F e t a l
A l c o h o l
S y n d r o m e

The Real Brain Drain

Paul Szabo, **M.P.**

"My son has fetal alcohol syndrome. He was diagnosed at age 8. I got pregnant between high school and college. I was a social drinker and have never had any problems with alcohol. I did not know I was pregnant until I was three-and-a-half months along. I stopped drinking then, but it was too late. The damage was done. Though I did not set out to harm my child, I did, and now I need to do whatever I can to make things easier for him."

Mother of an FAS child

"I don't know about you, but, I get really angry when I think about the fact that we are sacrificing kids to a life of anger and maladjustment, to potential violence, to potential criminal conduct and a life of incarceration – in and out of jails – when in fact, fetal alcohol syndrome is completely preventable."

The Honourable Anne McLellan,
Minister of Justice,
October 16, 1999

The "Uncopyright"

Paul Szabo, M.P.
March, 2000

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Foreward

In one week, as many as 10,000 babies are born in Canada. Of these, 3 are born with Muscular Dystrophy, 4 are born with HIV infection, 8 are born with Spina Bifida, 10 are born with Down Syndrome, 20 are born with Fetal Alcohol Syndrome and 100 are born with other alcohol-related birth defects.

Fetal Alcohol Syndrome, commonly known as FAS, refers to a group of physical and mental birth defects. Its primary symptoms include growth deficiency before and after birth, central nervous system dysfunction resulting in learning disabilities, and physical malformities in the face and cranial areas. Other alcohol-related birth defects involve central nervous damage like FAS but without the physical abnormalities. Since FAS is incurable, most victims will usually require special care throughout their lives. Depending on the severity, the estimated lifetime cost for the care of an FAS victim ranges from $3 million to $6 million.

The secondary symptoms of FAS victims relate to quality of life characteristics. 90% have mental health problems; 60% will be expelled or suspended from school or drop out; 60% will get into trouble with the law; 50% will go to jail or be confined in an institution; 50% will exhibit inappropriate sexual behaviour; 30% will abuse drugs or alcohol; 80% will not be capable of living independently; and 80% will have employment problems. Tragically, these severe problems could have been prevented if the mother had abstained from alcohol consumption throughout her pregnancy.

Alcohol is a drug and a toxic substance that can harm the fetus even at relatively low levels of exposure. Unfortunately, many do not believe this fact because of the mixed messages they

have received. In 1992, the Federal Minister of Health stated that, "Changes in fetal breathing and reduction of fetal blood flow to the developing brain have been linked to the ingestion of a single drink during pregnancy." However, in October 1996, a Joint Statement of 18 organizations recommended that "Health professionals should inform women who consumed small amounts of alcohol occasionally during pregnancy, that the risk to the fetus in most situations is likely minimal."

The terms moderate, social, and occasional drinking are all too loosely used in much of the literature. The degree of risk of these vague levels of consumption is also affected by factors such as the time in the pregnancy cycle, the amount of alcohol, genetics and nutrition. The literature, for the most part, suggests that everyone has to assess their own situation and define the terms for themselves. There is no standard nor consistency. However, experts do agree that "binge" drinking (five or more drinks on a single occasion) causes the most devastating effects on the fetus since it so sharply increases the amount of alcohol in the blood flow to the baby's brain in a very short period of time. On the other hand, some women who are alcoholics or heavy drinkers can occasionally deliver healthy babies. Is it any wonder that so many people are unsure or do not believe that low levels of alcohol consumption can hurt their unborn child?

Harm can also occur at any time during the pregnancy, even during the first month when most women do not even know that they are pregnant. Research findings suggest that days 15 to 22 is the period of pregnancy during which facial and cranial deformities could be caused by alcohol consumption. That is why women should not wait until they find out they are pregnant before they stop drinking.

Over 50% of pregnancies are unplanned. Therefore, if a woman is sexually active and pregnancy is possible, she should abstain from consuming alcohol. To choose not to abstain is the same as playing Russian roulette with the life-long health and well being of the child.

There is no recommended safe level of alcohol consumption during pregnancy and therefore the prudent choice for women is to abstain. Everyone in Canada should know that fact and they should have ready access to clear, concise, consistent and correct information about the risks and consequences associated with alcohol consumption during pregnancy.

FAS is most often described as the leading known cause of mental retardation. While it is true that it is more prevalent than both Down Syndrome and Spina Bifida, **FAS is not the cause.** The simple fact is that consumption of alcohol during pregnancy is the one and only cause. Why then are so many reluctant to say that? Part of the answer involves political correctness and sensitivity. Understanding the "why" is essential to explaining, in part, why FAS has not become an urgent national priority in Canada even though it should be.

FAS is a societal issue and we all have a vested interest and a role to play in reducing its incidence. It must become our cultural norm that drinking during pregnancy is inappropriate. Therefore, when we are in the company of a family member, friend or acquaintance, who is drinking and becoming at risk of harming themselves or others, we should intervene in an appropriate fashion to ensure that they do not become just another tragic statistic.

Strategies and recommendations have been proposed to Parliament in the past, but Health Canada has consistently

been unreceptive. For example, in 1996, health warning labels on the containers of alcohol beverages, as required in the U.S. since 1989, was unanimously supported by the 10 Provincial Ministers of Health, The Canadian Medical Association, The Canadian Nurses Association, The Addiction Research Foundation and The Canadian Centre on Substance Abuse among others. However, Health Canada and the Minister opposed the initiative and it was rejected. Coincidentally, the beverage alcohol industry also opposed labelling and the Canadian Brewers Association threatened to withdraw $10 million of their co-funding to Health Canada for other responsible use programs.

If programs to reduce alcohol consumption during pregnancy are successful, the alcohol industry loses. Since the objectives of Health Canada and the industry appear to be in conflict, possibly Health Canada should be weaned off its alcohol dependency. This would ensure that our health priorities are free of undue influence both in appearance and in fact.

This book is not just about FAS. It is about the wide range of alcohol-related birth defects, their cause, their symptoms and their consequences. The book also looks at caring for and interacting with victims, prevention approaches that have been tried, or are emerging, and research and studies that have been conducted over the past decade. In the final assessment, Canadians need to co-ordinate their efforts and consolidate their resources to convince governments that the prevention of Fetal Alcohol Syndrome should be an urgent national priority. Our children deserve nothing less.

Paul Szabo, M.P.
March, 2000

Chapter 1

FACTS ABOUT ALCOHOL

Alcohol is the most widely used and abused drug in North America. The active ingredient in all alcohol beverages is ethyl alcohol (ethanol), which is produced by yeast cells acting on carbohydrates in fruits and grains. Ethyl alcohol works much like ether, acting as an anesthetic to put the brain to sleep. Alcohol is a central nervous system depressant that slows down body functions such as heart rate and respiration. Small quantities of alcohol may induce feelings of well being and relaxation; but in larger amounts, alcohol can cause intoxication, sedation, unconsciousness and even death.

