatal medical record developed by Physicians Insurance. Suggestions were made to improve assessment and documentation of screening for substance abuse. Approximately 90% of the obstetric providers in Washington use this medical record. The new chart forms were available from Physicians Insurance starting in 2003. *Capacity Building*: Under the Disability Prevention Grant, a pilot study was conducted to screen children for FAS as they entered the Foster Care System. The FAS DPN, developed the computerized photographic screening tool. *(Note: Process, procedures, and screening techniques learned through conducting this study led to implementation of a larger, ongoing FAS effort in the foster care system of King County. This study was conducted in conjunction with the Seattle-King County Department of Public Health and the University of Washington FAS DPN.. The result of this study is a FAS photographic screening for children entering foster care in King County within the PASSPORT system, and who will be placed for more than ninety days.)* (*this cell is continued on next page*)

1998 to present	**FASD Programs/Policies within the Department of Health (continued)** DOH provides several direct supports to families and individuals, including those affected by FAS/FAE. DOH supports public health nursing visits to extremely high-risk families to provide parenting education, information on infant development, facilitate referrals and provide parental support. DOH supports adolescent development programs for at-risk youth, which include peer support groups, art, sports and career development activities, and parent education. DOH supports a system of Regional Genetic Clinics where at-risk individuals can be assessed and diagnosed. DOH supports the *Healthy Mothers, Healthy Babies Hotline,* which provides referral information for families, including the *ASK Line* that directs families to specific resources such as the Children with Special Health Care Needs coordinators in each county and Parent-to-Parent of Washington. Again, families affected by alcohol related birth defects have access to and can receive these services. *Technical Assistance:* DOH provided consultation to the FAS*FRI to assist in writing research objectives for FAS legislation developed at the federal level, e.g., legislation developed by Senator Tom Daschle (D, South Dakota) and others. Technical assistance was also provided to the Solutions Workgroup, a committee who is proactive in their advocacy for women and children's services. DOH provides on-going technical assistance and consultation to providers and other health care organizations related to conference planning and resource materials. The department works with key professional organizations to develop and maintain this standard of care and identifies and works with physicians who are interested in this area and will work to change peer practice. DOH staff attended FASIAWG meetings and actively participated in coordinating efforts among state agencies involved in providing services for individuals who have FAS and FAE. http://www.doh.wa.gov/cfh/mch/Programs.htm
1998 to present	**FASD training across Washington State**. The Washington State Resource Family Training Institute through the Department of Social and Health Services provides FASD training statewide. http://www1.dshs.wa.gov/

1998 to present	***Journey Through the Healing Circle*** **is a series of videotapes, video CDs, and professionally illustrated workbooks.** The series is narrated by Native American Storyteller Floyd Red Crow Westerman, who uses animal stories to talk about children with Fetal Alcohol Syndrome (FAS) and the problems families face with these effects. These stories present frank, honest information in a way that children and adults find inviting and even entertaining. Produced by the Washington State Department of Social and Health Services the series has attracted national and international attention, receiving and nominated for several awards as an outstanding educational video. In August 2002, the series was compacted for the use of public television stations. To date, it has aired on stations throughout Washington, Alaska and several Canadian provinces. Additionally, the Foster Parent Training institute has posted a workshop on its training website that allows foster parents to receive training from the convenience of their homes. http://www1.dshs.wa.gov/ca/Fosterparents/journey.asp
1999 to 2003	**FASD Training to Washington Tribes.** The Governor's Office of Indian Affairs, with funding from the Division of Substance Abuse (DASA) and Comprehensive Health Education Foundation (CHEF), offering trainings to all Washington tribes on FAS and partnering with the Northwest Portland Area Indian Health Board FAS Project.
1999 to present	**FAS Screening/Surveillance in Foster Care**. This program is a collaborative effort between the FAS DPN and Children's Administration Region 4 Foster Care Passport Program. All children entering long-term out-of-home placement in the Region 4 (King County) Foster Care Passport Program (FCPP) are screened for FAS using the FAS Facial Photographic Analysis Software developed by the FAS DPN. Over 2000 children have been screened to date. Ninety-eight percent of eligible children participate. Children who screen-positive for the FAS facial features receive a comprehensive FASD diagnostic evaluation at the UW FAS DPN clinic. All screening/diagnostic outcomes are entered into the child's medical "Passport". The prevalence of FAS in this population is 1/100 (roughly 10-times greater than in the general population). Astley SJ, Stachowiak J, Clarren SK, Clausen C. Application of the fetal alcohol syndrome facial photographic screening tool in a foster care population. Journal of Pediatrics, 2002;141(5):712-7. http://depts.washington.edu/fasdpn http://www1.dshs.wa.gov/basicneeds/cgs2ppfc.html

