Approved 3-28-85
Date sh

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin Littlejohn at
Chairperson

1:30 a.m./p.m. on March 26, 1985 in room 423-S of the Capitol.

All members were present except:

Representative Mike O'Neal, excused

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Secy. to Committee

Conferees appearing before the committee:

Representative Jessie Branson
Dr. James McHenry, Department of Social & Rehabilitation Services
Dr. Joseph Hollowell, Director of Division of Health, Dept.of Health and Environment
Dr. Virginia Tucker, Department of Health and Environment, and practicing peditrician.
Mr. Roger Howard, Regional Director of Distilled Spirits Council, United States, Inc.
Representative Kathryn Sughrue
Dr. Ron Harper, Department on Aging
Mr. Gary Petz, Executive Director of Kansas Coalition on Aging
Nadine Burch, consumer
Kathryn Forest, consumer, and Ks. Coalition on Aging
Mr. Ken Schafermeyer, Kansas Pharmacists Association
Mr. Peter Rinn, General Council for Social & Rehabilitation Services
Barbara Sabol, Secretary Department of Health and Environment
Mr. Michael Byington, Topeka REsource Center for the Handicapped

Visitor's register, see (Attachment No. 1.)

Chairman noted there will be hearings this date on HCR 5013, HCR 5015, HR 6046, and SB 131, and SB 162.

Chairman called meeting to order and recognized Rep. Branson as sponsor of HCR 5013.

Hearings began on HCR 5013:

Rep. Branson called attention to an amendment that she distributed to members at meeting yesterday which indicates changes proposed, i.e., line 59, after word physicians, to insert, "and other health care providers", and line 68, insert Sub (e), Encourage all providers of child health education and prenatal classes to provide to participants information on the effects of alcohol on pregnancy"; section (e) would then become (f).

Dr. James A. McHenry, Commissioner, Alcohol and Drug Abuse Services, Department of Social and Rehabilitation Services spoke to HCR 5013, and gave hand-out to members, see (Attachment No. 2, for details. He spoke in support of this Resolution, in that the bill will encourage greater educational efforts to make women more aware of the potential problems caused by alcohol during pregnancy.

Dr. Joseph Hollowell, Director of Division of Health, and he stated their Department in Health and Environment is in strong support of HCR 5013. He then introduced Dr. Virginia Tucker. See (Attachment NO. 3), for details of position of H. & E.

Dr. Virginia Tucker, Medical Director of crippled children's program, and is a pediatrician. Dr. Tucker gave hand-out to members, (see Attachment No. 4), for details. She stated Fetal Alcohol Effects first was recognized only 10 years ago as an important cause of birth defects. She explained how alcohol travels through the baby's bloodstream, and she cited various complications that are common in fetal alcohol snydrome, i.e., poor coordination, lower I.Q., facial deformation, cardiac symptons. One main topic she stressed was the mother has a choice as to the consumption of alcohol, the fetus does not. She then answered questions.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on March 26, 1985.

Hearings continue on HCR 5013:--

Mr. Roger Howard, Regional Director of Distilled Spirits Council, distributed hand-outs, see (Attachment No. 5-A, 5-B,5-C), for details. He stated their Council have long been committed to being a part of the solution to fetal alcohol effects and other abusive drinking problems. They have supported scientific investigations, studies, and educational programs, a model programs currently being implemented, There have been, and are programs being carried out, i.e, healthy mothers, healthy babies campaign; mass mailing to physicians offering educational materials from study results; brochures sent to public and private schools, colleges and trade schools; and other numerous programs are in effect. He stated the placing of posters in retail liquor stores puts the retailer in an awkward position, since the retailer is not qualified to answer questions of a pregnant woman that relate to alcohol consumption. He referred to Attachment 5-C, a study done by Dr. Henry L. Rosett, and paper published in Journal of American College of Obstetricians and Gynecologists that states in part, pregnant women who drank moderately gave birth to babies with no more problems than those women who drank moderately, so the language in lines 23 through 35 and lines 39 through 44 of the bill are misleading. He stated that surveys show there is no association between alcohol use and fetal development. Some of the characteristics brought on by fetal alcohol snydrome are also shared by other causes, i.e., nutrition of the mother; other drug use and abuse; lifestyle of the mother. He answered numerous questions from committee. He asked members then to take into consideration there are already programs in place to combat the issues related to in HCR 5013, and he asked, is this legislation really needed?

Hearings closed on HCR 5013.

Hearings began on HCR 5015:

Representative Kathryn Sughrue as sponsor of this resolution spoke to HCR 5015, and distributed printed testimony, (see Attachment No. 6), for details. She stated the proposed legislation would direct the Department of Aging, Secretary of Health and Environment and the Secretary of Social and Rehabilitation to jointly develop a comprehensive plan, and report concerning this plan to the Governor prior to January 13, 1986. She stated that it is better to explore and implement all alternatives to providing long-term care now, and not wait for a crisis. Concern, support, and encouragement of caregivers is needed, she said, and she urged for favorable consideration of HCR 5015.

Dr. Ron Harper, Department on Aging spoke to HCR 5015, and gave printed testimony, see (Attachment No. 7), for details. Their department, he said, strongly supports the development of a comprehensive plan of community long-term care services for the elderly of Kansas. Recently the definition of long-term care has been expanded to include services to the chronically ill, or impaired persons, most often the elderly that allow them to live outside institutional situations, and allow these persons to remain as independent as possible. He urged for favorable consideration of HCR 5015.

Mr. Gary Petz, Executive Director of Kansas Coalition on Aging gave hand-out to members, see (Attachment No. 8), for details. He urged members for favorable consideration on HCR 5015.

Mrs. Nadine Burch, speaking as a consumer today in regard to HCR 5015, saying that it will cost the state less money to provide help for elderly Kansans in long-term care services in their homes. She urged for a sliding scale of payment for care so that many who are barely above the poverty level can be eligible for these services. She urged for passage of HCR 5015.

Ms. Kathryn Forest then spoke to HCR 5015, and stated it is important legislation and speaks to the needs of the elderly in Kansas, and she urged for passage of this resolution.

Hearings closed on HCR 5015.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 / a/m//p.m. on March 26, 1985

Hearings began on HR 6046:

Rep. Branson spoke to HR 6046 as sponsor of the resolution, giving her printed comments to members, (see ATtachment No. 9), for details. This relates to packaging and labeling of camphor-containing products, and her hand-out indicated some specifics in case reports. She urged for favorable passage of HR 6046.

Mr. Ken Schafermeyer, executive Director of Kansas Pharmacists Association gave printed testimony to members, (see Attachment No. 10), for details. He stated their Association supports this and any measure that serves to protect the public against the potential hazards of poisoning from drug products containing toxic or potentially lethal amounts of camphor. He cited specifics and stated that camphorated oil had been removed from the US market. One gram of camphor can cause the death of a small child, and smaller amounts have resulted in toxic effects. He summarized by saying because of the potential toxicity of some products, they would like the State of Kansas to support the inclusion of camphor products intended for medicinal use in the Poison Prevention Act of 1970, to assure proper labeling and packaging of these products.

Hearings closed on Hr 6046.

Hearings began on SB 131:

Mr. Peter Rinn, General Counsel for Social Rehabilitation Services spoke to SB 131, and gave hand-out to members, (see Attachment No. 11), for details of comments prepared by Dr. Robert Harder. Mr. Rinn stated current penalties provides that any person convicted of welfare fraud shall be permanently ineligible to receive General Assistance, and their department feels this extreme penalty should be modified for first time offenders. Passage of SB 131 as amended by Senate committee will allow Department of SRS to apply a three-year General Assistance disqualification penalty for first time conviction, while maintaining the lifetime disqualification provision for repeat offenders. He cites some specific cases that show how unfair the current provision is. He stated their department is supportive of SB 131, and urged for favorable passage.

Mr. Michael Byington, Outreach Advocate/Case Manager for Topeka Resource Center for the Handicapped, gave printed testimony, see (Attachment No. 12), for details. He spoke to SB 131, saying there are situations where persons with whom he has worked that are going hungry, living on the streets, and are lacking essential medical care because they cannot get General Assistance Welfare due to one count of welfare fraud, which occurred years ago. He cited a specific case involving a 38 year old male who has struggled and somehow survived. He recommended the language in the bill be changed from the amended version that states"three-year suspension", to read, "one-year suspension". He answered questions from members of committee.

Hearings closed on SB 131.

Hearings began on SB 162:

Secretary Sabol, Departmetn of Health and Environment gave hand-out to members, see (Attachment No. 13), for details. She stated since the food service and lodging license and inspection program has been combined with the food and drug program within the Division of Health, the report required in current legislation is inappropriate, and SB 162 will change legislation according to current needs. This would place the responsibility for food service and lodging regulation and licensing under the direction of the Division of Health rather than the Director of Environment. She recommended favorable passage of SB 162.

Mr. Michael Byington spoke briefly to SB 162, agreeing with Secretary Sabol's remarks.

Hearings closed on SB 162.

Rep. Green moved the minutes of March 25, 1985, be approved as written, seconded by Rep. Wagnon, motion carried.

Meeting adjourned at 3:10 p.m.

GUEST REGISTER

DATE 3-26-85

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
[illegible] Miles	[illegible] Council On Aging	1144 Webster 66604
[illegible]	Topeka Resource Center for Handicapped	1119 W. 10th, Suite 2 Topeka, Ks. 66604
Virginia L. Tucker, M.D.	KDHE	Forbes Field, Topeka, Ks 66620
Robin Gomer	K.D.H.E.	Forbes Field, Topeka, KS. 66620
Kathern Forest	AARP	4700 W. 13th St. Wichita 67212
Ron Bates	Visitor	Topeka
Nadine Burch	KCOA	Topeka
Roger Hoffman	DISCUS	JC Mo
Gary Petz	KS coalition on Aging	Topeka 66603
Jim McHenry	SRS/Alcohol & Drug Abuse Services	Topeka
Keith R Landis	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	
Ken Schafermeyer	Kansas Pharmacists Assoc.	Topeka
[illegible]	KDOA	Topeka
J. G. Hollowell	KDHE	
Peter E Renn	SRS	State Office Bldg.

Attm. #1.
3-26-85

Attm. #2
3-26-5

STATE OF KANSAS

JOHN CARLIN, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALCOHOL AND DRUG ABUSE SERVICES

ROBERT C. HARDER, *Secretary*

2700 WEST 6TH STREET
TOPEKA, KANSAS 66606
(913) 296-3925
KANS-A-N 561-3925

TO: House Committee on Public Health and Welfare

FROM: Dr. James A. McHenry, Commissioner, Alcohol and Drug Abuse Services
Department of Social and Rehabilitation Services

DATE: March 26, 1985

RE: House Concurrent Resolution No. 5013

I am pleased to appear in support of House Concurrent Resolution No. 5013, and I applaud its encouragement of programs related to fetal alcohol syndrome and fetal alcohol effects.

Modern medicine can do a lot to help a woman have a healthy baby. But not without her help. During pregnancy, a woman must take special care of herself. The best advise is not to drink. Alcohol can harm a baby. It may cause serious birth defects. The safest choice is simply not to drink during pregnancy.

The effects include mental retardation, central nervous system disorders, growth deficiencies, facial abnormalities and other malfunctions of the

Attm. #2
3-26-85

skeletal, urogenital and cardiac system. Approximately one out of every 750 births is a Fetal Alcohol Syndrome birth. Fetal Alcohol Effects, caused by drinking during pregnancy, are permanent, irreversible and preventable.

Since House Concurrent Resolution No. 5013 encourages greater educational efforts to make women aware of the potential problems caused by alcohol during pregnancy, it represents a prevention strategy worthy of your support.

0292C

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Attm. # 3
3-26-5

TESTIMONY ON HOUSE CONCURRENT RESOLUTION 5013

PRESENTED TO House Committee on Public Health and Welfare, March 26, 1985

This is the official position taken by the Kansas Department of Health and Environment on H.C.R. 5013.

BACKGROUND INFORMATION:

Fetal alcohol syndrome is one of the three major causes of birth defects and mental retardation in this country. It is caused by maternal consumption of alcohol during pregnancy. We do not know at what level maternal alcohol consumption during pregnancy will permanently damage the fetus, but we do know that even a small amount can have an adverse effect.

Fetal alcohol effects include mental retardation, learning disabilities, central nervous system disorders, growth deficiencies, specific facial abnormalities and other malformations of the skeletal, urogenital and cardiac systems. Not all babies affected by fetal alcohol effects have all of the symptoms, but the more alcohol the mother has consumed during pregnancy, the more damaged the baby is likely to be. In addition, significantly decreased birth weight has been observed among the babies of some women who average only 1 ounce of absolute alcohol (2 standard drinks) per day during pregnancy. A baby's birth weight greatly affects its chances for survival.

Although the exact rate of fetal alcohol syndrome is not known, it is reported to be one baby in every 750 births. This would be between 50 and 55 babies in Kansas each year. Many of these babies, because of low birth weight and other fetal alcohol syndrome problems, require neonatal intensive care. At an average cost of $1,200 per day to maintain these babies in neonatal intensive care, the potential expenditure is enormous. The amount of funding needed to implement this legislation would maintain only one baby in care for approximately 8 days.

Fetal alcohol syndrome and fetal alcohol effects can be prevented if pregnant women and women considering pregnancy abstain from drinking alcohol. The general public needs information on the kinds of permanent damage alcohol can cause to the unborn. Health care providers and other professionals need to refine their knowledge of alcohol's effect on the fetus and their interviewing skills around alcohol consumption.

STRENGTHS:

The proposed legislation recommends voluntary educational activities, including voluntary posting of warnings in clubs and liquor stores and voluntary recording of suspected fetal alcohol cases by hospitals and maternity centers. The approach is broad based, involves a variety of disciplines from a number of agencies, and is preventive, and thereby cost savings in nature. The total cost of this project equals the average cost of maintaining one fetal alcohol syndrome infant in a neonatal intensive care unit for the first 8 days.