There are three types of alcoholic beverages: beer is fermented from grains that contain 3% to 6% alcohol; wine is fermented from fruit and normally contains 12% to 40% of alcohol; and liquor is made from distilled (boiled off) alcohol and contains 40% to 50% alcohol. In the industry, this is expressed as degrees of proof where two proof equals one-percent alcohol. Therefore, 80 proof liquor is 40% alcohol. As a comparison, 12 ounces of beer, a 5-ounce glass of wine and a cocktail with 1.5 ounces of 80 proof spirits all contain the same amount of absolute alcohol.

Drinking alcohol has different effects on different people. In addition, a certain amount of alcohol can affect the same

person differently on different occasions. Four factors influence how alcohol affects people:

- **Amount of alcohol** – The more alcohol, the stronger the effects. A person may drink beer, wine, or whiskey; what really matters is the amount of alcohol that is consumed.
- **Body weight** - people who weigh more are less affected by the same amount of alcohol than people who weigh less. Alcohol is water-soluble and heavier people have more blood and water in their bodies. Consequently, the same amount of alcohol will be more diluted. Gender also affects the influence of alcohol. Women have a higher proportion of fat and a lower proportion of water in their bodies than men. Therefore, a woman will have a higher blood alcohol content than a man who is of the same weight and drinks the same amount of alcohol.
- **Food** - alcohol "goes to the head" more slowly if one has just eaten or if one eats while drinking. Food slows the passage of alcohol from the stomach to the small intestine.
- **Attitudes** – What a person expects to happen after drinking does affect what does happen. The drinker who expects to get drunk is more likely to feel or act drunk. In one study, an experienced group of drinkers were given a glass of something non-alcoholic but were told it contained alcohol. Most of the group still got drunk.

When consumed, alcohol goes right to the stomach and passes through the small intestine where it is absorbed into the bloodstream. It takes about 30 seconds for the first amounts of alcohol to reach the brain after ingestion. Once there, alcohol acts primarily on the nerve cells deep in the brain. One drink for the average person will create a feeling of relaxation. Two drinks in an hour can affect the drinker's judgment and lower inhibitions. Five drinks in a two-hour period will raise the blood alcohol content (BAC) to 0.1

which is higher than the point of legal intoxication in most countries.

After five drinks of alcohol, the average drinker will experience blurred vision, slurred speech, poor muscle coordination, and a lack of rational judgment. Ten drinks will yield a BAC of 0.2. It will take 10 hours for the alcohol to be completely metabolized. After more than twelve drinks, the BAC will rise to 0.3 and the drinker will be in a stupor. A BAC of 0.4 to 0.5 will induce coma. A drinker in this condition may be near death because they could vomit and choke while unconscious. The breathing is likely to stop with BAC of 0.6. The BAC can be measured by using a person's breath, their urine or a blood test. The amount is measured as a percentage of how many parts of alcohol to how many parts of blood.

Eliminating alcohol from the body is a long process. About 90% is metabolized through the liver. The remaining 10% is eliminated through the lungs and urine. It takes about one hour to eliminate one-half ounce of alcohol.

Heavy drinking in a short period of time will often cause a hangover the next day. A hangover is a sign of alcohol poisoning; it is the body's reaction to alcohol withdrawal. Symptoms of a hangover include nausea, disorientation, headache, irritability and tremors.

Frequent and prolonged use of alcohol has many detrimental effects on the body. Heavy drinkers develop a tolerance for alcohol, which means that larger amounts of alcohol are needed to get the same effect. In addition to alcoholism, liver disorders, heart disease and reproduction problems are often prevalent with heavy drinkers.

The possible consequences of alcohol misuse are many. Based on recent data available from Health Canada, the Canadian Centre on Substance Abuse and the Addiction Research Foundation, the facts are as follows: 38,261 psychiatric and general hospital admissions; 17,080 cases of alcohol dependence syndrome; 966 cases of toxic poisoning; 19,163 deaths directly or indirectly caused by alcohol misuse; 10% of all neoplasms or tumors; 5% of all diseases of the circulatory system; 15% of all diseases of the respiratory system; 5% of all fetal defects; 45% of all motor vehicle accidents; 48% of all drivers killed in accidents are killed as a result of alcohol consumption, which means that 2,000 have been killed and over 10,000 injured in only one year; 40% of all accidental falls; 30% of accidents due to fire; 30% of all suicides; 60% of all homicides; 80% of all murders; 65% of child abuse; 50% of hospital emergency admissions; 70% of assaults; 50% of incidents of family violence and one in six divorces are all caused by alcohol consumption. It is also estimated that 10% of workers cost their employers 25% more than their basic pay due to alcohol related absenteeism, sick pay, and accidents.

Health research also continues to find other health consequences to babies whose mother drank during pregnancy. In 1996, Washington researcher, Xiao-Ou Shu, published a study which found that women who drink alcohol during the last six months of pregnancy increase by about 10 times, the risks that their babies will develop leukemia during infancy. Even with the steep increase in disease associated with drinking mothers, infant leukemia is extremely rare. The alcohol study was based on interviews with parents of 302 children who develop leukemia by the age of 18 months. For women who drank any amount at any time during the pregnancy, the risk of their babies developing infant leukemia

increased by 160%. For a specific type of the disease, acute myeloid leukemia, the risk was increased by 260% according to the study.

It is indeed tragic that one in ten deaths in Canada, or the deaths of about 19,000 Canadians, are from alcohol related causes each year. All of this is due to the irresponsible use of alcoholic beverages. It is costing Canada an estimated $15 billion each year in higher health, education, social, criminal justice and lost productivity costs, not to mention the devastating impact on family, friends and society as a whole.

Alcohol is a drug and a toxic substance which can affect the fetus even at relatively low levels of exposure. According to Health Canada, in terms of measurable adverse outcomes, reduced IQ scores at age seven years and low birth weight have been linked to having an average of two drinks or more daily during gestation. **Changes in fetal breathing and reduction of fetal blood flow to the developing brain have been linked to ingestion of a single drink during pregnancy.**

Due to its ready availability, and its potential for wide-ranging and life-long adverse impacts upon the developing brain, alcohol is clearly the most important of the intoxicant substances (including cocaine, heroin and solvents). Therefore, consumption of alcohol during pregnancy deserves more sustained attention from the public health community. The risk of adverse birth outcomes from alcohol depends on a combination of the alcohol dose (both the amount consumed and the pattern of consumption); the interaction of drinking with critical periods of development in different trimesters of pregnancy; and other factors such as poor nutrition and smoking. It is important to stress alcohol's impact on the fetal

brain, ranging from the subtle, but nevertheless significant, deficits and abnormalities, to severe learning disabilities and emotional / behavioural disorders.