1999 to present	**Parent-Child Assistance Program (PCAP) expands** to include Seattle, Tacoma, Spokane, Moses Lake, and Yakima (statewide capacity: 360 families). "Compared to the original PCAP demonstration project (1991-1995), outcomes at Seattle and Tacoma replication sites have been maintained (for regular use of contraception and use of reliable method; and number of subsequent deliveries), or improved (for alcohol/drug treatment completed; alcohol/drug abstinence; subsequent delivery unexposed to alcohol/drugs). Among women who were binge drinkers at enrollment, at exit from the replication sites 65% were no longer at risk of having an alcohol exposed pregnancy: 30% were using a reliable contraceptive method (e.g., tubal ligation, IUD); 23% were abstinent from alcohol (and drugs) at least 6 months; and 12% were both using a reliable contraceptive and abstinent." Grant T, Ernst C, Streissguth A, Stark K. Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. Am. J of Drug and Alcohol Abuse, (In Press, 2005). http://depts.washington.edu/fadu

2000 to present	**Comprehensive Program Evaluation Project (CPEP) serving substance abusing women and their children** begins [Snohomish, Benton-Franklin, Whatcom counties]. *RCW 13.34.803:* Required DOH and the DSHS to design a comprehensive program for Medicaid eligible women who gave birth to a drug or alcohol exposed infant. A report "A Comprehensive Program for Alcohol and Drug Abusing Mothers and their Young Children" was completed in January 1999. DOH continues to participate at the state and local level in the implementation and evaluation of Safe Babies, Safe Moms Project. This comprehensive program became a reality in January 2000 in Benton/Franklin, Whatcom, and Snohomish Counties. Since January 2000, program sites in these three counties served over 450 (through December 2003) women and their children through the provision of intensive, targeted case management, residential and outpatient chemical dependency treatment services and transitional housing support services. Safe Babies Safe Moms (formerly known as the Comprehensive Program Evaluation Project or CPEP) is a program designed to meet the needs of pregnant or parenting substance abusing women with children under the age of three. The goal of the Safe Babies Safe Moms program is to stabilize women and their young children, identify and provide necessary interventions, and assist women as they transition from public assistance to employment and greater self-sufficiency. Safe Babies Safe Moms seeks to improve the health and welfare of substance abusing mothers and their young children through early identification of pregnant substance abusers, improved access to health care coordinated with chemical dependency treatment, and family-focused early interventions services for mothers and children. Pregnant and parenting women are offered a variety of services including targeted intensive case management, a continuum of residential and outpatient chemical dependency treatment services, transitional housing, behavioral health services, child development screening and activities, parenting education and family planning. The project is a collaborative effort between the Department of Social and Health Services (DSHS) – DASA, MAA, Economic Services Administration (ESA), Research and Data Analysis (RDA), Children's Administration (CA), and DOH. The RDA evaluation of the program was completed December 2003 and encompassed several reports describing program development, implementation issues and lessons learned. Exciting Outcomes from the study include: • The rate of low birth weight for infants born after program entry decreased by 66%, compared to those born before program entry. • The rate of accepted CPS referrals during the first year of life decreased by 35% for infants whose mothers enrolled in Safe Babies, Safe Moms before delivery, compared to those enrolled after delivery. • Criminal justice involvement of Safe Babies, Safe Moms clients is extensive, with an average of 1.5 arrests per woman in the two years before program entry. The arrest rate for clients receiving chemical dependency treatment dropped more than 50 percent. http://www1.dshs.wa.gov/rda/research/4/36/a.shtm