WEAKNESSES:

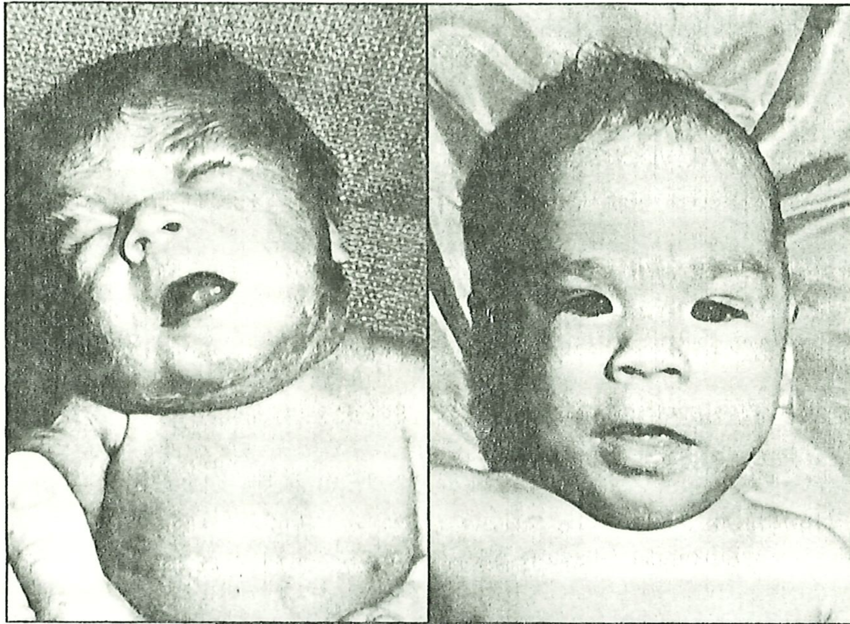
Because with all recommended activities participation is voluntary, there is no means by which sanctions could be taken against clubs, liquor stores, hospitals, and maternity centers who choose not to comply.

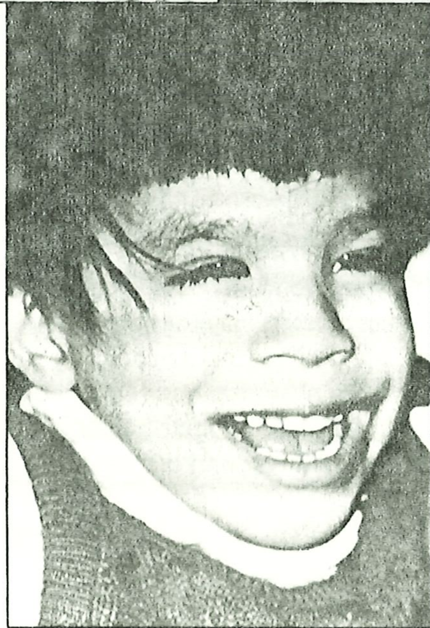
DEPARTMENT'S POSITION:

Attm. # 3
3-26-5

Kansas Department of Health and Environment supports passage of H.C.R. 5013.

Attm. #4
3-26-5





Attm. #4
3-26-85

26. Fetal Alcohol Syndrome

Incidence

Not known, but it is not uncommon.

Manifestations

GENERAL. Small for gestational age, postnatal growth deficiency, and hyperactivity.

CRANIOFACIAL. Microcephaly, broad nasal bridge, short palpebral fissures, ptosis, strabismus, abnormally shaped ears, and, occasionally, cleft palate.

CARDIAC. Various congenital heart defects have been reported.

CENTRAL NERVOUS SYSTEM. Mental retardation, which is usually not severe; tremulousness in the newborn period; and difficulty with fine motor movement.

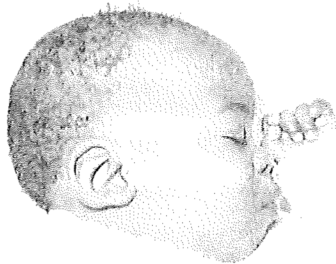
SKELETAL. Congenitally dislocated hips and inability to extend the metacarpophalangeal joints. Nail dysplasia.

Genetics

This is not an inherited disease but is secondary to maternal ingestion of alcohol during pregnancy.

Treatment

Medical and surgical treatment when indicated for various defects. Prevention consists of avoidance of alcohol during pregnancy.



Bibliography

Clarren, S. K., and Smith, D. W. The fetal alcohol syndrome. *N. Engl. J. Med.* 298: 1063–1067, 1978.

Hanson, J. W., Streissgutt, P., and Smith, D. W. The effects of moderate alcohol consumption during pregnancy on fetal growth and morphogenesis. *J. Pediatr.* 92:457–460, 1978.

FACT SHEET - FETAL ALCOHOL EFFECTS/FETAL ALCOHOL SYNDROME

FAE (Fetal Alcohol Effects) is the name given to any one of the damaging effects caused to the fetus by alcohol consumed by the mother during pregnancy. FAS (Fetal Alcohol Syndrome) is the name given to the whole set of symptoms.

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Fetal Alcohol Effects (FAE) first became recognized only ten years ago as an important cause of birth defects, but has now been reported as the third most common cause of mental retardation in this country.

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Alcohol interferes with many complex systems of the human body in both men and women so it is not surprising that drinking during pregnancy could harm the unborn child.

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When a pregnant woman takes a drink, the alcohol crosses the placenta to the fetus. The alcohol travels through the baby's bloodstream in the same concentration as that of the mother. So if the expectant mother drinks, her unborn baby drinks as well and does so as long as the mother continues to drink.

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Researchers are not sure at what level alcohol begins to harm the fetus, but there is evidence that a definite risk exists if the woman drinks six or more drinks a day. Between one and six drinks the risk factor is uncertain, but the risk increases as the number of drinks per day increases. What we do know for certain is that if the mother <u>does not</u> drink at all there is <u>no</u> risk of fetal damage from alcohol.

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A can of beer or a glass of wine has about the same alcohol content as a mixed drink and can do the same amount of harm to the unborn baby.

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Researchers suspect that "binge" drinking (taking six or more drinks once a week) is just as harmful to the unborn baby as if the mother drank every day.

****

Babies of teenagers are in double jeopardy if their mothers drink while pregnant. They may be born too small or too soon because their mothers' bodies are not mature enough to meet the demands of pregnancy. If they are also subjected to excessive alcohol from their mothers' drinking, they may suffer from fetal alcohol effects as well.

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The Fetal Alcohol Effects are permanent and cannot be reversed, whereas the mother may choose to become sober and may substain no permanent damage. The mother has a choice. The baby does not!

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Among heavy or frequent drinkers, the risk of spontaneous abortion is increased twofold. Significant increases in spontaneous abortion have been observed in women who report alcohol consumption as low as two standard sized drinks twice a week (one ounce of absolute alcohol).

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Between 50 to 70 percent of babies born to mothers with alcohol problems suffer from FAE.

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Significantly decreased birth weight has been observed among the babies of some women who average only 1 ounce of absolute alcohol (2 standard drinks) per day during pregnancy.

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Alcohol readily enters breast milk and is thus transmitted to the nursing infant. Heavy alcohol consumption is known to decrease the mother's milk.

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The developing brain cells of the fetus are much more sensitive to alcohol than is the adult brain.

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While the pregnant woman may become stimulated when she drinks, the fetus becomes sedated because of the anesthetizing effects of the alcohol. This slows the baby's heart beat, sometimes to a dangerous level.

****

The fetal alcohol effects include mental retardation, central nervous system disorders, growth deficiencies, specific facial abnormalities and other malformations of the skeletal, urogenital and cardiac systems. Not all babies affected by FAE have all of the symptoms, but the more alcohol the mother has consumed during pregnancy, the more damaged the baby is likely to be.

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Although the exact rate of FAS is not known, it is reported to be one baby in every 750 births. This would be between 50 and 55 babies in Kansas each year.

****

A high percentage of women of childbearing age (ages 15 to 44) drink at least occasionally. Nationally, these figures are estimated to be 69% of those 18 to 20 years of age; 77% of those ages 21 to 34; and 65% of those over 35. There are approximately 530,000 women of childbearing age in Kansas.

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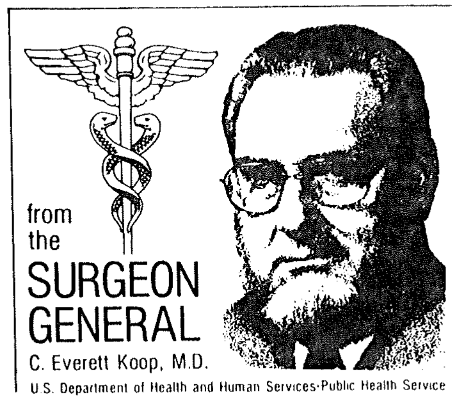
Bureau of Community Health
Kansas Department of Health and Environment

12-20-83



DRINKING AND PREGNANCY

The week of January 15, 1984, was designated by the Congress and proclaimed by the President as "Fetal Alcohol Syndrome Awareness Week." And with good reason: fetal alcohol syndrome (FAS) ranks only behind Down's syndrome and spina bifida as the most common cause of birth defects with associated mental retardation in newborn babies. If you are pregnant or are thinking about having a baby, FAS is a health problem that you should know something about.

Almost everyone is aware that alcohol abuse over a period of time can contribute to a number of serious disorders *in adults*, including muscle and heart disease, malnutrition, digestive problems and liver cirrhosis. It should not surprise us to learn, therefore, that alcohol, when abused during pregnancy, can also damage the far more delicate system of the unborn baby.

For a number of years, now, researchers have been studying infants born to women who drank heavily during their pregnancies. What they have found in a significant number of these infants is a disturbing pattern of physical, mental and behavioral abnormalities—fetal alcohol syndrome. Babies with FAS were shorter and lighter in weight than normal babies, and they didn't "catch up" later, even when given special postnatal care.

Babies with FAS also had abnormally small heads, several facial irregularities, joint and limb abnormalities, heart defects and poor coordination. Most were mentally retarded, as well, and exhibited a number of behavioral problems, such as hyperactivity, extreme nervousness and poor attention spans.

Not every symptom of FAS was seen in every baby, of course; symptoms varied from child to child. But even one symptom of fetal alcohol syndrome is an unnecessary tragedy. The point to be made, and remembered, is that alcohol can have devastating effects on the unborn baby. So, how should you approach the question of drinking during pregnancy? What should you think about it and what, if anything, should you do?

Research is just now beginning to show the amount of alcohol that may harm the developing baby. While there are, as of yet, no hard and fast rules, we do know that even moderate amounts of alcohol pose a risk to the unborn baby. Women who consume two normal-size drinks a day, for example, increase their chances of miscarriage and of having a baby that is smaller than babies born to women who drink infrequently or not at all. Women who drink heavily during pregnancy—six or more drinks a day—clearly risk giving birth to a child with fetal alcohol syndrome.

There is much that we still do not know about fetal alcohol syndrome. We are not sure, for instance, at what time during pregnancy the fetus is most susceptible to the damaging effects of alcohol. Nor do we know to what extent the effects of drinking may be compounded by such other factors as smoking and poor nutrition. Until all the facts are in, however, the best advice I can offer women who are pregnant or who want to become pregnant is to refrain, completely, from drinking alcoholic beverages. If we do not yet have all the answers, at least two facets of the drinking - and - pregnancy problem are beyond dispute: first, the more the mother drinks, the greater are the risks she takes with the health of her unborn baby; second, there is *no* possibility of fetal damage from alcohol when the mother doesn't drink at all.

The safest and wisest choice, I'm sure you will agree, is to avoid alcohol during this most important time of both your life and your baby's.

Attm. #5-A
3-26-5

STATEMENT OF ROGER W. HOWARD

REGIONAL DIRECTOR

DISTILLED SPIRITS COUNCIL OF THE UNITED STATES, INC.

BEFORE THE

PUBLIC HEALTH AND WELFARE COMMITTEE

KANSAS HOUSE OF REPRESENTATIVES

Attm. #5-A.
3-26-1985

ON BEHALF OF THE DISTILLED SPIRITS COUNCIL AND OUR MEMBERS WHO MANUFACTURE OR IMPORT 90 PERCENT OF THE DISTILLED SPIRITS SOLD IN THE UNITED STATES, I WELCOME THIS OPPORTUNITY TO BRIEF THE COMMITTEE ON OUR INDUSTRY'S PROGRAMS AND PERSPECTIVES RELATIVE TO THE PROBLEM OF DRINKING DURING PREGNANCY. THE LIQUOR INDUSTRY IS NOT A NEWCOMER TO ALCOHOL ABUSE PROBLEMS. WE HAVE LONG COMMITTED OURSELVES TO BEING PART OF THE SOLUTION TO FETAL ALCOHOL EFFECTS AND OTHER ABUSIVE DRINKING PROBLEMS.

LONG BEFORE THE FETAL ALCOHOL SYNDROME BECAME AN ISSUE, THE SCIENTIFIC ADVISORY COUNCIL TO DISCUS FUNDED SEVEN RESEARCH STUDIES INTO THE NATURE AND CAUSATION OF THIS PROBLEM. I REFER TO THE YEARS PRECEDING JUNE 1, 1977. SINCE THEN WE HAVE SUPPORTED EIGHT MORE SCIENTIFIC INVESTIGATIONS.

OVER THE DECADES IT HAS BEEN THE POLICY OF DISCUS AND ITS MEMBERS TO PROVIDE RESEARCH FUNDING TO QUALIFIED SCIENTIFIC INVESTIGATORS -- WITH NO STRINGS ATTACHED AND TOTAL FREEDOM OF PUBLICATION -- ON PROBLEMS AND RESEARCH HYPOTHESES OF THEIR OWN CHOOSING.

A FUNDAMENTAL PREMISE OF OUR APPROACH TO ALCOHOL ABUSE PROBLEMS IS THAT REAL PROGRESS TOWARD THEIR REDUCTION CAN ONLY BE MADE ON THE BASIS OF SOLID RESEARCH KNOWLEDGE, RATHER THAN SPECULATION.