When a pregnant woman drinks, the concentration of alcohol in her unborn baby's bloodstream is at the same or higher level than her own. Unlike the mother, the liver of the fetus cannot process alcohol at the same adult rate of 1 oz every two hours. High concentrations of alcohol can therefore stay in the fetus longer, even up to 24 hours. In fact, the unborn baby's blood alcohol concentration level can be even higher than the mother's during the second and third hour after a drink is consumed. This is because the fetal liver is so poorly developed in the early stages of pregnancy that it cannot metabolize the alcohol in their system as quickly as the mother.

Research for Canada's Drug Strategy has found that alcohol is "number one" among the drug problems experienced by Canadians. It is estimated that one in 10 Canadians is a drinker at risk. A 1990 survey by Health and Welfare Canada classified 84% of men and 77% of women as current drinkers (i.e., drank alcohol at least once in the past year). About two and one-half million Canadian women, in the reproductive age groups between 15 and 44 years of age, drank at least once weekly. Of these it was estimated that over 400,000 consumed eight or more drinks weekly. Men in these groups tended to be heavier drinkers than women.

According to Health Canada, researching the drinking habits of pregnant women and their partners is more difficult, and there are few Canadian studies. Preliminary findings of a study presented to a Parliamentary Sub-Committee in 1992 suggested that about 20% of pregnant women in an urban

sample consumed an average of 12 to 14 drinks weekly during the second half of pregnancy. Those who drank the most were often in disadvantaged circumstances, had no parenting partners or were involved in abusive relationships. Another small study conducted in 1990 in another urban area reported that over one-half of women contacted drank at least one to two drinks daily before pregnancy, and one-quarter of them drank that much during pregnancy. It remains difficult to estimate the numbers of drinking women at risk of having an FAS baby since national surveys tend to underestimate or not to reach the heaviest drinkers and do not cover the high-risk geographic areas in Northern Canada.

The women most likely to report having alcohol problems are under age 35, and the vast majority are between the ages of 20 and 34. Approximately 11% of this age group had alcohol-related problems or dependency. A 1995 school survey also found that in the months preceding the survey, 17% of the 9th grade girls and 35% of the 12th grade girls consumed four or more drinks at one time.

The economics of drinking also seems to affect consumption dramatically. It is interesting to note that according to CEA Economic Consultants, a 10% increase in disposable income leads to a 9.7% increase in the quantity of alcohol consumed. On the other hand, a 10% increase in the price of alcohol only leads to a 4% decrease in the quantity of alcohol consumed.

In August 1998, The Journal of the American Medical Association published a study by the Center for Disease Control on alcohol consumption by pregnant women in the United States during the period 1988 to 1995. The objective of the study was to examine the trends in alcohol use among pregnant women in the United States and to characterize

pregnant women who use alcohol, with emphasis on frequent use (at least five drinks per occasion or at least seven drinks per week). The findings indicated a substantial increase in alcohol use among pregnant women from 1991 to 1995. It was reported that despite a drop in consumption between 1988 and 1991, consumption increased from 9.5% of pregnant women to 15.3% in 1995. Among pregnant women who were frequent alcohol users, the number increased from 0.9% in 1991 to 3.5% in 1995.

Pregnant women who were at high risk for alcohol use were primarily college educated, unmarried, employed, or students, had household incomes of more than $50,000, or were smokers. Pregnant women who were at high risk for frequent alcohol use were more likely to be unmarried, or smokers. The report concludes that the increasing prevalence of alcohol use by pregnant women calls for increased ascertainment of alcohol use among preconceptional and pregnant women. Therefore it was recommended that brief interventions by clinicians, increased referral to alcohol treatment programs, and increased use of contraception by women of reproductive age who are problem drinkers should be considered as means of preventing alcohol-exposed pregnancies.

Chapter 2

FACTS ABOUT FAS

Virtually all Canadians are very familiar with the problems associated with drinking and driving and that is due to the relentless education of consumers. However, there is another problem virtually unknown, yet far more tragic. It is called Fetal Alcohol Syndrome, commonly known as FAS.

Fetal Alcohol Syndrome was formally identified in 1973. While conducting research on human behaviour teratology (the study of birth defects), Dr. Kenneth L. Jones and Dr. David W. Smith identified a specific pattern of malformations, growth deficiencies and central nervous system dysfunctions that were observable in some offspring of alcoholic mothers. They named this pattern Fetal Alcohol Syndrome.

Research shows that 5% of all fetal defects are due to alcohol consumption during pregnancy. FAS children can reflect some of the following symptoms: severe neurological disorders, social dysfunction, permanent behavioural problems, reduced lifespan, restricted brain development, learning disorders, hyperactivity, mental retardation, pre and post natal growth retardation, speech and vision impairment and physical deformities. In addition to retarded growth, FAS children usually display facial distortions, including a small head, small wide-set eyes, flattened cheekbones, a very thin upper lip and no groove between the upper lip and nose.

Each year, FAS costs Canada billions of dollars in direct costs. Since many FAS victims also end up in foster care, residential treatment, correctional and other out-of-home placements, there can be much higher costs. FAS is estimated to cost $3 million to $6 million during the lifetime of an FAS child. FAS is also estimated to cost Canadians $3 billion each year in terms of increased health, special education, social services and criminal justice costs.

Fetal Alcohol Effects, or FAE, is very similar to FAS, with the same range of problems but without the characteristic facial abnormalities. FAE occurs two to three times more frequently than does FAS and therefore its costs to society are proportionately higher.

There is little dispute in the medical profession that alcohol consumption during pregnancy can have harmful effects on the fetus. Their message is that there is no recommended safe level of alcohol consumption during pregnancy and that drinking during pregnancy can cause alcohol related birth defects, including FAS and FAE. All of these diseases are totally preventable. In the words of the beverage alcohol industry itself, drinking responsibly could mean not drinking at all.

The U.S. Surgeon General has stated that there is no known safe level of alcohol consumption during pregnancy. Social drinking increases the risk of subtle and lifelong brain damage but binge drinking (five or more drinks at one time) causes the most devastating effects according to many research studies.

Experts agree that the only way to prevent Fetal Alcohol Syndrome is to refrain from drinking any alcohol while pregnant. This also includes using many over-the-counter

medications that contain high levels of alcohol (cough syrups, some herbal tonics, etc). The public is warned that the simple absence of the physical characteristics associated with Fetal Alcohol Syndrome does not mean that serious brain injury has been avoided. As well, the facial characteristics are substantially being formed during days 15 to 22 of fetal development. Alcohol consumption during this period can therefore cause facial defects. Since most women pass through this period without knowing they are pregnant, it is equally important that they abstain from alcohol consumption whenever pregnancy is possible.