2001	**FASD Prevention Demonstration Project among Women with FASD.** In 2001 FADU was funded by the March of Dimes to conduct a one-year pilot project to study the special problems and needs of 19 women who themselves have FASD. Results indicate these women have high levels of psychiatric distress and behavioral problems, and poorer quality of life relative to other at-risk populations. The study also demonstrated a method for educating providers and providing individualized intervention resulting in clinically relevant outcomes. Grant T, Huggins J, Connor P, Pedersen J, Whitney N, Streissguth A. A pilot community intervention for young women with fetal alcohol spectrum disorders. Community Mental Health Journal. 2004;40(6):499-511. Grant T, Huggins J, Connor P, Streissguth A. Quality of life and psychosocial profile among young women with fetal alcohol spectrum disorders. Mental Health Aspects of Developmental Disabilities. (In press, 2005). http://depts.washington.edu/fadu

2001	**A Targeted Approach to FAS Prevention: The FAS DPN First Bridges Program.** The FAS Diagnostic & Prevention (FAS DPN) is a network of diagnostic and referral clinics in Washington. A clinically feasible protocol was developed in the FAS DPN to identify and reach out to birth mothers of children born alcohol-affected. A tailored brief intervention of targeted FAS prevention services was then created and linked to the central FAS DPN clinic. This "First Bridges Program" (FB) was aimed at accomplishing FAS prevention by helping the women "bridge" the gap to needed alcohol treatment, family planning, or mental health services after being identified because of their children's alcohol-related diagnosis. This FB program involved up to 4 sessions between birth mother and social worker over a 3-month period, using motivational interviewing (MI) techniques. A pilot study examined the feasibility and efficacy of FB services. 16 fertile, still-drinking women were identified in the FAS DPN database, and 50% enrolled: 4 in the FB intervention group and 4 in a comparison group receiving standard of care (no FAS prevention outreach). Groups were similar on key matching variables and linkage to community services at baseline, but comparison subjects had lower IQs and more environmental stress. Participants were aged 24 to 35 years, averaged 10.8 years of education, 50% were of minority status, addiction severity ranged from mild to severe, and all had complex psychiatric histories. These women had already borne 26 children, but 7 of 8 had lost custody of all or some of their children. Three intervention subjects participated in all 4 possible MI sessions; the remaining subject was linked via FB to a long-term advocacy program. All were positive about FB at exit interview, and FB services appeared feasible and cost-effective. As hypothesized, group difference findings revealed improvement in readiness to change drinking behavior, one indicator of alcohol use, and improvement in a measure of general distress among intervention subjects. Intervention subjects typically reported receiving 1-2 community referrals (most from FB), while comparison women obtained no referrals. Significant change was not seen on other measures, but statistical power in this study was low. These women were effectively contracepting at baseline, so improvement in birth control attitudes and behavior could not be discerned. Yet one comparison subject began drinking heavily and ceased birth control to become pregnant. Carmichael Olson H, Gendler B, Kraegel P, Rosengren D, Clarren S, Astley SJ. A targeted approach to FAS prevention: the FAS DPN first bridges program. Alcoholism: Clinical and Experimental Research, 2002;26(5):176A. Seattle, WA 98195.