THE LIQUOR INDUSTRY SINCE THE FORTIES HAS HELPED SCIENTISTS FIND ANSWERS TO THE MANY QUESTIONS SURROUNDING ALCOHOL ABUSE AND PROBLEM DRINKING. SINCE 1960 OUR SCIENTIFIC ADVISORY COUNCIL (A SEVEN-MEMBER, MULTI-DISCIPLINARY GROUP OF INDEPENDENT EXPERTS) HAS ADMINISTERED A UNIQUELY VALUABLE SEEDING GRANT PROGRAM. THIS PROGRAM HELPS BRING NEW RESEARCHERS INTO THE FIELD OF ALCOHOL STUDIES WITH PROJECTS DESIGNED TO

TEST BASIC THEORIES AND ESTABLISH DIRECTION FOR LARGER RESEARCH PROJECTS. ALL APPLICATIONS ARE REVIEWED QUARTERLY BY THE MEMBERS OF THE SCIENTIFIC ADVISORY COUNCIL. SOME OF THE MOST PROMINENT NAMES IN ALCOHOL RESEARCH HAVE BENEFITED FROM THIS PROGRAM. SOME 400 GRANTS HAVE BEEN AWARDED TO OVER 200 INSTITUTIONS.

BUT WHILE SIGNIFICANT AMOUNTS OF FURTHER RESEARCH ARE NEEDED TO PROVIDE FUNDATMENTAL ANSWERS TO BASIC QUESTIONS, WE CANNOT STAND STILL. MUCH IS ALREADY KNOWN AND NUMEROUS PUBLIC AND PRIVATE AGENCIES ARE WORKING HARD TO HELP REDUCE ALCOHOL ABUSE AND RELATED PROBLEMS BASED ON CURRENT KNOWLEDGE. AN IMPORTANT ELEMENT OF OUR PROGRAM FOR MANY YEARS HAS BEEN TO COOPERATE WITH KNOWLEDGEABLE AND OBJECTIVE ORGANIZATIONS TO FURTHER PROGRESS IN THE FIELD. WE ARE ESPECIALLY INTERESTED IN WORKING WITH PROGRAMS WHICH HAVE THE POTENTIAL FOR NATIONAL APPLICATION. SUCH ORGANIZATIONS INCLUDE: THE NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS, RUTGERS, NATIONAL COALITION FOR ADEQUATE ALCOHOLISM PROGRAMS, THE NORTH CONWAY INSTITUTE, AND MANY OTHER HEALTH GROUPS.

WE ARE EQUALLY PROUD OF DISCUS' SUPPORT OF PIONEERING MEDICAL EDUCATION IN THIS COUNTRY ON DIAGNOSIS AND TREATMENT OF ALCOHOLISM AND ALCOHOL ABUSE. FOR THE PAST TEN YEARS WE HAVE FUNDED THE DEVELOPMENT AT HARVARD MEDICAL SCHOOL OF MODEL COURSES FOR MEDICAL STUDENTS AND ESTABLISHED PHYSICIANS. THESE COURSES ARE NOW BEING APPLIED AT 88 MEDICAL SCHOOLS ACROSS THE COUNTRY. A MEDICAL BEST-SELLER BOOK HAS BEEN PUBLISHED BY DR. JACK MENDELSON OF HARVARD AND IN DECEMBER, 1983 A SPECIAL COMPENDIUM WAS MAILED TO 260,000 PHYSICIANS. THESE SOURCEBOOKS INCLUDE EXTENSIVE INFORMATION ON FETAL ALCOHOL EFFECTS.

DISCUS ALSO CO-SPONSORS AN ANNUAL SYMPOSIUM AT WHICH WORLD-RANKED SCIENTISTS AND MEDICAL EDUCATORS INTEGRATE THE LATEST KNOWLEDGE ON SUBJECTS SUCH AS FETAL ALCOHOL EFFECTS INTO TEACHING CURRICULUM.

A SPECIAL AREA FOR EMPHASIS IN OUR COOPERATIVE PROGRAMS IS EDUCATION. YOUNG PEOPLE NEED TO BE BETTER PREPARED IN AMERICA FOR LIFE IN A SOCIETY WHERE MODERATE ALCOHOL USE IS THE NORM. WHAT LITTLE ATTENTION IS GIVEN TO ALCOHOL BEVERAGES HAS HISTORICALLY FOCUSED ON NEGATIVE, SCARE PROPAGANDA.

A MODEL PROGRAM WHICH WE ARE SUPPORTING IS BEING CONDUCTED AT PENN STATE UNIVERSITY'S EIGHTEEN CAMPUSES.

ANOTHER EXCELLENT PROGRAM IS KNOWN AS BACCHUS, WHICH WAS FORMED SEVERAL YEARS AGO AT THE UNIVERSITY OF FLORIDA AND QUICKLY SHOWED THAT STUDENTS CAN HELP OTHER STUDENTS WITH REALISTIC GUIDANCE ABOUT ALCOHOL NONUSE, USE AND ABUSE. TODAY, BACCHUS HAS CHAPTERS AT A GROWING NUMBER OF UNIVERSITIES IN THE U.S. AND CANADA.

DISCUS HAS MADE OTHER CONTRIBUTIONS TO ALCOHOL EDUCATION PROGRAMS. OVER THE YEARS WE HAVE FUNDED THE INDEPENDENT DEVELOPMENT OF THREE EXCELLENT ALCOHOL EDUCATION SOURCE BOOKS FOR HIGH SCHOOL AND COLLEGE TEACHERS.

WE HAVE ALSO ESTABLISHED A COOPERATIVE PROJECT WITH THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION (NASBE) WHICH IS HELPING STATE AGENCIES MEET ALCOHOL EDUCATION NEEDS IN THE CLASSROOM AND IN THE COMMUNITY THROUGH EMPHASIS ON RESPONSIBLE DECISION MAKING.

IN 1979 DISCUS WAS A FOUNDING MEMBER OF THE LICENSED BEVERAGE INFORMATION COUNCIL, WHICH IS DEDICATED TO PUBLIC AND MEDICAL EDUCATION, INCLUDING THE DISSEMINATION OF SOLID SCIENTIFIC INFORMATION, ON THE ISSUE OF DRINKING AND PREGNANCY.

THE COUNCIL IS COMPOSED OF DISCUS AND NINE OTHER NATIONAL INDUSTRY ASSOCIATIONS REPRESENTING THE BEER, WINE AND SPIRITS INDUSTRIES AT THE PRODUCER, WHOLESALER, AND RETAILER LEVELS. THE INITIAL AND CONTINUING PURPOSE OF LBIC IS TO RAISE THE AWARENESS OF AMERICAN WOMEN CONCERNING DRINKING AND PREGNANCY.

WE FACED A DELICATE AND COMPLEX CHALLENGE. WE IN THE INDUSTRY ARE NOT PRACTITIONERS OF MEDICINE OR SCIENTIFIC EXPERTS, BUT WE KNOW WHO THEY ARE. THE SO-CALLED FETAL ALCOHOL SYNDROME ITSELF WAS AND IS A CONTROVERSIAL ISSUE IN SCIENTIFIC AND MEDICAL CIRCLES.

WE ALSO WANTED TO AVOID NEEDLESSLY SCARING EXPECTANT MOTHERS, MANY OF WHOM MAY HAVE BEEN FRIGHTENED OR CONFUSED BY ALARMIST REPORTS.

WE WANTED TO MOTIVATE, AS WELL AS INFORM.

AFTER CONSIDERABLE STUDY AND CONSULTATION THE LBIC ADOPTED A MULTI-MEDIA, MULTI-AGENCY STRATEGY. WE LEARNED THAT THERE WAS NO ONE SINGLE GROUP IN THE HEALTH FIELD POSSESSING ALL OF THE EXPERTISE, ACCEPTANCE, AND OUTREACH NECESSARY FOR SUCH A PROGRAM.

ON ADVICE OF QUALILFIED EXPERTS WE ADOPTED A PLATFORM STATEMENT AS A GUIDE TO ALL INTERESTED PARTIES AS TO WHAT THIS CAMPAIGN WAS ALL ABOUT, ITS BASIC APPROACH AND ITS BOUNDARY LINES. THREE KEY PLANKS IN THAT PLATFORM INCLUDE:

- WOMEN OF CHILDBEARING AGE HAVE A RIGHT TO KNOW THE FACTS ABOUT DRINKING AND PREGNANCY.
- WOMEN ARE URGED TO CONSULT THEIR PHYSICIANS ON THE ENTIRE RANGE OF HEALTH CONCERNS IN PREGNANCY, INCLUDING DRINKING.
- INFORMATION COMMUNICATED TO THE PUBLIC SHOULD BE BASED ON OBJECTIVE APPRAISALS OF THE LATEST SCIENTIFIC RESEARCH FINDINGS. PERSONAL OPINIONS SHOULD BE IDENTIFIED AS SUCH.

WE WANTED TO MOTIVATE EXPECTANT MOTHERS -- AS WELL AS THE RELATIVES OF ALCOHOLIC WOMEN -- TO FOLLOW PHYSICIAN ADVICE ON DRINKING AND OTHER HEALTH ASPECTS RELEVANT TO PREGNANCY.

THIS WAS OUR PROGRAM THEME: "WHAT YOU DO MAKES A DIFFERENCE. YOU OWE IT TO YOURSELF AND YOUR UNBORN CHILD TO BE INFORMED ABOUT DRINKING DURING PREGNANCY AND TO AVOID EXCESSIVE OR ABUSIVE DRINKING."

WE IDENTIFIED TWO MAJOR AUDIENCES FOR OUR CAMPAIGN: WOMEN OF CHILD BEARING AGE , EDUCATORS AND HEALTH PROFESSIONALS.

IT BECAME CLEAR, AS A RESULT OF DISCUSSIONS WITH QUALIFIED ORGANIZATIONS AND EXPERTS, THAT THEY AGREED WITH OUR CAMPAIGN PLATFORM STATEMENT.

OUR CAMPAIGN WAS PLANNED IN SUCH A WAY THAT IT WOULD HIT A SERIES OF PEAKS. THE FIRST SUCH PEAK INVOLVED A MASS MAILING TO 260,000 PHYSICIANS. DR. JACK MENDELSON OF HARVARD MEDICAL SCHOOL PREPARED A MEDICAL UPDATE OF WHAT WAS KNOWN ABOUT FAS, WHICH WAS PEER REVIEWED AND PUBLISHED BY THE RALEIGH HILLS FOUNDATION.

RESEARCH FINDINGS TO DATE WERE, OF COURSE, PRESENTED IN MEDICAL LANGUAGE IN THAT PAPER.

THEN THE LBIC ENLISTED THE SUPPORT OF THE MARCH OF DIMES. MOD FEATURED ITS COOPERATION WITH THE LBIC AT ITS ANNUAL CONVENTION, CALLING FOR MAJOR EMPHASIS BY ITS 935 CHAPTERS.

MOD'S PRINCIPAL OFFERING WAS AN ENGLISH LANGUAGE PAMPHLET, WHICH WAS EXTENSIVELY DISTRIBUTED THROUGHOUT THE COUNTRY.

WE WERE ALSO CONSCIOUS OF THE TEENAGE POPULATION. THE EDUCATION COMMISSION OF THE STATES SENT ITS BROCHURE TO 16,000 PUBLIC SCHOOL DISTRICTS, 2,000 PRIVATE SCHOOLS, AND 14,000 COLLEGES AND TRADE SCHOOLS.

THE GOVERNORS AND CHIEF SCHOOL OFFICIALS OF THE VARIOUS STATES ARE MEMBERS OF THE EDUCATION COMMISSION OF THE STATES, AND THEIR ENDORSEMENT HELPED IN URGING SCHOOLS TO UTILIZE THIS ECS MATERIAL IN THEIR CURRICULA.

THE LBIC WAS ALSO CONCERNED ABOUT ALCOHOLIC WOMEN AND THEIR FAMILIES. THIS IS AN EXCEEDINGLY DIFFICULT POPULATION TO REACH. OFTEN THESE WOMEN WILL NOT ADMIT THEY ARE ALCOHOLICS AND THUS THEY DON'T REACH OUT FOR HELP. OFTEN A RELATIVE OR FRIEND SEEKS INFORMATION AND GUIDANCE. THE AMERICAN COUNCIL ON ALCOHOLISM PROVIDED AN IDEAL WAY TO MEET THIS DIFFICULT CHALLENGE.

THE COUNCIL OFFERED ITS EXTENSIVE OUTREACH NETWORK THROUGH ITS LOCAL COUNCILS AND OTHER HEALTH INSTITUTION MEMBERS. ONE MILLION COPIES OF THEIR BROCHURES HAVE BEEN DISTRIBUTED THROUGH LOCAL COUNCILS AND OTHER ACA MEMBERS. THEY PUBLISHED ANSWERS TO THE MOST FREQUENT ASKED QUESTIONS BY THE PUBLIC ON DRINKING AND PREGNANCY. THE ANSWERS WERE DERIVED FROM AUTHORITATIVE SCIENTIFIC RESEARCH.

THIS SAME BOOKLET WAS OFFERED BY AMERICAN BABY MAGAZINE AS PART OF ITS 1981 EDUCATION SERVICE TO 16,000 PRE-NATAL COURSE INSTRUCTORS THROUGHOUT THE UNITED STATES. THEY REACH AN AUDIENCE CONSERVATIVELY ESTIMATED AT 400,000.

THE LBIC PROGRAM WAS ENHANCED BY A MEDICAL EDUCATION AND CLINICAL INTERVENTION PROJECT PIONEERED BY DR. HENRY ROSETT AND HIS ASSOCIATES AT THE BOSTON UNIVERSITY SCHOOL OF MEDICINE. HE FELT THAT THE PRIME NEED WAS TO EDUCATE THE PRACTICING PHYSICIAN WITH THE LATEST SCIENTIFIC INFORMATION ON WAYS TO IDENTIFY AND PREVENT FETAL ALCOHOL EFFECTS.