The effects of alcohol on the developing fetus have been well documented. The degree of injury depends on many factors including the timing, length and severity of the exposure, binge drinking, use of other drugs and genetic variations. It is also important to note that women who have delivered one child with fetal alcohol syndrome are at greater risk for delivering another child with the syndrome. International expert, Ernest Abel, estimates the risk at 70%. The Government of Alberta reports this number to be even higher at 77%. Abel also found that 35% of FAS children are born breech and that the figure would be 70% if cesarean section deliveries were included.

When a pregnant woman consumes alcohol, she does not drink alone. Alcohol is a known teratogen, which means that it is a substance that can damage or disrupt the developing embryo and fetus. The brain and the central nervous system of the unborn child are particularly vulnerable to prenatal alcohol exposure. Health Canada says that available evidence points to a still poorly understood, but worrisome, relationship between alcohol consumption and fetal injury. The concern is that women are at least as much at risk of alcohol dependence

as are men, given current drinking patterns. The important point to remember is that FAS/FAE impacts are serious and lifelong in their consequences for affected individuals and their caregivers. No safe level of alcohol exposure has been identified for the unborn baby.

Too many Canadians still believe that "moderation" in alcohol consumption is consistent with a healthy pregnancy. In their efforts to avoid causing undue anxiety or guilt, it is believed that many physicians still counsel "moderation" to their pregnant patients and thus give mixed messages about alcohol. The fact is that moderate use of alcohol has no place in pregnancy. The prudent approach, given what is now scientifically known or suspected about alcohol's fetal impacts, would be to recommend that pregnant women consume no alcohol, so as to reduce to zero the potential for harm to the unborn baby.

Four factors affect how severe the damage will be to the unborn baby:

(1) The time in the pregnancy at which alcohol is consumed.

Although the fetus may be most at risk in the first three months when vital organs are being formed, damage can occur anytime during the pregnancy. Alcohol may affect whatever growth or development is taking place at the time of the mother's consumption. The unborn baby's brain develops throughout a pregnancy.

(2) The amount of alcohol consumed during the pregnancy.

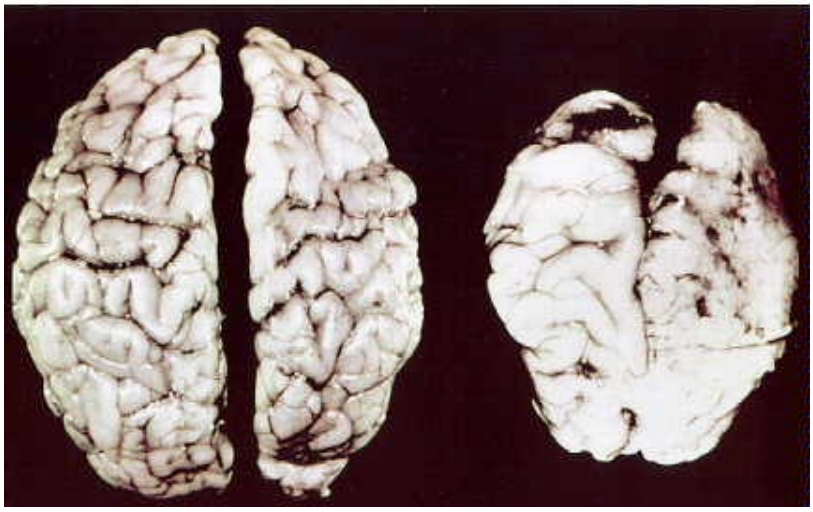
We know that there is a significant risk of FAS as well as stillbirth and spontaneous abortion with "heavy" drinking. However, no one knows how much alcohol a pregnant woman can drink without hurting the baby. "Binge"

drinking, which sharply raises the amount of alcohol in the blood, greatly increases the risk to the baby.

(3) Individual susceptibility to alcohol.
Genetic factors determine the baby's ability to deal with the alcohol in its system. These genetic factors also determine how quickly the alcohol in the baby's system can be broken down.

(4) Nutrition.
Alcohol affects how the placenta transfers important nutrients necessary for fetal growth. Good nutrition for the fetus is important throughout the entire pregnancy.

The most often quoted description of FAS comes from Stratton, Howe & Battaglia who authored **"Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention and Treatment"** in 1996. They defined FAS as referring to a constellation of physical and mental birth defects that may develop in individuals whose mothers consume alcohol during pregnancy. It is an organic disorder which is characterized by central nervous system involvement, growth retardation and characteristic facial features. FAS is a medical diagnosis that can only be made when a child has signs of abnormalities in each of these three areas, plus known or suspected exposure to alcohol prenatally. Other physical defects caused by prenatal exposure to alcohol may include malformation of major organs including heart, kidneys and liver and other parts of the body (e.g. muscles, genitals, bones).



6-Week Old Baby "Normal Brain" **6-Week Old Baby "Fetal Alcohol Syndrome Brain"**

In 1996, the U.S. Institute of Medicine published new diagnostic procedures for FAS to address confusion in terminology. They have recommended that the term Fetal Alcohol Effects ("FAE") be replaced by two terms; Partial FAS referring to the collective presence of some facial characteristics and physical and neurodevelopmental abnormalities and Alcohol-Related Neurodevelopmental Disorder ("ARND") referring to the presence or only neurodevelopmental abnormalities. The following is a brief summary of the diagnostic criteria for FAS and Alcohol-Related Effects:

1. FAS with confirmed maternal alcohol exposure

A. Confirmed maternal alcohol exposure

B. Evidence of a characteristic pattern of facial anomalies that includes features such as a flat

upper lip, flattened philtrum (upper lip just below the nose) and flat midface.

C. Evidence of growth retardation (below tenth percentile) as in at least one of the following:
   - low birth weight for gestational age
   - decelerating weight over time not due to nutrition
   - disproportionate low weight to height

D. Evidence of central nervous system neurodevelopmental abnormalities, as in at least one of the following:
   - decreased cranial size at birth (below the third percentile)
   - structural brain abnormalities
   - neurological hard or soft signs such as impaired fine motor skills, neurosensory hearing loss or poor eye-hand co-ordination

2. FAS without confirmed maternal alcohol exposure

B, C, and D as above. This new diagnostic category is helpful for the many children with FAS in foster and adoptive homes where details of their prenatal histories are unavailable.

3. Partial FAS with confirmed maternal alcohol exposure

A. Confirmed maternal alcohol exposure. This refers to a pattern of excessive intake characterized by substantial, regular intake or heavy episodic drinking. Evidence of this pattern may include frequent episodes of intoxication, development of tolerance or withdrawal, social problems related to drinking, legal problems related to drinking, engaging in physically

hazardous behaviour while drinking, or alcohol-related medical problems such as hepatic disease.