2001 to 2005	**Intervention for Children with FASD and their Families:** The FAS DPN was funded by the CDC to evaluate the effectiveness of intervention targeted to children with FASD and their families. Objective: Challenging, disruptive behavior among school-aged children with fetal alcohol spectrum disorders (FASD) is a significant problem for the families who raise them, and a "high-priority" treatment issue. An important task is to develop and test clinically feasible interventions that use empirically-supported techniques, are manualized and targeted to this population, acceptable to parents and interventionists when implemented, and have potential to be replicated in the community. Method: A new, 9-11 month home-visiting intervention model was developed and manualized, and received an initial test of efficacy in a randomized control trial as compared to the community standard of care. The 52 enrolled children (age 5-11) showed externalizing behavior problems of clear clinical concern and complex neurodevelopmental disabilities. Most had experienced considerable cumulative postnatal risk and also showed clinical levels of internalizing problems. Their families showed great diversity in demographics, family structure, and intervention needs. The "Families Moving Forward" intervention offered caregiver support, education, advocacy assistance, community linkages, and sustained behavioral consultation for parents. Targeted school and community provider consultation were provided as needed. Interventionists used motivational interviewing, cognitive behavioral therapy, and positive behavior support techniques, and within limits could individualize intervention if needed. Study aims included meeting family needs, improving caregiver attitudes, increasing self-reported use of targeted parenting practices, and reducing child disruptive behavior. Data analysis is underway. Results will be published in 2005. Carmichael HC, et. al., Efficacy of a new model of behavioral consultation for families raising school-aged children with FASD and behavior problems. (Abstract, 2004). http://depts.washington.edu/fasdpn
2001 to present	**FASD Prevention Demonstration Project using PCAP Model of Shorter Duration.** In 2001, FADU was funded by CSAP to conduct a research demonstration project to focus on mothers who abuse primarily alcohol during pregnancy, and using a PCAP intervention model of shorter duration. As of March 31, 2004, 3142 women have been screened at two major hospitals in Seattle and Tacoma, and 85 women and their babies have been enrolled in the study. The primary aim of the project is to prevent future alcohol- affected births, either by motivating women to abstain from alcohol during their next pregnancy, or by educating and encouraging alcohol-abusing women to use reliable birth control methods on a regular basis. http://depts.washington.edu/fadu

2002 to 2004	**FAS Family Resource Institute (FAS*FRI) Policies and Programs**. FAS*FRI was compelled to shift time and energies from the state level to the federal level. This happened for many reasons, including the downward spiral of the state's budget combined with the public mood against raising taxes. There was no money for FASD and no potential for it in sight at the state level. FAS*FRI staff had not lost their focus and overarching goal to help affected children and their families. But they knew that in order for states to be able to fund an eligibility door (and thus services) for a "new" disability, the most likely source of money would be the federal government. So in the last few years, FAS*FRI concentrated on raising national public awareness and advocating for Congressional leaders and federal policymakers to allocate money for FASD intervention and prevention. Although federal money has been spent on FAS issues for over 30 years, none of it has filtered down to directly help affected children and their families. FAS*FRI's message is that new federal funding priorities need to be set in order for an eligibility door to be established so that children and families can actually receive the services. If more money is needed than can be re-allocated, they encourage an alcohol tax set-aside to fund both prevention and intervention programs. To this end, their time during 2002 through 2004 was spent on the following: • Gathering testimonies of families and professionals in 13 regional Town Hall Meetings from many different geographical locations and cultural tribes and communities to determine the national state of the field of FASD. • Analyzing and organizing the data collected at the Town Hall Meetings. • Writing and distributing educational material from the national Collective Family Experience on FASD. • Organizing a national coalition of the leaders of family-run groups throughout the United States to support, strengthen and encourage each other; to build an educational collaboration to develop new parent leadership in the field; and to have a strong family voice in determining federal policy and funding priorities on FASD issues. Activity Summary: Activities were mainly focused on planning and coordinating 13 U.S. regional Town Hall Meetings on FASD around the country (Washington State, Colorado, Texas, Arizona, Florida, New York, Michigan, Illinois, Minnesota, South Dakota, California and Mississippi, Hawaii). The goal of the Town Meetings was to document the state of the field of FASD across the nation. FAS*FRI also organized and conducted 7 U.S. regional conferences entitled, "FASD: Creating Intervention Touchpoints." The goal of the Touchpoint conferences is to educate the social service workforce and build state capacity to identify, understand and develop appropriate care for those with FASD. Jocie DeVries continued to serve on the National Task Force and the External Partners Group of the National Center of Birth Defects and Developmental Disabilities. FAS*FRI published their first article on the behavioral phenotype in the scientific journal, *Addiction Biology*, and they are scheduled to publish the first photo book on FASD in April 2005. DeVries J, Waller A. Fetal alcohol syndrome through the eyes of parents. Addiction Biology 2004;9(2):119-26. www.fetalalcoholsyndrome.org