DR. ROSETT'S NEW INTERVENTION METHOD BASED ON HIS CLINICAL EXPERIENCE ENABLED HIM TO ESTABLISH THAT PHYSICIANS COULD INTERVENE UP TO AS LATE AS MID-POINT IN PREGNANCY WITH EXCELLENT CHANCES FOR A HEALTHY

OUTCOME, EVEN WITH CHRONIC ALCOHOLIC WOMEN. HIS RESEARCH FINDINGS HAVE BEEN EXTENSIVELY PUBLISHED IN MEDICAL JOURNALS.

DR. ROSETT IDENTIFIED MAJOR MEDICAL CRITERIA TO HELP PHYSICIANS IDENTIFY THE PROBLEM:

1) PRENATAL AND/OR POSTNATAL GROWTH RETARDATION

2) CENTRAL NERVOUS SYSTEM INVOLVEMENT

3) CHARACTERISTIC FACIAL DYSMORPHOLOGY

HE RELATED HIS FINDINGS TO THREE MAJOR CATEGORIES OF FEMALE DRINKERS: HEAVY, MODERATE AND RARE. HIS FINDINGS SHOWED THAT FETAL ALCOHOL EFFECTS WERE LINKED OVERWHELMINGLY WITH HEAVY DRINKERS -- THOSE WOMEN CONSUMING AT LEAST 45 DRINKS EACH MONTH, WITH FIVE OR MORE DRINKS ON SOME OCCASIONS.

UNFORTUNATELY, MOST PHYSICIANS ARE NOT TRAINED OR EQUIPPED TO TAKE A PATIENT'S DRINKING HISTORY. DR. ROSETT MET THIS NEED WITH HIS DIAGNOSTIC FIFTEEN-MINUTE INTERVIEW.

AT EDUCATION AND TRAINING WORKSHOPS DR. ROSETT TAUGHT FIVE BASIC METHODS OF INTERVENING WITH EXPECTANT MOTHERS WHO ARE HEAVY DRINKERS:

1) UTILIZE MOTHER'S CONCERN FOR UNBORN TO ENGAGE HER IN SUPPORTIVE PSYCHOTHERAPY

2) AVOID GUILT-PROVOKING CRITICISM

3) ASSIST WITH REAL SOCIAL PROBLEMS

4) AVOID DISULFIRAM (ANTABUSE) AND OTHER POTENTIAL TERATOGENS

5) WITHDRAW ALCOHOL GRADUALLY IF TOLERANCE HAS DEVELOPED

THE LBIC POSTER IS NOW IN ITS THIRD PRINTING AND HAS BEEN WIDELY USED BY A VARIETY OF GOVERNMENT AND PRIVATE HEALTH ORGANIZATIONS. MORE THAN 30,000 HAVE BEEN USED BY HEALTH CLINICS AND HOSPITALS.

RECORDED INFORMATION MESSAGES WERE SENT TO RADIO STATIONS. THEY FEATURED A SERIES OF INTERVIEWS WITH DRS. MENDELSON AND ROSETT, AS WELL AS SEPARATE STATEMENTS FOR THE MARCH OF DIMES, EDUCATION COMMISSION OF THE STATES AND THE AMERICAN COUNCIL ON ALCOHOLISM.

THREE TV PUBLIC SERVICE MESSAGES WERE PRODUCED AND DELIVERED TO TV STATIONS THROUGHOUT THE COUNTRY, AS WELL AS THE THREE MAJOR TV NETWORKS. THESE THREE MESSAGES WERE SPONSORED IN COOPERATION WITH THE U.S. TREASURY DEPARTMENT. ONE MESSAGE, IN PAN-HISPANIC, WAS DELIVERED TO STATIONS SERVING LARGE HISPANIC POPULATIONS.

WHILE THE LICENSED BEVERAGE INFORMATION COUNCIL IS THE FIRST INDUSTRY-WIDE PUBLIC EDUCATION EFFORT, IT IS BY NO MEANS THE ONLY ACTIVITY IN THIS FIELD. INDUSTRY TRADE ASSOCIATIONS AT THE NATIONAL, STATE AND LOCAL LEVELS CARRY ON EXTENSIVE PUBLIC EDUCATION CAMPAIGNS. IN ADDITION, MANY ALCOHOL BEVERAGE COMPANIES HAVE THEIR OWN PUBLIC EDUCATION EFFORTS AND RESEARCH SUPPORT PROGRAMS.

ONE OF THE PROJECTS OF WHICH WE ARE MOST PROUD ACTUALLY COMMENCED IN AUGUST, 1983 A NATIONAL PUBLIC AWARENESS PROGRAM TO PROMOTE GOOD MATERNAL HEALTH, ENTITLED "HEALTHY MOTHERS/ HEALTY BABIES" WAS DEVELOPED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. IT BRINGS TOGETHER A COALITION OF MORE THAN 50 NATIONAL HEALTH, PARENTING AND RELIGIOUS ORGANIZATIONS AS WELL AS MEMBERS OF THE INDUSTRY. OUR ROLE INVOLVES SPONSORSHIP OF A POSTER AND INFORMATION CARD THAT CAUTION PREGNANT WOMEN ABOUT HEALTH RISKS ASSOCIATED WITH EXCESSIVE DRINKING.

OUR POSTER IS ONE SIX BEING DISTRIBUTED TO MORE THAN 8,000 PUBLIC HEALTH SERVICE CLINICS NATIONWIDE. THE PURPOSE IS TO REACH DISADVANTAGED AND LOW-INCOME PREGNANT WOMEN WHO RECEIVE MATERNAL AND OTHER SERVICES IN THESE HEALTH CARE FACILITIES. THE CLINICS HAVE RECEIVED POSTERS -- ONE

EVERY OTHER MONTH FOR A YEAR. ALONG WITH THE POSTERS, HHS HOPES TO PUT INTO THE HANDS OF PREGNANT WOMEN MILLIONS OF POSTCARD-SIZE INFORMATION CARDS ON THE SAME SUBJECTS.

THE HHS/LBIC POSTER ADVICES PREGNANT WOMEN THAT "THERE ARE TIMES WHEN DRINKING AND DREAMS DON'T MIX...WHEN YOU'RE PREGNANT, ASK YOUR DOCTOR ABOUT DRINKING."

HERE ARE SOME SPECIFIC WAYS IN WHICH WE HAVE ACCOMPLISHED FURTHER PROGRESS IN THE CONTINUATION OF OUR EDUCATION AND RESEARCH CAMPAIGN:

AN IMPORTANT PART OF THE COUNCIL'S WORK HAS BEEN THE FUNDING OF BASIC COOPERATIVE PROJECTS IN WHICH AUTHORITATIVE GROUPS AND EXPERTS HAVE INFORMED TARGETED AUDIENCES ABOUT DRINKING AND PREGNANCY. WITH LBIC FUNDING THE MEDICAL PUBLICATION AND HOSPITAL INTERVENTION PROJECT CONDUCTED BY DR. HENRY L. ROSETT AND HIS COLLEAGUES AT BOSTON UNIVERSITY MEDICAL SCHOOL HAS CONTINUED FROM 1979 TO THE PRESENT. HIS INTERVENTION AND EDUCATION PACKAGE IS BEING INTRODUCED TO HOSPITAL PRACTICE AND HIS MODEL IS BEING ADOPTED AT MAJOR MEDICAL SCHOOLS. DR. ROSETT'S OUTREACH TO THE MEDICAL PROFESSION IS OUTSTANDING AND THE SWEDISH GOVERNMENT HAS ADOPTED HIS APPROACH IN ITS TRAINING PROGRAM FOR MIDWIVES.

IT IS GRATIFYING TO REPORT THAT DR. ROSETT AND HIS COLLEAGUES HAVE JUST COMPLETED A LARGE-SCALE STUDY THAT ESTABLISHES THAT WOMEN WHO DRINK MODERATELY HAVE BABIES WITH NO MORE PROBLEMS THAN WOMEN WHO DRINK RARELY OR NOT AT ALL. THE STUDY, CONDUCTED AT THE BOSTON CITY HOSPITAL, ALSO FOUND THAT CHRONIC ALCOHOLIC WOMEN CAN HAVE NORMAL-SIZED INFANTS IF THEY MODERATE THEIR DRINKING AS LATE AS MID-POINT IN PREGNANCY. THE RESULTS OF THE ROSETT STUDY WERE REPORTED IN THE MAY, 1983 ISSUE OF <u>OBSTETRICS AND GYNECOLOGY</u>, THE JOURNAL OF THE 24,000 MEMBER AMERICAN

COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS. I SUBMIT FOR THE RECORD A COPY OF THIS IMPORTANT RESEARCH REPORT. THE LICENSED BEVERAGE INFORMATION COUNCIL JOINED WITH DISCUS AND OTHER GOVERNMENT AND PRIVATE HEALTH ORGANIZATIONS IN FUNDING THIS HIGHLY IMPORTANT RESEARCH PROJECT.

DR. ROSETT IS NOW COMPLETING WORK ON A BOOK, TO BE PUBLISHED LATER THIS YEAR WITH DISCUS SUPPORT, TARGETED AT OB/GYN SPECIALISTS PEDIATRICIANS, MIDWIVES, PSYCHOLOGISTS, SOCIAL WORKERS AND OTHER PROFESSIONALS. DR. ROSETT'S TWO-YEAR INTERNATIONAL STUDY WILL BE THE KNOWLEDGE CORNERSTONE OF DRINKING AND PREGNANCY RESEARCH WORLDWIDE.

DR. ROSETT'S RESEARCH, WHICH HAS BEEN REPLICATED BY OTHER SCIENTIFIC STUDIES, HAS ESTABLISHED THE FACT THAT SOME OFFSPRING OF SOME CHRONIC ALCOHOLIC WOMEN EXPERIENCE FETAL ALCOHOL EFFECTS. A CLOSE FOCUS ON ALCOHOLISM AS A TREATABLE ILLNESS IS AN EFFECTIVE WAY TO GET AT THE HEART OF THE FETAL ALCOHOL EFFECTS PROBLEM.

VAGUE TALK ABOUT "ALCOHOL" PER SE IS NOT APPROPRIATE OR SUFFICIENT. THIS IS AN AMBIGUOUS TERM AND IT FAILS TO FOCUS ON THE ACTUAL PROBLEM, i. e. THE ROLE OF CHRONIC EXCESSIVE DRINKING DURING PREGNANCY AND ITS EFFECT ON BIRTH OUTCOME.

WE SHARE WITH AUTHORITIES IN THE RESEARCH, HEALTH EDUCATION AND TREATMENT FIELDS THE DEEP BELIEF THAT PREVENTING FETAL ALCOHOL EFFECTS CAN MOST EFFECTIVELY BE ACCOMPLISHED THROUGH MEDICAL INTERVENTION AND HEALTH INFORMATION, BASED ON FACTUAL KNOWLEDGE OFFERING A MESSAGE OF HOPE.

THREE KEY QUESTIONS NEED TO BE ADDRESSED IN THIS CONTEXT: FIRST, WHAT IS THE LEVEL OF AWARENESS AMONG WOMEN OF THE EFFECTS OF DRINKING ON PREGNANCY OUTCOME?

FOUR NATIONAL SURVEYS OF FEMALE OPINION CONDUCTED UNDER THE SPONSORSHIP OF U.S. GOVERNMENT AGENCIES HAVE ESTABLISHED AN EXTRAORDINARILY HIGH LEVEL OF SUCH AWARENESS.

TWO NATIONAL OPINION SURVEYS WERE SPONSORED BY THE U.S. DEPARTMENT OF THE TREASURY, AND TWO BY THE FOOD AND DRUG ADMINISTRATION. THESE SURVEYS, CONDUCTED BETWEEN EARLY 1979 AND LATE 1982, FOUND THAT AMONG WOMEN RESPONDENTS, AGES 18-44, AWARENESS OF THE POSSIBLE DANGERS OF EXCESSIVE DRINKING ON THE FETUS WAS CONSISTENT AND QUITE HIGH. OF WOMEN OF CHILDBEARING AGE, 77% TO 86% WERE AWARE OF THE PROBLEM AND CONSIDERED IT SERIOUS; LIKE NUMBERS OF WOMEN RECALLED HEARING MESSAGES ADVISING CAUTION IN THE CONSUMPTION OF ALCOHOL DURING PREGNANCY.

THE SECOND MOST SIGNIFICANT QUESTION INVOLVES THE MOST EFFECTIVE METHODS OF RAISING AND MAINTAINING PUBLIC AWARENESS. A STUDY BY THE GROUP ATTITUDES CORPORATION (GAC) OF ALL THE MAJOR HEALTH COMMUNICATIONS RESEARCH PUBLISHED IN THE USA OVER THE LAST 35 YEARS HAS ESTABLISHED THAT POSITIVE MESSAGES OF HOPE ARE FAR MORE EFFECTIVE THAN SCARE TACTICS. VAGUE ADMONITIONS ABOUT "ALCOHOL", JUDGED BY THIS STANDARD, DO NOT QUALIFY AS CONSTRUCTIVE MESSAGES.

ALSO A GROUP ATTITUDE PANEL SURVEY BY NIAAA HAS ESTABLISHED THAT WOMEN LOOK TO THEIR PHYSICIANS AND OTHER HEALTH PROFESSIONALS FOR GUIDANCE AND COUNSEL DURING PREGNANCY.

LBIC'S PIONEERING MEDICAL INTERVENTION AND TRAINING PROGRAM IS DESIGNED PRECISELY TO MEET THIS PRIMARY FUNDAMENTAL NEED.