B. Evidence of some components of the pattern of characteristic facial anomalies

And either C, D or E.

C. Evidence of growth retardation (below tenth percentile) as in at least one of the following:
   - low birth weight for gestational age
   - decelerating weight over time not due to nutrition
   - disproportionate low weight to height

D. Evidence of central nervous system neurodevelopmental abnormalities, as in at least one of the following:
   - decreased cranial size at birth (below the third percentile
   - structural brain abnormalities
   - neurological hard or soft signs such as impaired fine motor skills, neurosensory hearing loss or poor eye-hand co-ordination

E. Evidence of a complex pattern of behaviour or cognitive abnormalities that are inconsistent with developmental level and cannot be explained by familial background or environment alone, such as learning difficulties; deficits in school performance; poor impulse control; problems in social perception; deficits in higher level receptive and expressive language; poor capacity for abstraction or metacognition; specific deficits in mathematical skills; or problems in memory, attention, or judgment.

Note that the term Partial FAS does not mean that the condition is less severe than FAS. In fact, Partial FAS can have equally serious implications for education, social functioning and vocational success. Many children diagnosed as Partial FAS would have been designated FAE ("Fetal Alcohol Effect") under the old system. The new category, like FAE, still requires knowledge of a child's prenatal history which is not always available in adoption situations. However, because children with Partial FAS do not exhibit all of the distinguishing characteristic facial features of full-blown FAS, the birth mother's drinking history becomes a crucial piece of the puzzle from a medical point of view - the piece needed to rule out other medical conditions that may be present. Nevertheless, the lack of a definitive diagnosis can be frustrating for adoptive parents whose children are exhibiting troubling behaviours.

The Institute of Medicine has included two additional categories which are used to describe very specific outcomes of prenatal alcohol exposure:

4. Alcohol-Related Birth Defects (ARBD)

This refers to a child who displays specific physical malformations resulting from confirmed maternal alcohol exposure. These may include heart, skeletal, sight, hearing and visual problems.

5. Alcohol-Related Neurodevelopmental Disorder (ARND)

This applies to a child with the confirmed history of prenatal alcohol exposure who exhibits central nervous system damage as in FAS, inconsistent with

> developmental level and cannot be explained by family background or environment alone (e.g. learning difficulties, poor impulse control, poor social skills, problems with memory, attention and judgment). Children's disabilities due to prenatal alcohol exposure frequently come from environments where there has been neglect and/or abuse. Therefore, it can be very difficult to separate which problems are due to alcohol effects and which can be explained by the family living situation. Usually there is a combined effect.

The forgoing represents the clinical description of the symptoms but the practical consequences to a human life are far more dramatic. Here are some of the many facts, points and comments you will see throughout the literature on FAS:

- FAS is 100% preventable by abstaining from alcohol consumption if you are pregnant or attempting to conceive.
- FAS is one of the leading causes of preventable birth defects and developmental delay.
- 60% of FAS victims over 12 years of age had been suspended, expelled or dropped out of school; 50% had inappropriate sexual behaviour; and 30% were abusers of drugs or alcohol.
- FAS occurs at least three times more often than Down Syndrome and almost eight times more often than Spina Bifida making it the number one cause of mental retardation and developmental disabilities. 95% of FAS/FAE victims suffer from mental health problems.
- A recent study of young offenders in Saskatchewan revealed that nearly 50% had been born with Fetal Alcohol Syndrome. Manitoba also found that over 50% of the young people in detention suffer from some degree of FAS.

- 75% of men with FAE and 55% of men with FAS get in trouble with the law. For the most part, crimes involve "borrowing without permission," but incidents of homicide do occur.
- Alberta Family and Social Services found that 29% of all children in their care have been affected by their mother's use of alcohol during pregnancy.
- 80% of FAS victims are unable to live independently and 80% experience problems with employment.
- An important social cost of FAS is the orphaning of young children. Studies have estimated that 69% of mothers with severely affected FAS children die before their child's third birthday, and 75% die before their child's sixth birthday.
- Health Canada, based on incidence rates found in the United States, estimates that there are one to two per 1000 children born with FAS in Canada.
- FAS is not genetic or inherited. It is permanent and irreversible and there is no cure or treatment.
- FAS affects children of all socio-economical levels. It is not just a poor person's problem and it is not restricted to any particular culture.
- FAS is more likely to occur following continuous or heavy intake of alcohol during pregnancy. However, some women who binge or drink sparingly have babies with alcohol-related damage. There is no definitive information regarding a safe quantity of alcohol use during pregnancy.
- Prevention of FAS is not just a woman's issue. Many pregnant women need support from their partners, extended family members and community in order to abstain from alcohol.
- The role of paternal alcohol consumption is unclear. While the term FAS describes the damage to the fetus caused by maternal alcohol exposure, research also

suggests that a father's use of alcohol may cause damage to the sperm. It is not yet known whether this damage affects the fetus and therefore men are also urged to abstain from alcohol consumption when planning or risking a pregnancy.

- Behavioural problems associated with FAS are not necessarily the results of poor parenting or a bad environment. People with FAS are born with some brain damage therefore they do not process information in the same way as most people and do not always behave in a manner that others expect them to. This brain damage can permeate even the best environments to cause behaviour problems and present parenting challenges.
- Children cannot outgrow FAS. It lasts a lifetime, although its manifestations and associated complications vary with age. Children with brain damage usually require a longer period of sheltered living and many need a stronger than usual support system to achieve their best level of adaptive living. Understanding this can help families plan effectively for structured transitions between school and work.
- Children with FAS may have poor impulse control and social skills, problems with money, attention or judgment. To compound the problem, many children are not eligible for special education or vocational education services because their IQ scores are often in the normal range.
- People with FAS often appear unmotivated and uncaring or act in ways that are considered irresponsible or inappropriate. This is because of their basic organic problems with memory, distractibility, processing information and being overwhelmed by stimulation. Basically, they have difficulty understanding. In addition, the repeated experience of failing to meet expectations can generate a general reluctance to meet challenges even in

someone with the best intentions. Self-control can be severely impaired and may result in crime, delinquency and other anti-social behaviour.