2002 to present	**Housing for Substance Abusing Mothers and their Children.** In 2002, PCAP collaborated with the Community Psychiatric Clinic in Seattle to obtain funding from the Bill and Melinda Gates Foundation, the King County Housing Opportunity Fund, the Washington State Housing Trust Fund, and the Paul Allen Foundation to develop a new transitional housing facility. The Willows will serve 15 single mothers recovering form mental illness and substance abuse, and their children. PCAP will make referrals to the program, assess ongoing needs, advocate for, and be involved with each family throughout their duration of stay. All other services and treatment for Willows residents will be provided by Community Psychiatric Clinic through licensed and certified treatment programs. The facility is scheduled to open in 2005. http://depts.washington.edu/fadu
2002 to present	**Family Advocacy/Education**. Annual Washington State FASD Family Summer Camp sponsored by FAS DPN, SAMHSA, and Volunteers of America. The camp provides children with disabilities recreational and outdoor opportunities that may not be available to them, or that they may be excluded from in their communities. In addition, it is also an opportunity for siblings to interact and receive support. Activities are organized in a recreational camp environment. Parent activities emphasize self-care and respite as well as opportunities to receive education on raising children with disabilities. Parent activities include workshops on understanding and advocating for their child's needs, understanding difficult behaviors and an informal adult craft group. Children's activities are both educational and recreational and are carefully structured and planned to meet the unique developmental needs of the children. Activities include crafts, music, nature activities, and physical activities such as field games, swimming, nature walks and evening campfire programs. FASDSupport@aol.com FAStFriends2004@yahoogroups.com
2002 to present	**Contraceptive Coverage Rule: WAC 284-43 (822).** In 2001 WAC 284-43(822) was passed requiring health plans to cover FDA-approved prescription contraceptives and devices. The contraceptive coverage rule signed by Insurance Commissioner Mike Kreidler on Sept. 5, 2001 took effect Tuesday, Jan. 1, 2002, enabling most insured women access to the prescription contraceptive of their choice. The rule states that it is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. The rule states that all plans regulated by the Office of the Insurance Commissioner that offer a generally comprehensive prescription drug benefit must also cover FDA-approved prescription contraceptives as well as the medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive http://www.insurance.wa.gov/news/dynamic/newsreleasedetail.asp?rcdNum=294