IN 1980 THE US. DEPARTMENT OF HEALTH AND HUMAN SERVICES CONDUCTED EXTENSIVE CONSULTATIONS WITH RESEARCH, EDUCATION, TREATMENT AND MASS COMMUNICATIONS EXPERTS ON THE MOST EFFECTIVE METHODS OF ALERTING THE

PUBLIC TO THE DANGERS OF EXCESSIVE DRINKING. AS THE RESULT OF EXPERT CONSENSUS THAT AGENCY RECOMMENDED IN ITS REPORT TO THE CONGRESS THAT EDUCATION WAS MORE EFFECTIVE THAN SIMPLISTIC WARNINGS.

THE THIRD MAJOR QUESTION IS: WHO IS THE POPULATION INVOLVED OR AT GENUINE RISK OF FETAL ALCOHOL BIRTH DEFECTS?

PART OF THE ANSWER IS IN THE RESEARCH BY ROSETT AND HIS ASSOCIATES REFERRED TO EARLIER IM MY STATEMENT. ONLY 9% OF WOMEN WERE HEAVY DRINKERS. DR. ROBERT SOKOL, AN OBSTETRICIAN WHO HAS ALSO STUDIED THE INCIDENCE OF BIRTH DEFECTS UNDER FEDERAL GRANTS, HAS CONCLUDED THAT PERHAPS 2% TO 4% OF PREGNANT WOMEN ARE AT GENUINE RISK OF BEARING BABIES WITH ABNORMALITIES. IN THE MARCH 19 EDITION OF TIME MAGAZINE, DR. SOKOL STATED, "IT'S QUESTIONABLE WHETHER THERE HAS EVER BEEN A CASE OF AN FAS CHILD BORN TO LESS THAN A CHRONICALLY ADDICTED WOMEN."

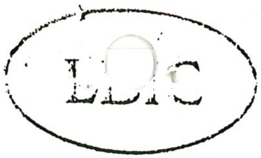
TURNING TO THE MATTER OF THE MEASURE BEFORE THIS COMMITTEE, WE WOULD POINT OUT THAT THE PROPOSED LANGUAGE IS VAGUE AND CAN ONLY SUCCEED -- IF IT ACCOMPLISHES ANY PURPOSE AT ALL -- IN NEEDLESSLY SCARING THE VAST MAJORITY OF PREGNANT WOMEN. THUS, WELL OVER 90% OF WOMEN WOULD BE WARNED ABOUT A POTENTIAL PROBLEM THAT DOES NOT IN THE REAL WORLD INVOLVE THEM AT ALL. AS DR. ROSETT'S EDUCATION, INTERVENTION AND COUNSELING PROGRAM SHOWS, THE MOST EFFECTIVE WAY TcO REACH HEAVY DRINKING PREGNANT WOMEN IS IN A FACE-TO-FACE, PROFESSIONAL ENCOUNTER.

IF THE PURPOSE OF THE PROPOSED BILL IS TO STIGMATIZE ALCOHOL, THEN ENACTMENT MAY ACHIEVE A SHORT-TERM GAIN -- UNTIL WOMEN DISCOVER IN CONSULTATION WITH THEIR PHYSICIANS THAT THE WARNING IS NOT BASED ON VALIDATED SCIENTIFIC KNOWLEDGE.

WE SUGGEST IT IS NOT PRUDENT PUBLIC POLICY TO USE SUCH A VAGUE, AMBIGUOUS MESSAGE AND METHOD: EXPERIENCE I HAVE SHARED WITH YOU TODAY CONFIRMS THERE ARE PREFERABLE, EFFECTIVE ALTERNATIVES TO A WARNING POSTER AS A MEANS TO ACTUALLY BRING ABOUT A REDUCTION IN THE PROBLEM OF FETAL ALCOHOL EFFECTS.

DISCUS, ITS MEMBERS AND INDEED THE ALCOHOL BEVERAGE INDUSTRIES, ARE TOTALLY COMMITTED TO BEING A CONSTRUCTIVE FORCE IN ALL OBJECTIVE EFFORTS TO REDUCE ALCOHOL ABUSE IN GENERAL AND FETAL ALCOHOL EFFECTS IN PARTICULAR. WE WELCOME THIS OPPORTUNITY TO TESTIFY BEFORE THIS COMMITTEE, AND TO SHARE OUR EXPERIENCE.

PFG/JO



LICENSED BEVERAGE INFORMATION COUNCIL
1250 EYE STREET, N.W. • SUITE 900 • WASHINGTON, D.C. 20005 • (202) 628-3544

Attm 5B
3-26-5

FOR IMMEDIATE RELEASE

For Information Contact:
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Washington, D.C., January 22, 1985 -- The Licensed Beverage Information Council was honored January 18 by an award for its co-sponsorship of an extensive poster and information card campaign conducted in 1983/1984 through more than 8,000 public health service clinics in this country.

The commendation was presented to LBIC as one of six sponsors of information cards and posters designed to reach low-income pregnant women. The awards were signed by Dr. Edward Brandt, HHS Assistant Secretary for Health and Dr. C. Everett Koop, U.S. Surgeon General.

Elaine Bratic Arkin, Deputy Director, Public Affairs, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Sources, presented certificates of commendation during a meeting of the Steering Committee of the Healthy Mothers/Healthy Babies coalition. That coalition is comprised of federal departments, private sector organizations, and health and education groups with a shared comprehensive program promoting maternal and fetal health, through early and regular pre-natal care.

The Healthy Mothers/Healthy Babies clinical program is now being evaluated for the effectiveness of its outreach. Initial reactions indicate that recipients appreciate the materials and are satisfied with the messages.

more . . .

Attm. # 5-B
3-26-5

American Beverage Alcohol Association
Association of American Vintners
Distilled Spirits Council of the United States, Inc. (DISCUS)
National Association of Beverage Importers, Inc.
National Licensed Beverage Association
National Liquor Stores Association, Inc.
National Restaurant Association
United States Brewers Association, Inc.
Wine and Spirits Wholesalers of America, Inc.
Wine Institue

Ex officio: National Conference of State Liquor Administrators

The goal in this phase of the program is to encourage women to consult qualified health professionals and to follow physicians' advice in pregnancy.

The LBIC sponsored card reads, "When you're pregnant, ask your doctor about drinking ... if you drink too much and can't control your drinking, there is something you can do. Reducing or stopping your drinking, will improve your chances of having a healthy baby. Your doctor can see that you get the help you need."

The national goal of the Healthy Mothers/Healthy Babies coalition is to form state level organizations, drawing together key health and education organizations for intensive local education and intervention. LBIC has been asked to co-sponsor a series of regional meetings of the state coalitions planned for 1985.

Licensed Beverage Information Council is a consortium of alcohol beverage industry associations, formed in 1979 to conduct public education programs aimed at raising levels of awareness among pregnant women and health professionals about the possible danger to the fetus of excessive drinking during pregnancy.

# # #

1/22/85

Attm. # 5 3-26-5

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Obstetrics and Gynecology

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Patterns of Alcohol Consumption and Fetal Development

HENRY L. ROSETT, MD, LYN WEINER, MPH, AUSTIN LEE, PhD, BARRY ZUCKERMAN, MD, ELIZABETH DOOLING, MD, AND EDGAR OPPENHEIMER, MD

Effects of heavy, moderate, and rare alcohol consumption on fetal development were analyzed in a prospective study of 469 mother-infant pairs. Differential effects of heavy drinking in early and late gestation were evaluated by separate analysis of neonates born to women who reduced consumption before the third trimester. Using χ^2 analysis, multiple regression, and matched sets, statistically significant associations ($P < .01$) were observed between sustained heavy drinking and both intrauterine growth retardation and congenital anomalies. These associations were independent of eight other risk factors. No differences were observed between offspring of rare and moderate drinkers. Infants born to women who reduced heavy drinking did not differ in growth from offspring of rare and moderate drinkers but demonstrated a higher frequency of abnormalities. Sustained heavy drinking represents a major risk; reduction in midpregnancy can benefit the newborn. Identification and therapy of heavy drinking are important components of prenatal care. *(Obstet Gynecol 61:539, 1983)*

From the Departments of Psychiatry, Obstetrics and Gynecology, and Pediatrics, Boston University School of Medicine, Boston City Hospital, and the Department of Mathematics, Boston University, Boston, Massachusetts.

Supported in part by: ADAMHA Career Teacher Awards (TO1DA00031 [NIDA] and PHSAA 07008 [NIAAA]), NIAAA (R01-AAP2446, R01-AA0127), R01-AA2133, R01-AA02446-04), Beverage Alcohol Information Council and the Distilled Spirits Council of the United States, Inc.

The association between alcohol abuse during pregnancy and fetal development has been of medical concern for more than 250 years.[1] A specific pattern of alcohol-related malformations was described by Lemoine et al in 1968[2] and by Jones and Smith, who termed it the fetal alcohol syndrome, in 1973.[3] All cases reported in the clinical literature have involved children of chronically alcoholic women.[4] In the absence of the fetal alcohol syndrome, associations have been demonstrated between heavy alcohol consumption and reduced birth weight,[5–7] increased incidence of malformations,[7,8] and functional disturbances.[9,10]

Effects of consuming moderate amounts of alcohol remain unclear. Inverse linear relationships between alcohol use and infant birth weight have been reported.[11,12] Other studies have observed no relationships between moderate consumption and birth weight or frequency of physical anomalies.[13,14] Also unanswered is whether there are differential effects of ethanol at various stages of gestation. The present study analyzes the effect of rare, moderate, and heavy drinking on fetal outcome with consideration of potential confounding variables. Alcohol's effects during early and late stages of gestation were assessed by analyzing the outcome among neonates born to women who reduced heavy drinking in midpregnancy.

Attm. #5-C 3-26-5

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Methods

At the time of registration for prenatal care at the Boston City Hospital Women's Clinic, all English-speaking women were asked to participate voluntarily in a 15-minute interview conducted in the clinic. Information was obtained on alcohol use, smoking, diet, use of other psychoactive drugs, demographic variables, and pregnancy history.[15] Although a structured format was used, the interviewers encouraged the women to elaborate when relevant.

Questions were asked about the quantity, frequency, and variability of the use of beer, wine, and whiskey.[16] A drink was defined as the volume of beverage containing 15 ml (0.5 oz) of absolute alcohol, eg, 360 ml (12 oz) of 4% beer, 120 ml (4 oz) of 12% wine, or 36 ml (1.2 oz) of 80-proof liquor. Self reports involving larger or smaller quantities were standardized to the defined unit of 15 ml (0.5 oz) of absolute alcohol.

Patients were divided into three groups according to their reported pattern of alcohol use. Heavy drinkers were those who consumed at least five drinks on some occasions and no less than 45 drinks per month. Rare drinkers either abstained or used alcohol less than once a month and never consumed five drinks on any occasion. All women who drank more often than once a month but did not meet the criteria for heavy drinking were classified as moderate drinkers.

Women who reported drinking heavily were told that they had a better chance of having a healthy child if they abstained from alcohol use for the duration of the pregnancy. They were encouraged to meet with the project psychiatrist (HLR) and/or counselor (LW) in the prenatal clinic at the time of their scheduled obstetric appointment. Supportive counseling at these sessions focused on reduction of alcohol use. Criticism, which can evoke guilt, was avoided. The frequency of counseling sessions, determined by the schedule of routine prenatal visits, varied from once every three weeks to once a week. In addition, supplementary appointments were scheduled and referrals were made to alcoholism treatment centers when indicated.

Changes in drinking patterns were monitored for the heavy drinkers when possible. The decision as to whether a particular patient had abstained, moderated, or continued heavy drinking was based on the evaluations of the project staff supplemented by observations of the prenatal clinic staff. When there were discrepancies between reported reduction in alcohol use and clinical observations suggesting continued heavy consumption, the woman was considered to have continued drinking. Heavily drinking women for whom there was no additional information were grouped according to their responses during the survey interview at registration. Thus, reduced drinkers are heavily drinking women who were known to have markedly decreased their alcohol consumption before the third trimester. All decisions about changes in drinking patterns were made without knowledge of pregnancy outcome.

Pediatric examinations, including neurologic and dysmorphology evaluations, were administered by one of four pediatricians as part of a study that included all births at Boston City Hospital, regardless of whether the mothers had been interviewed in the prenatal clinic.[14] Infants were assigned to a pediatrician according to the day of the week. The majority (66%) of the examinations were conducted on the second or third day of life. Twenty-three percent were done on the first day and 10% on the fourth day and beyond. Length and head circumference were measured by the examining pediatrician. Weight was obtained from the hospital chart. Gestational age was calculated using the Dubowitz score.[17] The Colorado Medical Center Classification of Newborns[18] was used to calculate growth percentiles. This standard was used as it allows comparisons with earlier studies done at Boston City Hospital as well as with programs at other sites. Infants who were at or below the tenth percentile in weight, length, and/or head circumference were considered to be growth retarded. Infant examinations were conducted without prior awareness of the mother's drinking history or obstetric or interview data, with the exception of one infant.

Infants were classified according to the number of major and minor congenital malformations they exhibited. Any infant with three or more minor abnormalities or one or more major abnormalities was rated as abnormal. A full description of the criteria has been published.[14] The diagnosis of fetal alcohol syndrome, made in accordance with the definition of the Fetal Alcohol Study Group of the Research Society on Alcoholism, was restricted to infants who showed signs in each of three categories: prenatal and postnatal growth retardation, central nervous system involvement, and characteristic facial dysmorphology.[19]

Relationships between maternal characteristics and growth retardation and incidence of abnormality were assessed by χ^2 analysis. Stepwise multiple regression analyses were employed to assess the strength of the association between fetal development and those variables thought to be related to growth. Birth weight, length, head circumference, and gestational age were used as dependent variables in four separate analyses. Independent variables entered were the log of gestational age, mother's age, ethnicity (black/nonblack,

Table 1. Maternal Characteristics by Drinking Group

Characteristic	Heavy (N = 25)	Reduced (N = 18)	Moderate (N = 164)	Rare (N = 262)	P value
Mean age	24.2 (5.8)	22.9 (4.6)	22.9 (5.6)	22.1 (5.2)	NS*
Mean prepregnancy weight (kg)	56 (9)	61 (15)	59 (12)	62 (15)	NS*
Mean absolute alcohol consumption (ml/day)	154 (174)	139 (172)	9 (9)	0 (0.3)	<.001*
Cigarette use (half pack or more/day) (%)	78	73	34	19	<.001†
Marijuana use (during pregnancy) (%)	41	39	22	10	<.001†
Ethnicity (black) (%)	52	67	67	65	NS†
Parity (nulliparous) (%)	20	55	33	42	NS†

Numbers in parentheses are standard deviation.
NS = not significant.
* F test.
† χ^2 test.