- FAS children often fail to consider the consequences of their actions. Many have problems that make it difficult for them to function independently as maturing teens and adults. They often are diagnosed as having other disabilities such as attention deficit or hyperactivity but treatment approaches for these other conditions are not always successful for children with FAS.
- The two greatest worries of many parents are that their FAS children may never be able to live independently or may get onto trouble with the law when they reach adolescence because of their disabilities. Studies have found that boys with learning disabilities, compared to those without, were more likely to become involved in violence, substance abuse and school disruption.
- FAS irreversibly reduces human potential. Those affected suffer brain damage that can result in an inability to learn from mistakes or to interact with others. They often exercise poor judgement and as adults, they frequently cannot keep a job.
- FAS significantly impairs information processing. This is the most devastating characteristic since our ability to process information impacts so many areas of our day-to-day lives. It affects their ability to translate information into appropriate action, or to judge the link between action and consequences. It reduces their ability to take information learned from one situation and apply it to another. It inhibits their ability to perceive and understand similarities and differences in people, places, things, and events. Finally, it affects their ability to assess a situation, to request direction, or to identify similar circumstances and take appropriate action.

As mentioned, drinking by the father can also directly and indirectly affect their offspring. Here are a few possible consequences noticed in the research literature:

- Alcohol lowers a man's testosterone levels.
- Heavy alcohol consumption during adolescence may permanently alter the DNA in the man's sperm.
- Alcohol use at the time of consumption inhibits sexual performance.
- Alcohol, used at the time of conception, decreases the mobility of healthy sperm thereby increasing the risk of birth defects.
- Babies born to alcoholic parents have an 80% risk of inheriting the tendency to become alcoholics.
- Children born to fathers who consume large amounts of alcohol are at greater risk for problems in life such as learning disabilities, behavioural problems, and mental health issues.
- Children born to alcoholic fathers may inherit a genetic tendency to become alcoholics themselves.
- Pregnant women are more likely to drink if their male partner drinks.
- Children of alcoholic fathers are at higher risk of being victims of abuse (physical, emotional, sexual).
- Children of alcoholic fathers are at higher risk of being victims or witnesses of domestic violence.

Considering the breadth of consequences of FAS and other alcohol-related birth defects to society, it is not surprizing that so many formal and informal groups have made this an important priority. Their advocacy has been responsible for most of the national attention that FAS has received to date.

The latest national focus came FAS in Canada came in October 1996. Health Canada and 18 of Canada's leading

bodies developed and issued a joint statement entitled **"Prevention of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) in Canada".** The Canadian Paediatric Society co-ordinated the project and the co-signers included the following organizations: Aboriginal Nurses of Canada, Assembly of First Nations Health Commission, BC FAS Resource Society, Canadian Centre on Substance Abuse, Canadian College of Medical Geneticists, Canadian Confederation of Midwives, Canadian Council on Multicultural Health, Canadian Institute of Child Health, Canadian Medical Association, Canadian Nurses Association, Canadian Paediatric Society, Canadian Public Health Association, College of Family Physicians of Canada, National Association of Friendship Centres, Native Physicians Association in Canada, Newborn Follow Up Program, Health Sciences Centre (Manitoba), Pauktuutit, Inuit Women's Association and the Saskatchewan Institute on Prevention of Handicaps.

This paper on FAS in Canada should serve as a good starting point for understanding the nature of FAS and the current thinking on how to address this tragic but preventable illness. The following are extracts from the Joint Statement:

"Fetal Alcohol Syndrome has been recognized in Canada as one of the leading causes of preventable birth defects and developmental delay in children." *(Authors note: FAS is not a cause. It is a medical diagnosis. The cause is alcohol consumption during pregnancy)*

"The purpose of this statement is to provide relevant and factual information to guide health care professionals in the treatment or counselling of women, their partners and families with respect to alcohol intake during pregnancy."

"No single group, organization, community, ministry, or level of government can deal effectively with the problem on its own. Broad-based efforts are required, given that everyone has a stake in addressing this complex issue."

"Still, there is no definitive information that can be conveyed to women regarding a safe quantity of alcohol use during pregnancy. Consequently, **the prudent choice for women who are or may become pregnant is to abstain from alcohol."**

"Prevention Efforts

Prevention is clearly the first line of defense against the effects of alcohol in pregnancy, and should include the following:

- **Primary prevention** - actions that avert a health problem before it occurs. In the case of FAS/FAE, this would include informing the public, particularly young people, about the dangers of drinking during pregnancy and on a broader level, addressing determinants of health.

- **Secondary prevention** - actions that identify persons at risk. Strategies should include screening and early intervention programs and services for pregnant women and women of childbearing potential who may be at risk for having a child with FAS/FAE.

- **Tertiary prevention** - actions that prevent recurrence of the condition through treatment and attempts to lessen the cognitive, behavioural, and social impact of FAS/FAE. Strategies should include diagnosis and programs designed specifically for children with FAS/FAE and their

caregivers, as well as treatment for women and their partners who already have one FAS/FAE child and plan to have more children."

"Because pregnant women generally are receptive to suggestions about controlling their alcohol consumption during pregnancy, the health care professional is presented with an excellent opportunity to encourage behavioural change. Early recognition of women who drink alcohol during pregnancy and appropriate counselling are the cornerstones of treatment. Health professionals can play a key role in reducing the risks associated with alcohol use during pregnancy."

"Recommendations

FAS/FAE are preventable. To that end, it is recommended that:

1. **Prevention efforts should target women before and during their childbearing years, as well as those who influence such women, including their partners, families, and the community.** All efforts should be: family-centred and culturally sensitive, to address the pregnant woman as well as her partner and family in the context of their community; and comprehensive, to draw on all services appropriate to the often complex social, economic and emotional needs of these women.

2. Information should be provided to all health professionals regarding the risks of alcohol use during pregnancy to facilitate early recognition of at-risk drinking and early intervention.
3. Continuing education programs for health professionals

designed to enhance counselling skills that motivate and support lifestyle change for at-risk drinkers, should be widely disseminated and evaluated. Furthermore, health professionals should acquaint themselves with resources available in their community to provide support and motivation for change for at-risk drinkers.

4. **Health professionals working with members and leaders of communities must provide consistent information to women and their partners that the prudent choice would be not to drink alcohol during pregnancy.**

5. Health professionals play an essential role in identifying women who drink at levels that pose a risk to the fetus and themselves. Screening methods should be applied to identify women at high risk for heavy alcohol consumption before and during pregnancy. Similarly, health professionals have a responsibility to inform women at risk, and to initiate appropriate referrals and supportive interventions.

6. Alcohol and drug addiction treatment services should incorporate the needs of women, including transportation and daycare, into their program design. Pregnant women seeking help should be given high priority at alcohol and drug addiction treatment centres.

7. **Health professionals should inform women who consumed small amounts of alcohol occasionally during pregnancy, that the risk to the fetus in most situations is likely minimal.** They should also explain that the risk is relative to the amount of alcohol consumed, body type, nutritional health and other life-style characteristics

specific to the expectant mother. If exposure has occurred, health professionals should inform mothers that stopping at anytime will have benefits for both fetus and mother.