2003	**Training of Washington State Patrol:** DASA worked with the Washington State Patrol (WSP) during the last year providing technical assistance in developing training for officers at the WSP Academy. The WSP will be providing education and training specific to FAS, and include it as part of the lesson plan in dealing with individuals with special needs/concerns. The officers will be instructed to provide an arrest report that would contain all behaviors/actions prior to and during the suspect's arrest that could later be used to identify a specific health condition, including FASD
2004	**Training Medical Providers**: March of Dimes "Project Double Jeopardy" tracked quality of life for mothers of children with FAS who were currently parenting. The project also included 1-hour presentations to medical providers educating them on current FAS facts as well as ways to interact with high-risk clients to prevent future at-risk pregnancies.
2004	**Alcohol and Other Drug Abuse are a Significant Social, Health, and Economic Issue in Washington State** (Krupski, 2004). Alcohol and other drug abuse is a major risk to public health and safety in Washington State. It is also very costly. For example, economic costs of alcohol and other drug abuse were estimated to be $2.54 billion in 1996 (Wickizer, 1999). According to a Columbia University study, Washington State spent $1.51 billion on services related to the impacts of substance abuse in 1998. In that same year, the state spent $2.65 billion on higher education, $1.46 billion on Medicaid, and $1.09 billion on transportation (National Center on Addiction and Substance Abuse at Columbia University, 2001). The Costs of Not Providing Chemical Dependency Treatment Are Very High • The absence of chemical dependency treatment during pregnancy is associated with lower infant birth weights, higher infant medical costs (over $1,750 more during an infant's first two years of life) (Cawthon & Schrager, 1995), more frequent Child Protective Service (CPS) referrals (Cawthon, 2004), and a higher rate of arrests for mothers in the baby's first year of life (Cawthon, 2004). Krupski T, (September 15, 2004) Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, Decision Package Recommendation Summary, Overview Document. Cawthon, L. (2004). Fact Sheet: *"First Steps Database. Safe Babies, Safe Moms."* Olympia, WA: Research and Data Analysis Division, Department of Social and Health Services. Cawthon, L., & Schrager, L. (1995). Fact Sheet: *"First Steps Database. Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State."* Olympia, WA: Office of Research and Data Analysis, Department of Social and Health Services. http://www1.dshs.wa.gov/rda/research/default.shtm

2004 to present	**NOFAS Washington: FASt Friends: A FASD Family and Community Support Network.** Mission: To provide support, education, advocacy and training on Fetal Alcohol Spectrum Disorders through the positive cooperation and collaboration of families, caregivers, community providers, professionals, and individuals affected by prenatal alcohol exposure. Current programs include a list serve support system, monthly meetings for caregivers and community members, social/support group for teenagers affected by prenatal alcohol exposure, building of a parent mentorship program, weekend parent retreats, quarterly family activities, and annual FASD Family Summer Camp. This support network (NOFAS Washington) is the Washington State Affiliate for the National Organization on Fetal Alcohol Syndrome (NOFAS). www.nofaswa.org

Washington State FASD History

Year (from 1968 to 2004)

68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04
No Change in statewide prevalence of unintended pregnancy resulting in a live birth (%) Health People 2010 Goal = 30%. (PRAMS)																										38.7	39.0	38.5	36.6	38.1♠				♠		
No Change in prevalence of contraceptive use at time of pregnancy among women with unintended pregnancy resulting in a live birth (%) (PRAMS)																												43.2	43.4	44.0	40.7					
♣ Significant decline in statewide prevalence of maternal drinking during pregnancy (%) (PRAMS)																									51.5	57.3	49.8	49.6	46.5	44.3						
♣ Significant decline in prevalence of FAS among King County foster care children born in these years (%) (FAS DPN-DSHS)																									6.7	4.8	0	0	2.2	0						
Ulleland first to discover alcohol-affected infants					FAS Coined					FAE Coined																		ARND Coined									FASD Coined
Statewide FASD Training/Education increased exponentially in the 1990's reaching tens of thousands by 2004. This training was conducted by State, private, academic, and family advocacy groups/individuals																																				
Surgeon General Advisory on Alcohol and Pregnancy																																				
Alcohol Beverage Labeling Act																																				
ADATSA policy to fast-track pregnant women into treatment																																				
First Steps Program to help low-income pregnant women obtain health/social services (Expands statewide 1993)																																				
FAS-FRI public awareness and education program																																				
DASA tripled number of gender-specific inpatient residential treatment beds (55 to 148) for pregnant women from 1991 to 2003																																				
Iceberg Newsletter on FASD distributed by FASIS																																				
PCAP: Parent Child Advocacy Program for drug/alcohol abusing women and their children (0-3 years of age)																																				
FAS diagnosed at University of Washington, and pediatricians/geneticists statewide using gestalt method																									♣ Statewide FAS DPN using FASD 4-Digit Diagnostic Code and FAS Facial Photographic Analysis Software												
♣ PRAMS: Annual statewide surveillance of maternal risk behaviors during pregnancy																																				
♣ FCPP: Foster Care Passport Program: Electronic medical and education information tracking system for children in out-of-home placement..																																				
Point-of-Purchase FASD warning signs posted in restaurants, bars, liquor stores																																				
WA State FAS Interagency Work Group Established (FAS IAWG):Senate Bill 5688																																				
Invention of the World Wide Web (www) allowing broad, cost-effective dissemination of information																																				
Pilot Foster FAS Screen (FAS DPN) Pilot Juvenile Detention FAS Screen (FAS DPN)																																				
♣ FAS Screening Program in Foster Care (FAS DPN – DSHS-FCPP)																																				
♣ FAS DPN FAS Surveillance by Birth Cohort in the King County Foster Care Passport Program. The FAS Screening Program started in 1999. The oldest child eligible to participate in the screening was 12 years old in 1999, thus born in 1987. Thus FAS surveillance could extend back to the 1987 birth cohort.																																				
CPEP – Safe Babies Safe Moms																																				
♠ Contraceptive Coverage																																				
NOFAS WA																																				