Spanish/non-Spanish), prepregnancy weight, education, parity, previous history of spontaneous or induced abortions, alcohol group (heavy/not heavy, reduced/not reduced, moderate/not moderate, rare/not rare), use of cigarettes, marijuana, and iron supplements, alcohol use by baby's father, and baby's sex.

To assess the impact of heavy and reduced drinking on impaired growth and neonatal abnormality, heavy drinkers and reduced drinkers were matched to every moderate and rare drinker who was similar to them on eight variables thought to influence fetal growth.[18,20] Six heavy drinkers could not be matched and were not included in this analysis. Two infants of the six had growth parameters below the tenth percentile. χ^2 tests showed that these six babies did not differ from the remaining babies in the heavy drinking group in either growth parameters or abnormalities. Five reduced drinkers could not be matched; their infants did not differ from those born to the other reduced drinkers. The variables used for matching were: parity (nulliparous or not), ethnicity (black/nonblack), cigarettes (less than half pack daily/half pack or more), use of marijuana (during pregnancy/not during pregnancy), mother's prepregnancy weight (less than 58.5 kg/58.5 to 72kg/over 72 kg), mother's age (16 or younger/17 to 35/36 or older), baby's sex, and gestational age (within two weeks). Analysis of variance was performed to test differences in birth weight, length, and head circumference between the cases and matched controls.

To investigate the effects of several substances, women were grouped according to their use of alcohol (heavy/not heavy), cigarettes (less than half pack daily/half pack or more) and marijuana (during pregnancy/not during pregnancy). Neonatal outcome was compared for four groups: sustained heavy drinking without cigarettes and/or marijuana, sustained heavy drinking with cigarettes and/or marijuana, cigarettes and/or marijuana without sustained heavy drinking, and neither sustained drinking nor use of cigarettes or marijuana.

Results

A total of 937 women with an expected date of confinement after February 1977 were interviewed in the prenatal clinic at Boston City Hospital. Between February 1977 and October 1979, 623 eligible babies were born. At the end of the study period, 110 women remained undelivered. Abortions or stillbirths were known to have occurred among 33 women, and 133 did not return to Boston City Hospital for care. Offspring of 38 women were excluded because they were twins or repeat pregnancies. Examinations were conducted on 469 (75%) of the 623 eligible infants. There were no differences in patterns of alcohol use between the women whose offspring were examined and the other women interviewed. Characteristics associated with drinking patterns were comparable for both groups.

Among the 469 women, heavy drinking was reported by 43 (9%), moderate drinking by 164 (35%), and rare drinking or abstinence by 262 (56%). Median daily absolute alcohol use reported by heavy drinkers was 15 times higher than that of the moderate drinkers. The heavy drinkers differed statistically from the rest of the sample on several behavioral characteristics: They smoked more cigarettes, used more marijuana during pregnancy, and had had more experience with psychoactive drugs at some time in their lives. There were no differences between the women in ethnicity, parity, age, and mother's prepregnancy weight. Maternal characteristics are presented in Table 1.

Of the 43 women who reported drinking heavily at registration, 23 participated in at least three counseling

Table 2. Neonatal Outcome by Maternal Drinking Group

Outcome	Heavy (N = 25)	Reduced (N = 18)	Moderate (N = 164)	Rare (N = 262)	P value (F test)
Weight (g)	2596 (584)	3119 (366)	3217 (533)	3298 (551)	<.001
Length (cm)	46.2 (2.8)	48.4 (1.9)	48.9 (2.50)	49.2 (2.3)	<.001
Head circumference (cm)	32.6 (1.8)	33.8 (1.0)	34.3 (1.4)	34.4 (1.5)	<.001
Gestational age (wk)	38.1 (1.9)	39.4 (1.0)	39.3 (1.6)	39.5 (1.3)	<.001

Values are mean ± SD.

sessions in the prenatal clinic. Of these, 16 (69%) were judged to have abstained or significantly reduced their consumption below heavy levels before the third trimester. Two of the 20 women who did not participate in counseling sessions reported reduced consumption and were considered reliable informants. The category of reduced drinkers consists of the 18 women who were judged to have markedly changed their drinking patterns; 11 abstained, seven moderated. The women who modified their drinking habits and those who did not reported similar daily absolute alcohol consumption at the time of registration. The two groups also did not differ in sociodemographic characteristics.

The 469 infants had a mean birth weight of 3225 g, mean length of 48.9 cm, and mean head circumference of 34.2 cm (Table 2). Twenty-two (4.7%) babies were small for gestational age, 12 (2.5%) had length measurements below the tenth percentile, and 13 (2.7%) had head circumference below the tenth percentile.[17] Congenital anomalies were observed in 16 (3.4%) babies. Major abnormalities as defined in the present study were identified in four (hypospadias in three, tuberous sclerosis in one); three or more minor anomalies occurred in 12. One neonate, born to a heavy drinker, was diagnosed as having fetal alcohol syndrome. Twenty neonatal deaths were recorded: 11 (2%) within the rare group, five (1%) in the moderate, one (3%) in the reduced, and three (6%) in the continued heavy drinking group.

Using χ^2 tests, drinking group was associated with weight ($P < .001$), length ($P < .001$), and head circumference ($P < .01$) below the tenth percentile for gestational age and abnormality ($P < .01$). Separate χ^2 tests for each drinking group demonstrated that only heavy drinking was related to retarded growth and abnormalities (Table 3). No other maternal characteristic studied was related to all four outcome measures. Previous history of abortions was associated with reduced length ($P < .01$) and head circumference ($P < .01$). Cigarette smoking ($P < .05$) and use of amphetamines ($P < .05$) were associated with reduced weight.

In stepwise multiple regression analyses, 33% of the variance in birth weight was explained by gestational age. Prepregnancy weight, heavy drinking, baby's sex, race, cigarette smoking, education, and parity, in this order, were also related to birth weight at a statistically significant level ($P < .01$). Together these seven characteristics contributed 11% to the variance. In multiple regressions with length as the dependent variable, gestational age accounted for 33% of the variance. Seven other statistically significant variables (heavy drinking, baby's sex, parity, previous history of abortion, race, cigarette smoking, and prepregnancy weight) contributed an additional 8%. In the analysis of head circumference, gestational age contributed 30%, and six other variables (mother's prepregnancy weight, baby's sex, use of iron pills, previous history of abortion, race, and education) accounted for 9%. Heavy drinking was not found to be associated with head circumference. Correlations of the independent variables with gestational age were low. Of all the variables entered in the regression equation, only mother's prepregnancy weight was related to gestational age ($P < .01$), accounting for 3% of the variance.

Analyses of variances showed differences in growth measurements among offspring when heavy drinkers were matched to rare and moderate drinkers: birth weight ($P < .0008$), length ($P < .07$), and head circumference ($P < .03$). Further analysis using multiple comparison showed that offspring of the heavy drinkers had the lowest birth weight, length, and head circumference; there were no differences between off-

Table 3. Growth Retardation and Morphologic Abnormalities by Drinking Group

	Heavy	Reduced	Moderate	Rare
	(N) %	(N) %	(N) %	(N) %
N	25	18	162	264
Weight 10th percentile or less	(8) 32	(0) 0*	(7) 4†	(7) 3†
Length 10th percentile or less	(5) 20	(0) 0	(2) 1†	(5) 2†
Head circumference 10th percentile or less	(3) 12	(0) 0	(2) 1*	(8) 3
Morphologic abnormalities	(3) 12	(2) 11	(2) 1*	(9) 3

χ^2 with Yates correction: heavy drinkers versus each of the other groups.
* $P < .05$; † $P < .001$.

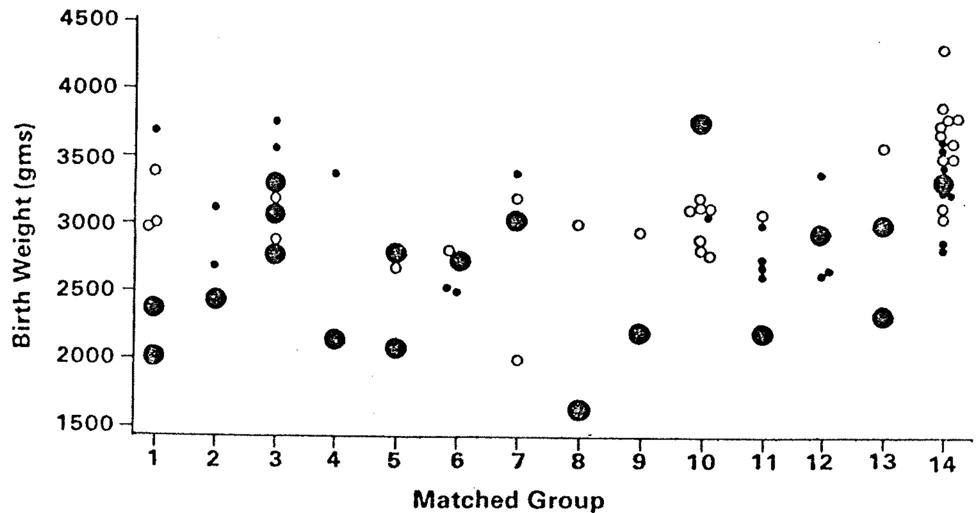

Figure 1. Birth weights of neonates born to heavy drinkers and matched moderate and rare drinkers. Large dots = heavy, small dots = moderate, open dots = rare.

spring in the rare and moderate groups. Figure 1 demonstrates the birth weights of offspring of the heavy drinkers as compared to the matched rare and moderate controls.

When women were grouped according to substance use, the number of babies with growth retardation in weight, length, and head circumference was highest among women who used alcohol heavily throughout pregnancy whether or not they smoked cigarettes and/or marijuana. In the absence of sustained heavy drinking, use of cigarettes and/or marijuana did not increase the risk of having a growth-retarded infant (Table 4). Abnormalities were also more frequent among neonates born to women who drank heavily throughout pregnancy; the risk was not increased by the use of cigarettes or marijuana.

Infants born to the reduced drinkers had more abnormalities than those born to the rare and moderate but did not differ in weight, length, or head circumference in either χ^2 tests or matched pair analysis. Frequency of abnormalities did not differ between offspring of the reduced and heavy drinkers. Significantly more growth retardation occurred among offspring of heavy drinkers than among offspring of reduced drinkers (Table 3). No differences were observed between the offspring of moderate and rare drinkers in either growth retardation or incidence of abnormalities.

Discussion

Heavy alcohol consumption identified in the prenatal clinic and sustained throughout pregnancy was associated with a higher incidence of growth retardation and congenital abnormalities among neonates. This association was independent of eight other risk factors demonstrated to be related to growth in this population. No differences were found between offspring of rare and moderate drinkers. Neonates born to women drinking heavily in early pregnancy who reduced consumption before the third trimester were similar to offspring of the rare and moderate drinkers in growth parameters, but exhibited more congenital anomalies.

These findings on 469 mother-infant pairs delivered between February 1977 and September 1979 confirm observations on 322 mother-infant pairs born between May 1974 and June 1976 that drinking heavily throughout gestation was associated with retarded fetal growth and increased abnormality[7,21] (Figure 2). The prenatal clinic data on maternal alcohol consumption and other characteristics were collected and analyzed

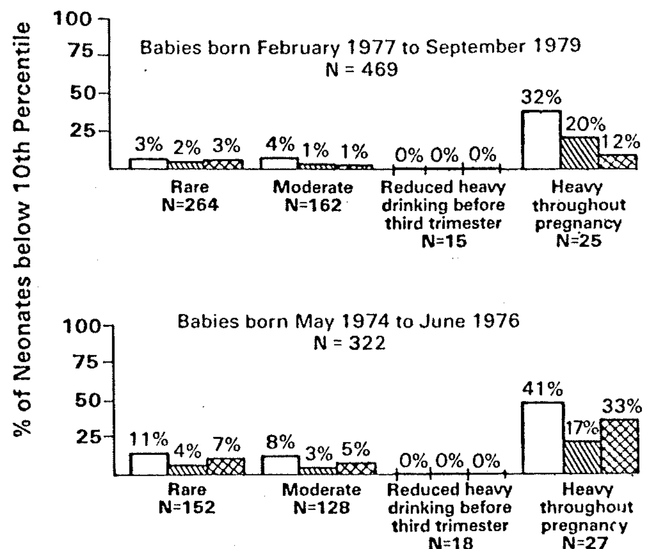

Figure 2. Growth retardation by maternal drinking pattern in prenatal clinic. Growth below tenth percentile: open boxes = weight, hatched bars = length, crosshatched bars = head circumference.

Table 4. Substance Use and Incidence of Birth Weight Below Tenth Percentile for Gestational Age

Substance use	Babies born 2/77–10/79 (N)	%	Babies born 5/74–6/76 (N)	%	Combined (N)	%
A Sustained heavy drinking without cigarettes and/or marijuana	(3/7)	43	(6/11)	54	(9/18)	50
B Sustained heavy drinking with cigarettes and/or marijuana	(5/18)	28	(5/16)	31	(10/34)	29
C Cigarettes and/or marijuana without sustained heavy drinking	(5/121)	4	(9/76)	12	(14/197)	7
D No sustained heavy drinking, cigarettes, or marijuana	(9/323)	3	(18/211)	8	(27/534)	5
Total	(22/469)	5	(38/314)	12	(60/783)	8

* χ^2 with Yates correction: combined population.