8. Health professionals, including family physicians, paediatricians and others to whom children are referred, should increase their awareness of maternal alcohol use in pregnancy to identify the possible causes of birth defects and other developmental disorders and to identify and prevent adverse risks for subsequent pregnancies.

9. Communication between researchers and health-care providers must be an ongoing process to determine and evaluate the most effective means of primary, secondary, and tertiary prevention of FAS/FAE."

"Conclusion

Alcohol use during pregnancy is a national health concern. Health professionals across Canada are committed to identifying and implementing prevention strategies that will reduce the incidence of FAS/FAE."

When you have so many different groups involved in a project, it is understandable that any consensus document would be general and low risk in terms of specific actions.

I was particularly pleased with the first recommendation because it acknowledges that we all have a vested interest and a role to play when it comes to alcohol abuse. This theme is covered more fully in the chapter on Drink Smart Canada.

I was not pleased, however, with recommendation 7. You will

note in recommendation 4. that the message is to provide consistent information that the prudent choice is to abstain from drinking alcohol during pregnancy. However, what kind of message do you send to women in recommendation 7, when you say to women, who had consumed small amounts of alcohol occasionally during pregnancy, that the risk to the fetus in most situations is minimal? Not only is this inconsistent, it is contradictory. The statement does not define "small amounts" or "occasionally" and therefore, the judgement as to what constitutes "minimal risk" is left with the individual. The consistent message is that there is no safe level of alcohol consumption during pregnancy but the leading health organizations in Canada took a soft stand on some consumption. This is one of the reasons why FAS is not a national priority. The qualified position is simply not strong enough to change the status quo.

The preferred message is: **"If you are pregnant, do not drink. Otherwise you are taking a risk."** Furthermore, if we are to get the message out, we need the political will to launch a massive public awareness campaign**. It has to become the cultural norm that it is totally unacceptable for pregnant women to drink.** It is a strong but necessary message which protects the best interests of the unborn child ahead of the individual needs and rights of the mother. Therein lies the dilemma. The ethical and legal considerations are complex but crucial to making any meaningful progress on the FAS tragedy.

Chapter 3

CARING FOR FAS VICTIMS

Once a child is diagnosed with FAS or other alcohol-related birth defects, the challenge for society shifts from prevention to damage control. FAS is incurable and its symptoms are forever. Therefore those responsible for the formal and informal care must to be educated on how to respond to the needs, wants and actions of the affected person. Very few FAS persons will ever be able to care for themselves or to be independent. It is a lifetime of care and supervision for most.

According to Dr. Julianne Conry of the Department of Psychology and Special Education at the University of British Columbia, "*Awareness of what FAS/E means often comes about as a result of a personal experience with an affected child. These are the children whose learning and behaviour baffle their parents, teachers, doctors and social workers. The children are frequently misunderstood by those around them, but the puzzle is unlocked with the diagnosis of FAS/E. … Complex problems such as FAS/E do not have simple and quick solutions. There is no single right way to parent or teach a child with FAS/E. Each child is unique. By recognizing each child's particular strengths and weaknesses, it becomes possible to devise ways of teaching/parenting that will allow him/her to be successful. However, even our best efforts may be defeated. This is a lifelong effort and success is often measured in small increments. Support for children,*

their families and communities begins with knowledge and understanding of this invisible disability. … Many individuals with FAS/E, but not all, are prone to mental health problems, disrupted school experiences, trouble with the law, alcohol and drug problems and difficulties living independently in adulthood. On the positive side, the factors protecting the child from this outcome include - not surprisingly – a nurturing, stable home environment and an early diagnosis so that interventions can be put in place at an early age."

In February 1998, The Adoption Council of Canada published the second edition of **"Parenting Children Affected by Fetal Alcohol Syndrome – A Guide for Daily Living"**. This publication was updated to incorporate significant advances in the field.

In 1996, in addition to the Canadian Joint Statement, there were two other developments in the United States. The University of Washington published **"Understanding the Occurrence of Secondary Disabilities in Clients with FAS and FAE"** which was the first comprehensive long-term follow-up into adolescence and adulthood of individuals with FAS/FAE. In addition, the Institute of Medicine of the National Academy of Sciences published new terminology and diagnostic procedures for FAS. This publication was based on recommendations of an international committee mandated by the U.S. Congress to review FAS in response to confusion around terminology, diagnostic practices and the disorder itself. They examined issues including those surrounding diagnostic categories and techniques, the prevalence of FAS and related disorders, and the availability of treatment programs for affected individuals.

The Adoption Council publication is one of the most current and objective compilations which I encountered in my research. They have relied, where possible, on authoritative sources which enhances not only credibility but promotes consistency and clarity. Too often, I found articles and web sites which are more a reflection of enthusiasm than facts. If we are to make progress on prevention, diagnosis and caregiving of affected persons, **we need to sing from the same song sheet.**

After laying the foundation with definitions and facts, the publication paints a picture of common manifestations of FAS persons at various stages of life. Here are a few extracts:

Infancy – often tremulous; weak sucking reflex; sensitive to sights, sounds and touch; and slow to learn to walk and talk.

Preschool – poor motor co-ordination; delay in expressive speech; unable to comprehend danger; does not respond well to verbal warnings; and prone to non-compliance.

Early School – delays in reading, writing and arithmetic; requires constant reminder for basic activities; information is learned, retained for a while and then lost; memory deficits; and difficulties with social skills and interpersonal relationships.

Middle School - delayed physical and cognitive development; difficulty maintaining attention; hence to fall further behind peers as work becomes increasingly abstract and concept based; and a pattern of school suspensions may start.

Adolescence - Increased truancy, school refusals and school dropouts; increased behavioural disruption in school; math

tends to be the most difficult task; difficulty showing remorse or taking responsibility for actions; high risk for problems with the law and involvement in the criminal justice system; and problems managing time and money.

Adulthood (18+) - difficulty holding down jobs; poor social skills; unpredictable behaviour; depression; and possible drug or alcohol abuse.

Considering the range of manifestations noted above, it is readily apparent that caregivers of persons affected by FAS need to be aware that traditional responses to inappropriate behaviour may not be constructive. FAS children need a structured environment and they need to be carefully supervised so that they do not get into trouble or place themselves in dangerous situations. Parents and teachers need to offer simple directions and orders, stated briefly in simple language and each task has to be broken down into small steps and be taught through repetition and reward. Finally, skills should be taught in the context in which the skills are to be used, rather than assuming children will generalize from one context to another or understand in which situations their behaviour is appropriate.

Managing behaviours is a big part of addressing the needs of persons with FAS. Patience, a structured environment and close supervision are key to successful approaches. According to the Alcohol Related Birth Injury Resource Center, there are approaches that will not work such as analysing the behaviour, moralizing and traditional methods of discipline.