Key		Training / Education	Family Support/Advocacy	Treatment / Intervention	Screening / Diagnosis of FASD	Surveillance
	♣	Programs involved in documenting significant decline in maternal drinking during pregnancy and significant decline in prevalence of FAS in foster care				
	♠	• 1998 Report by the Washington State Office of the Insurance Commissioner, Olympia WA. Key findings: 77% of Washington State insurance plans paid for abortion, but only 30% provided coverage for contraceptives. Four out of 5 women did not have contraceptive coverage. • In 2002 WAC 284-43(822) was enacted requiring health plans to cover FDA-approved prescription contraceptives and devices.				

Abbreviations	
ADATSA	Alcohol and Drug Abuse Treatment and Support Act
ARND	Alcohol Related Neurodevelopmental Disorder
CA	Children's Administration
CDC	Centers for Disease Control (federal)
CHEF	Comprehensive Health Education Foundation
CPEP	Comprehensive Program Evaluation Project
CSAP	Center on Substance Abuse and Prevention (federal)
DOH	Department of Health
DOC	Department of Corrections
DSHS	Division of Social and Health Services
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FADU	Fetal Alcohol and Drug Unit, University of Washington
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
FAS*FRI	Fetal Alcohol Syndrome Family Resource Institute
FASD	Fetal Alcohol Spectrum Disorders
FAS DPN	Fetal Alcohol Syndrome Diagnostic & Prevention Network, University of Washington
FASIAWG	FAS Interagency Work Group
FASIS	Fetal Alcohol Syndrome Information Service (Washington State)
FCPP	Foster Care Passport Program
GOIA	Governor's Office of Indian Affairs
HB	House Bill
JRA	Juvenile Rehabilitation Administration
MAA	Medical Assistance Administration
NIAAA	National Institutes of Alcohol Abuse and Alcoholism (federal)
NIDA	National Institute of Drug Addiction
NOFAS	National Organization of FAS
OSPI	Office of the Superintendent of Public Instruction
PCAP	Parent Child Assistance Program
PRAMS	Pregnancy Risk Assessment Monitoring System
RCW	Revised Code of Washington
RDA	Research and Data Analysis (DSHS)
SAMHSA	Substance Abuse and Mental Health Services Administration (federal)
SB	Senate Bill
SKCDPH	Seattle-King County Department of Public Health
UW	University of Washington
WA	Washington State
www	world wide web (the internet)