A vs B	NS	B vs C	$P < .001$
A vs C	$P < .001$	B vs D	$P < .001$
A vs D	$P < .001$	C vs D	NS

NS = not significant.

identically for both cohorts. During both study periods weights were taken from the infants' charts. The statistical techniques used to examine the effects of confounding variables on birth weight in the second cohort were applied to the earlier data. As criteria for length, head circumference, and abnormality were not standardized for the two cohorts, further analysis of these outcome measures within the first cohort was not performed. When matched pair analysis was used, the association between sustained heavy drinking and low birth weight was found to be independent of eight other risk factors. The risk for growth retardation was increased by heavy alcohol consumption but not by cigarette or marijuana smoking (Table 4).

The adverse effects of sustained heavy drinking have been demonstrated repeatedly by both epidemiologic and experimental research.[4] In some epidemiologic studies, no effect of moderate doses has been observed.[13,14] Others have reported an association between 30 ml (1 oz) absolute alcohol and a reduction in mean birth weight of 180 g.[11] The discrepancies may stem in part from inherent problems in the assessment of alcohol consumption from self reports. The scoring of drinking patterns in terms of a daily average of absolute alcohol implies a precision that does not exist. Each respondent's definition of a drink may vary to include amounts from one to eight ounces. Few women consume the same amount each day. Some women discuss their most recent drinking patterns while others speak only of past times. Recall of quantity and frequency may be blurred due to forgetfulness and denial. Prospective and retrospective responses differ. At Boston City Hospital, among a group of 328 women who were interviewed both prenatally and after delivery, 10.1% reported drinking two or more drinks daily at the prenatal interview while only 3.8% reported drinking two or more drinks daily during pregnancy in the hospital interview.[14]

The absolute alcohol score is based on the average quantity consumed but does not account for frequency and variability. A daily average of 30 ml (1 oz) of absolute alcohol can describe the woman who consumes two drinks a day as well as the one who has 14 drinks once a week. Differences in the resulting blood alcohol concentrations, which may affect the fetus, are blurred in the analysis. Categorization into rare, moderate, and heavy drinkers which considers quantity, frequency, and variability provides a reliable method of identifying women likely to have high blood alcohol concentrations. In test-retests of drinking habits, 70% of respondents remained in the same quantity-frequency-variability group, whereas only 24% reported the same absolute alcohol scores.[22]

Because heavy drinking and growth retardation were rare occurrences in this population, statistical techniques were employed which considered the impact of alcohol and other risk factors within subsets of drinking groups as well as within the population as a whole. The matched pair technique and substance use categories facilitated analysis of the association between particular patterns of alcohol consumption and associated risk factors and neonatal outcome. The 9% of the population in the heavy drinking group reported a median daily consumption 15 times greater than the moderate drinkers. This is consistent with other reports that a small group of the heaviest drinkers consumes far greater amounts than the rest of the population.[23,24]

Smallness for gestational age was used as the criterion for growth retardation because of its clinical relevance, marking infants at higher risk for morbidity and mortality. In contrast, a lower mean birth weight of 100 to 200 g may result from a number of maternal conditions, including cigarette smoking, yet not predict morbidity and mortality.[18]

Growth retardation was not observed in infants born to heavy drinkers who reduced consumption before the third trimester. At prenatal registration, similar levels of alcohol consumption were reported by the group of women who reduced heavy drinking and those who continued throughout pregnancy. Studies that have examined third trimester consumption separately from first and second trimester have reported a marked reduction in consumption during preg-

nancy.[6,13,25,26] The relationship between low birth weight and maternal alcohol use has been reported to be stronger late in pregnancy than early in pregnancy.[25,27] If analysis of infant data had not considered changes in drinking patterns, measurement of the adverse effects of sustained heavy drinking would have been weakened and benefits from reduction would have been missed.

The data on reduction of heavy drinking were derived from a therapy program conducted in the prenatal clinic. It was not possible to collect equivalent data on changes in drinking or on other substance use among heavy drinkers who did not return to the Women's Clinic for prenatal care or on women in other drinking categories. Because the authors' knowledge is incomplete, some women included in the continued heavy drinking group may have actually reduced consumption. This would weaken statistical differences between offspring born to heavy drinkers and the rest of the population. Adverse effects of sustained heavy drinking and benefits from reduction were demonstrated despite this.

Women who reduced consumption did not differ significantly from those who sustained alcohol use on several maternal characteristics considered to place the fetus at risk, including cigarette smoking and drug use. Although the authors did not systematically collect data on changes in other behaviors, clinical observations from counseling sessions suggested that nutrition improved, drug use decreased, and cigarette smoking remained relatively stable for both the women who reduced and those who continued heavy drinking.

The finding that no infants born to reduced drinkers were below the tenth percentile in weight, length, or head circumference probably occurred as a result of the small number in the reduced category. χ^2 tests revealed that growth retardation among the offspring of reduced drinkers did not differ from that in the moderate and rare groups.

Growth retardation probably results from multiple effects of high ethanol concentrations on the maternal-placental-fetal system.[4] These include effects on fetal metabolism and endocrine function,[28] transport of amino acids across the placenta,[29] decreased absorption of nutrients across the intestinal mucosa, and altered hepatic metabolism in the mother.[30] When alcohol consumption ceases, these adverse effects are diminished and catch-up growth may occur.

The incidence of abnormalities was greatest among infants born to women who reported heavy drinking early in pregnancy. In fetal mice, facial dysmorphology characteristic of fetal alcohol syndrome has been reported after acute intraperitoneal administration of high doses of ethanol on day 7, a developmental stage comparable to the third week of gestation in humans.[31] High doses administered to mice on days 9 or 10 produced limb abnormalities.[32] While reduction in consumption can benefit growth, structural malformations persist.

Follow-up studies are needed to determine if offspring of the reduced drinkers continue to grow and develop appropriately, as subsequent examinations frequently reveal problems that could not be diagnosed in the neonate. For example, neurologic impairment may only become apparent in later years when developmental delays and learning problems can be measured. In each cohort of infants born at Boston City Hospital, fetal alcohol syndrome was diagnosed during subsequent clinical examinations in two children whose signs became apparent only with maturation. In all four instances, the mothers had sustained heavy drinking throughout gestation.

In summary, alcohol consumed in large amounts throughout pregnancy is associated with a spectrum of adverse fetal effects, with the fetal alcohol syndrome as the extreme. No associations between alcohol use and fetal development were observed in the newborn nursery among offspring of moderate or rare drinkers. Women who reduced heavy drinking before the third trimester bore children who were similar in size to the offspring of the rare and moderate drinkers; the infants did, however, show an increase in abnormalities. The mechanism of the benefits from reduction of heavy drinking in midpregnancy are not yet fully understood. Although much remains to be learned, these findings suggest that identification and therapy of heavy drinking are essential components of prenatal care.

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STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

attm. #6
3-26-5

COMMITTEE ASSIGNMENTS
MEMBER FEDERAL AND STATE AFFAIRS
ENERGY AND NATURAL RESOURCES
GOVERNMENTAL ORGANIZATION

March 26, 1985

H.C.R. 5015 - calls for the development of a plan for community long term care services for older Kansans. The resolution directs the Department of Aging, the Secretary of Health & Environment and the Secretary of Social and Rehabilitation to jointly develop a comprehensive plan. A report concerning the plan to be submitted to the Governor prior to Jan. 13, 1986.

The 3 agencies shall work with various state and community agencies.

Guidelines for the plan:

1. Analysis of the need
2. Consider goals and objectives
3. Recommendations for implementation
4. Analysis of gaps in programs and service
5. Methods of coordination of efforts between the appropriate state agencies
6. Estimate of the costs of such services
7. Any anticipated cost savings and efficiencies

Kansas' older population is growing in numbers and in average age.

The Kansas Census 1980 shows there are 132,852 people 75 and older. 17,847 of these are in adult care homes, ½ of those in adult care homes are on medicare. It is estimated that 35,694 are house restricted elderly. Providing care for the frail elderly is of extreme importance.

attm. #6
3-26-5

Without effective alternatives the nursing home population is expected to increase by 80% by the turn of the century.

We must explore and implement all alternatives to provide long term care now and not wait for a crisis.

Our choice as a state is whether we will continue with our current strong institutional emphasis in meeting our needs or whether we will have more of a balance of alternatives for care of the elderly.

Another group that agencies should include in their deliberation is that group that give care for the older Kansans. Very little attention has been given to the needs of family "care-givers" in our society. Yet they provide 80% of all the care the frail elderly receive. Concern support and encouragement of caregivers are needed.

All 3 agencies are involved with the care of the elderly. By passing this Resolution agencies are encouraged to develop a long term care plan.

I urge your favorable consideration of H.C.R. 5015.

Dr. Ron Harper

Attm. #7
3-26-85

TESTIMONY ON H.C.R. 5015
TO THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
BY THE KANSAS DEPARTMENT ON AGING
MARCH 26, 1985

Bill Summary:

Directs the Secretaries of Aging, Health and Environment, and Social and Rehabilitation Services to develop jointly a plan on community long-term care services for the elderly.

Bill Provisions:

1. Develop a comprehensive plan for providing community alternative long-term care services for the elderly.

2. Plan Provisions

   a. Analysis of need for services.
   b. Develop goals and objectives for services.
   c. Recommend an implementation plan.
   d. Analyze gaps in programs and services.
   e. Suggest methods for coordinating efforts between state agencies and between state and community agencies.
   f. Estimate costs.
   g. Anticipate cost savings and efficiencies.

3. Prepare and submit a report to the Governor and Legislature prior to January 13, 1986.

Bill Testimony:

The Kansas Department on Aging strongly supports the development of a comprehensive plan of community long-term care services for the elderly of Kansas. One of the most difficult issues facing the State of Kansas is the determination of the most appropriate and cost-effective mix of long-term care services designed to address the needs of the increasing numbers of the frail elderly population. For many years, long-term care services were perceived as institutional services - primarily nursing homes. Therefore, federal payment mechanisms were developed to support that institutional approach, often leading to higher cost care.

More recently, the definition of long-term care has been expanded to include services to the chronically ill or impaired persons, most often elderly, that allow them to live outside of institutions and as independently as possible. The non-institutional component, i.e., community long-term care services, is provided by either or both the formal (agencies) or informal support systems (families, friends or neighbors). A recent GAO study reports that 60-80% of long-term care is informally provided by spouses, other relatives or friends.

Attm. #7
3-26-85

These informal caregivers and the elderly whom they care for often encounter difficulties when they look for assistance.

- Gaps in community services essential to remaining in their homes.
- Lack of information about availability of services.
- Lack of coordination between services.
- Varying eligibilities for services across programs.
- Funding that has encouraged institutional care.

There are a variety of changes occurring which make planning for Community Long Term Care services more imperative.

1. The changing composition of the elderly with increased numbers of frail older persons making greater demands on the long term care system, including many older persons who suffer more from chronic rather than acute illnesses.
2. Changes in federal programs and federal funds shifting more care and long term care costs to the state.
3. Growing elderly population in rural areas.
4. Need to control costs.
5. The elderly's preference to remain independent in homes and communities as long as possible.

KDOA supports a planned and coordinated approach to providing community long term care services. In our review of other states with strong systems, there were several major components necessary prior to developing cost effective approaches:

1. Formalized state level planning process with the various departments and agencies involved.
2. A formalized charge related to the scope of the plan.
3. Development of a plan based on findings, which included mechanisms for coordination and fiscal impact.

Kansas has made some good beginnings. HCR-5015 would provide an opportunity to plan for the future. The Resolution affirms policy directions and provides a basis for future policy.

1. That the elderly who are in need of long term care services should be assisted to remain in the community as long as possible and economically feasible.
2. Effectiveness is increased through coordination with community and state agencies.
3. That the policy of the State is to seek the most effective, non-duplicative methods of providing long-term care.

Recommendations

The Kansas Department on Aging believes that HCR 5015 addresses the need to develop a plan on which future policy decisions can be made. One that will provide service programs responsive to

- The demographic projections that are most likely to be correct.
- The growing number of frail elderly who will suffer from chronic rather than acute health problems and who will need some maintenance.
- Institutional care that is and will continue to be expensive.
- Non-institutional care that is the appropriate care for many elderly.

Therefore, KDOA strongly supports the passage of HCR 5015.

RH:mj
3/26/85

Attm. #8
3-26-5

KANSAS COALITION ON AGING
500 Kansas Ave.
Topeka, KS 66603
(913) 232-1456

Testimony before the House Public Health and Welfare Committee
3/26/85

Bill: HCR 5015

Bill Provisions: Directs the secretaries of Aging, S.R.S. and H&E to do a study of long-term care and make a report by 1/86

Testimony

I am Gary Petz, Executive Director of the Ks. Coalition on Aging. As many of you know, the Coalition supports H.B. 2491. This bill is what we want to happen in long-term care. It would provide for screening, assessment, care plans and a sliding scale provision of services. The program would be financed by a state, local, user combination of resources. That's what we feel is needed. So the Coalition takes no position on this resolution, which calls for a plan to be written by the three secretaries.

In pursuit of our priority on H.B. 2491 we have agreed with Chairman Littlejohn that an interim study is advisable. So we just ask you not to consider this resolution as an alternative to the interim study. And if you pass out this resolution, we suggest that you insert a provision that calls for a preliminary report or plan to be submitted to the interim committee during its study of 2491. This report could be an analysis of all the research reports and plans that now exist on long-term care in the state as well as a summary of applicable research findings from other states or communities. I think that much is doable by Summer or early fall, when hearings would likely be held by the interim committee.

Attm. #8
3-26-85

atm. #9.
3-26-5

JESSIE M. BRANSON
REPRESENTATIVE, FORTY-FOURTH DISTRICT
800 BROADVIEW DRIVE
LAWRENCE, KANSAS 66044
(913) 843-7171

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: EDUCATION
PENSIONS, INVESTMENTS AND BENEFITS
PUBLIC HEALTH AND WELFARE

March 26, 1985

TO: Representative Marvin Littlejohn, Chairman
and Members
House Committee on Public Health and Welfare

FROM: Representative Jessie Branson Jessie

This is to ask for your favorable action on HR 6046 which relates to packaging and labeling of camphor-containing products.

Currently required to be in safety packaging by regulation promulgated under the Poison Prevention Packaging Act of 1970 are certain drugs and household products. Camphor products are not presently included, but at the time the list was adopted, the U.S. Consumer Product Safety Commission stated as follows:

> "Careful monitoring of accidental ingestion data and other statistics may show in the future the need for regulations covering camphor and antihistimines".

I believe that we now have more than sufficient data as a basis to urge the Commission to proceed with safety packing and labeling of camphor-containing products. (See attachment)

HR 6046 was introduced at the request of the Kansas Chapter of the American Academy of Pediatrics.

atm #9
3-26-5

Atm # 9
3-26-5
Rep Branson

Mid-America Poison Center
University of Kansas Medical Center
39th and Rainbow
Kansas City, Kansas 66103

Reported Exposures (1983)

	Kansas	National
Topicals		
*Camphor	24	723
*Camphor and Methylsalicylate	13	1174

Case Report:

On 2-12-85 at approximately 1943 a physician called Mid-America Poison Center. He had a male patient, 3 years old who presented in the emergency room comatose. He evidently became comatose at home and was transported via ambulance. Ambulance attendants reported he seized during transport. Parents believe he ingested some Strawberry Shorkcake Pretty Nails Cuticle Cream. They don't know how much or when. The container was only 0.5 oz. Physician described child as very sick and mentioned pH was 7.1. He wanted to know the product composition.

The person answering the call at the Mid-America Poison Center checked Poisindex for a product listing under Strawberry Shortcake,Pretty Nails and Cuticle Cream. Nothing was found under any of these headings. It was noted that several of the products under cuticle cream that were for adult use were listed as non-toxic. The physician was informed that although nothing could be found on the specific product in Poisindex, it was likely to be the cause of such serious symptoms. The physician was asked if he wished to speak with the Medical Director of the poison center. The physician said no, that he was working with the childs pediatrician and that they were planning on investigating all possible causes. They believed the problem may not be toxicologic in nature. The physician felt that the child was too sick to be handled in Concordia and planned to transfer the child to Salina.

Approximately 30 minutes later (2015) the physician called back to say that the parents now thought possibly the child may have gotten into Camphophenique. They had bought a 2 ounce bottle and wanted to know if the symptoms of a Camphophenique ingestion were consistent with this childs symptoms. He stated that there was no odor

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3-26-5

of camphor on the child's breath or clothes. Camphophenique contains 10.8% camphor and 4.7% phenol. Phenol symptoms did not seem to fit, except for the absence of odor and acidosis. The poison center representative suggested to the physician that the acidosis could be respiratory in nature and secondary to seizures. All symptoms and treatment information was given to the physician from Poisindex listed for "Camphor-Phenol Management(1EOS)". The physician was asked again if he wanted to speak with the medical director of the poison center. Again he felt it was not necessary.

Approximately one hour and 15 minutes (2134) later the poison center representative called back to St. Joseph's Hospital in Concordia to check on the patients progress. The physician relayed that a Camphophenique ingestion had been confirmed by the patients older brother. At this time the patient was doing much better. He had had no more seizures. He was intubated and being ventilated. The Dr.stated that the patient really woke up quite a bit during intubation and that he was now more alert. He had had some vomiting and that there was no odor of camphor in the vomitus. Repeat gases were much better, the acidosis seemed to be resolving. The original physician had been in touch with another physician an Wesley Medical Center in Wichita who was a pediatric neurologist. The plan was to transfer the patient to Wesley Medical Center ICU in the evening. The patient was described as having a conjugate gaze. It was unknown at that point if any aspiration had occured, chest X-ray had not yet been done. The physician was instructed to call back if the Poison Center could be of any further help that night and that the medical director was still available. The physician was informed that a poison center specialist would check on the patient at Wesley on the morning of 2/13/85.

Attm. #10
3-26-5

THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

KENNETH W. SCHAFERMEYER, M.S., CAE
PHARMACIST
EXECUTIVE DIRECTOR

Statement to the House Public Health and Welfare Committee
March 26, 1985

Subject: House Resolution Number 6046

Mr. Chairman and Members of the Committee: My name is Ken Schafermeyer and I am the Executive Director of the Kansas Pharmacists Association, an organization representing 1,000 practicing pharmacists in the State of Kansas. I appreciate the opportunity to address you today on House Resolution 6046.

The Kansas Pharmacists Association supports this resolution and any measure that protects the public against the potential hazards of poisoning from drug products containing toxic or potentially lethal amounts of camphor. Allow me to provide some backgroud.

The Problem

In 1970, the Consumer Product Safety Commission enacted by regulation, the Poison Prevention Packaging Act that requires special "child-resistant" packaging for certain hazardous substances "to protect children from serious personal injury or serious illness resulting from handling, using or ingesting such substances".

These regulations suggest that on the basis of adequate statistical evidence, substances could be added to the list requiring special packaging should these substances pose a hazard to children through accidental ingestion, illness or injury by reason of their packaging.

Attm. #10
3-26-85

Attm #10
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Camphor products have long posed a threat to the public health. The American Academy of Pediatrics named Camphorated oil as the worst offender because a large number of ingestions were reported when campor-ated oil was mistaken for other medicines (eg. castor oil, mineral oil, cod liver oil, olive oil, cough medicines, etc.). These ingestions have resulted in seizures or deaths. In 1982, all products containing camphor in oil or labeled camphorated oil, camphor oil, camphor liniment or camphorated liniment were removed from the US market (Federal Register announcement 21 CFR 310.526 September 21, 1982). This legislation how-ever did not include camphor containing products such as Campho-phenique (10.8%), Absorbent Rub, etc.

These products continue to be a potential public health hazard. One gram of camphor (the amount of camphor contained in two teaspoonfuls of Campho-phenique or 1/6 of a bottle) has caused the death of a small child. Smaller amounts have resulted in toxic effects such as severe nausea, vomiting and seizures. Two grams is enough to produce toxic symptoms in an adult. A 2 ounce bottle of Campho-phenique contains a total of 6.48 gms of camphor. It is available currently over-the-counter without child resistant packaging and without any warning on its label as to its toxic potential.

In 1983, 1,897 camphor related poisonings were reported nationwide to the American Association of Poison Control Centers. Over 90% of these incidents were in children and more than 95% were accidental. The Mid-American Poison Center at the University of Kansas Medical Center alone reported 37 of these camphor poisonings in 1983.

Atm #10
3-26-5

Reasons for Supporting Resolution 6046

In summary, because of the potential toxicity of these products I would like to state again that we support inclusion of camphor products intended for medcinal use in the Poison Prevention Packaging Act of 1970 to assure proper labeling and packaging of these products.

This statement by the Kansas Legislature will serve as a fitting reminder to the federal agencies that our citizens are concerned about the public health. Hopefully, this advice will be accepted and appropriate uniform labeling and packaging requirements will be adopted throughout the country.

Thank you for the opportunity to address you on this issue.

Attm. # 11
3-26-5

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding S.B. 131

Title

AN ACT concerning social welfare; penalties for welfare fraud amending K.S.A. 1984 supp. 39-709 and repealing the existing section.

Purpose

The administrative penalty for persons convicted of welfare fraud is severe and should be amended for first time offenses.

Background

Persons convicted of welfare fraud pursuant to K.S.A. 39-720 become forever ineligible for General Assistance. This is a harsh penalty; especially, if the conviction is the persons's first.

People served by programs administrered through the Department are often in times of great stress and hardship. Additionally, the persons served by these programs frequently have physicial, mental, emotional, or educational handicaps which at times may limit their ability to make appropriate choices or decisions. The permanent restriction under these circumstances is too harsh when there may well be no alternate income source available.

Further, the effects of the penalty may be delayed for several years since it does not apply to federally funded programs. For example, a young mother receiving Aid for Dependent Children is convicted of fraudulently receiving $200 in welfare benefits. She is required to repay the assistance. Twenty years later, after her children are grown, she is hurt on the job and applies for General Assistance while she recovers enough to work again. At that time, under current law, the penalty for the one conviction 20 years earlier would be applied and she would be permanently disqualified from receiving General Assistance.

Alternatives which can be considered include: 1) Amend K.S.A. 39-709(d) so that an initial conviction will not make a person ineligible for General Assistance for the rest of their lives; the lifetime prohibition would not come into play until the second conviction. 2) Amend K.S.A. 39-709(d) to delete the lifetime prohibition clause. 3) Maintain the status quo which applies a lifetime penalty to anyone convicted of welfare fraud.

SRS Recommendations

Amend K.S.A. 39-709(d) so that an initial conviction will not make a person ineligible; the lifetime prohibition would not come into play until the second conviction.

Attm. #11
3-26-85

Effect of Passage

Passage of S.B. 131, as amended by the Senate Public Health and Welfare Committee, will allow the Department of Social and Rehabilitation Services to apply a three-year General Assistance disqualification penalty for a conviction of first time welfare fraud, while maintaining the lifetime disqualification provision for repeat offenders.

Fiscal Impact

Necessary data to project the exact fiscal impact of this change is not available; however, information collected from local offices regarding denials resulting from this penalty indicates the impact would be minimal. Many people do not reapply after conviction or reapply and qualify for other federally funded programs.

Robert C. Harder
Office of the Secretary
Social and Rehabilitation Services
296-3271
March 26, 1985

attm #12
3-26-5

MITCH COOPER, L.M.S.W.
Executive Director

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

West Tenth Professional Building
1119 West Tenth, Suite 2
Topeka, Kansas 66604-1105

Telephone
913-233-6323

I am Michael Byington, Outreach Advocate/Case Manager for the Topeka Resource Center for the Handicapped. I appreciate the Committee's giving me this opportunity to present. I appear in support of SB 131.

As Case Manager for my agency, I have been involved over the past few years with a number of situations where individuals with whom my agency works are going hungry, living on the streets, and/or lacking essential medical care because they can not get general assistance welfare due one count of welfare fraud which occurred many years ago. Currently, a person can commit murder, do a few years prison time, perhaps a few more on parole, and then assume that he/she has paid his/her debt to society. In the case of welfare fraud, however, current laws require the person to pay for ever; they can never get welfare again no matter how needy they may become.

I manage a team of specialists who provide direct services to disabled individuals. My team members could give you a number of examples of the type of tragic situations referenced above, but in consideration of time constraints, I shall offer only one. Our center works with a 38 year old black male who lost an arm in an auto accident a few years ago. In his early adult years, this individual used to be a Topeka community leader in food and services drives for the needy. Quite a number of years ago, however, the man became involved with drugs and alcohol. During that time, he forged a medical perscription to get narcotics, and paid for the drugs with his Medicade card. He was caught and convicted of welfare fraud as well as some other drug related crimes. He went to prison and did over two years time. When he got out of the prison, he went almost immediately to a hospital where he had massive abdominal surgery. Given his past chemical dependency, the perscription pain killers he was placed on caused him addictive related problems again. Not wanting to get back into the drug scene, he went to an addictive treatment program where he was brought down off of the prescription pain killers. At that point he was turned back out to face the community. He was a one armed, ex-con, ex-addict who had no marketable job skills, and considerable chronic medical problems. (He had worked as a professional drummer before losing his arm.) He looked for a job, and for some reason there just were not many jobs out there for a person of his description. He applied for SSI through the Social Security Administration, but found out he was not considered disabled enough to get anything. There was nothing for him, no welfare because of a fraud conviction over which he had already done prison time. He is still living on the streets today. He still has nothing, no benefits of any kind. He has not gone back on drugs, but he has to use virtually all of his energies figuring out

attm #12
3-26-85

ways to survive. He has nearly died at least once since be re-integrated into the community. This is the kind of person the current law is keeping off welfare.

The Senate amended this bill to read that the first conviction of welfare fraud would result in a three year suspension from benefit eligibility. The bill had initially been written to read, "one year." My personal feeling is that one year is long enough. While the person I have just described has survived well over three years through street wisdom, I do not believe others should have to or, would necessarily be able to, live as he has had to live.

Thank you for hearing me. I will be glad to respond to questions.

Attm. #13
3-26-85

March 22, 1985

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON SUPPLEMENTAL NOTE ON SB 162, AS AMENDED
PRESENTED TO THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE - March 26, 1985

This is the official position taken by the Kansas Department of Health and Environment on Supplemental Note to SB 162.

BACKGROUND INFORMATION:

Current legislation requires the Secretary of KDHE to review and submit an annual report to the Governor and Legislature relative to the status of Food Service and Lodging Licensing and Inspection program. This requirement was initiated when the Food Service and Lodging Board was abolished and inspection services and licensing responsibilities were transferred to KDHE. Since then the food service and lodging licensing and inspection program has been combined with the food and drug program within the Division of Health. Given the current program report and monitoring capabilities within the current budget system, it seems that a separate annual report is an inappropriate reporting means.

Reorganization of KDHE has transferred the responsibilities for food service and lodging regulation from the Division of Environment to the Division of Health. As a result of this intra-departmental transfer of program responsibilities, it has been recommended that the appropriate statutes be amended transferring the authority for issuing civil penalties from the Director, Division of Environment to the Director, Division of Health.

STRENGTHS:

The amendment to KSA 1984 Supp. 46-1212c deletes the reference in the statute to KSA 36-514. KSA 36-514, is repealed by SB 162 as amended. This action eliminates the requirement for the Secretary to submit the separate annual report on the status of the Food Service and Lodging licensing and inspection program.

SB 162 as amended, amends KSA 36-515b, placing the responsibility for food service and lodging regulation and licensing under the direction of the Division of Health rather than the Director of Environment.

WEAKNESSES:

There are no perceived weaknesses in the adoption of the proposed legislation.

DEPARTMENT'S POSITION:

The Department of Health and Environment recommends the passage of SB 162 as amended.

Attm. #13
3-26-85