If you ask an FAS student why they did something, they will tell you “I don't know.” The fact is that no matter how long you make them sit and reflect on the reasons for their

outbursts, insight will not occur. They truly do not know why they did it, but teachers with an understanding of FAS will know the real cause for the "I don't knows" is the alcohol that has injured the child's brain. In addition, explaining in detail why their behaviour has a negative impact on the learning environment of the other children may make the teachers feel better, but it certainly will not impact the behaviour of the FAS child. Again, it is extremely important to remember that the injured brain is not able to process thoughts in traditional ways. The moral of the story is that when it comes to dealing with behaviour patterns of FAS victims, do not expect traditional approaches to obtain the desired responses.

Discipline in traditional methods is also a non-starter. The FAS child is not able to truly understand the principle of cause and effect. It is essential that the teacher change the focus of discipline as a consequence to unruly behaviour to prevention of the opportunities for bad behaviour. The following is an excellent example of why the concept of cause and effect may not apply to FAS kids.

Mike was a five year-old FAS diagnosed child who recently entered kindergarten. He was a small child but was constantly moving about and quickly became a behaviour problem. David was also five years old and of small stature but he was willing to fight for his toys. It did not take long before Mike and David were labelled as problem students. But they both had a habit of hitting other kids without provocation. The teacher felt that the only way to change their behaviour was to remove them into the hallway outside of the classroom when they were acting up. She felt they would realize that by hitting, they would suffer the consequence of isolation.

After nearly two weeks of behaviour management strategy, the teacher noticed something interesting. When David began fighting with another child, he would look her way and stop the activity once eye contact had been established. Mike responded differently. The next time the teacher observed him becoming agitated with another student, she was stunned to see that Mike hit the child and then ran straight to the hallway and assumed the timeout posture. There was a response, but not the one that was desired.

This scenario depicts the impaired cognitive functioning suffered by FAS students. David quickly learned that by causing disruption in class, he would suffer the consequences of isolation. Mike interpreted the situation differently. He determines the ritual to be a process. "I fight then I go to the hallway and stare at the wall. Remember, do not ask why because FAS kids really do not know.

The Adoption Council publication correctly points out that all children, alcohol affected or not, are first and foremost individuals with distinct personalities, preferences and temperaments. What works for one child may prove inappropriate or ineffective for another. **If you have told the child a thousand times and he still does not understand, then it is not the child that is the slow learner** (Walter Barbee). Caregivers of FAS persons need to be educated particularly on how to communicate effectively, how to give constructive feedback and how to provide a structured, consistent environment. As the child reaches adolescence and adulthood, the risk of a crisis developing increases. Whether it is sexuality, school, independence, work or involvement with the criminal justice system, they all provide new stresses on top of the special needs that caregivers have coped with since childhood.

Due to these stresses, caregivers need respite care which may not always be accessible or available. The book quotes an adoptive parent as follows: "We felt like prisoners in our own home because we dared not expect friends or grandparents to manage the children in our absence." The final message to parents is quite powerful. It reads: "Even if you're faced with what seems like a worst-case scenario - the interventions have failed or come too late, the child has left home or the child has been removed from the home - this doesn't mean you have failed as a parent. It is helpful to remember that you are not there to make a person's life – you are there to be with them while they live it. You can help them, hold their hand and support them, but there are some things you cannot control. Being a parent does not mean you have to live with the child 24 hours a day. Being a parent means being an advocate, somebody sending that child love from somewhere in the world, making sure that the child gets services, and providing a safe place for the child to phone home to. In some circumstances, parenting from a distance is the best way of taking care of yourself and taking care of your child."

There is much said about the financial costs associated with FAS but we should not forget that there are substantial the human costs. In their presentation to the Standing Committee on Health, the Alcohol Policy Network noted those human costs as follows:

GRIEF…over a child who will never lead an independent life;

BETRAYAL… by a system that says, "Don't ask questions; you're lucky we found a baby for you to adopt."

ABUSE…of caregivers, from systems that tell them they are entirely at fault for their child's behaviour.

ABANDONMENT…by spouses and partners who burn out trying to cope.

SENSE OF FAILURE…that despite all the best efforts, the child will end up in a specialized foster home, the penal system or on the streets.

REMORSE…because the other children in the family have been neglected, because the afflicted child (or adult) requires all the attention.

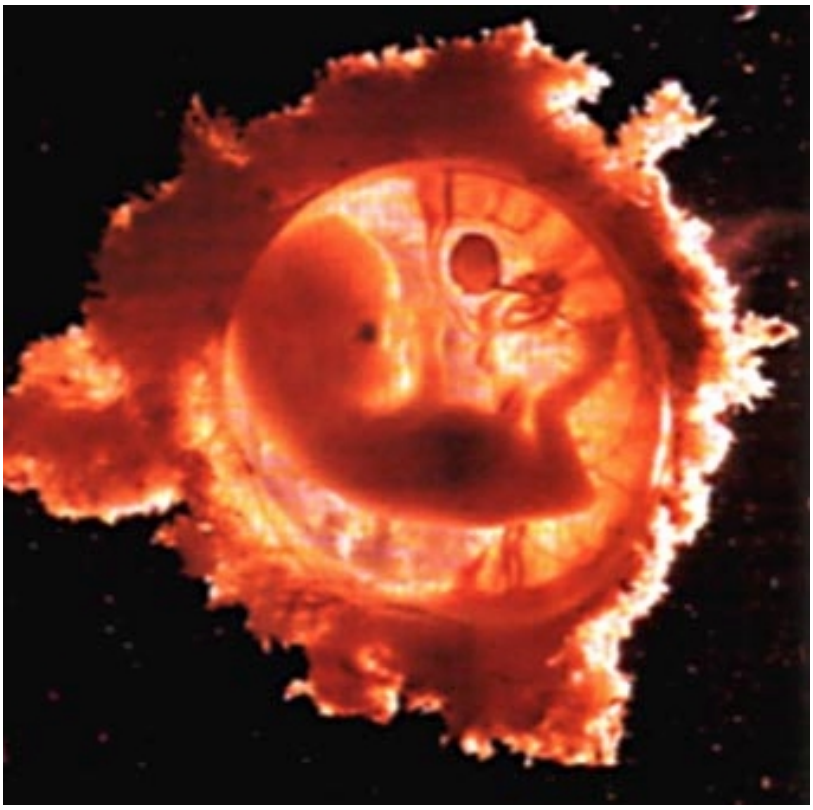
Caring for FAS victims requires knowledge, patience, love and the ability to cope in stressful and often frustrating situations. Their families and other caregivers need our help and support while we work to reduce the incidence of FAS.

Chapter 4

PARLIAMENT STUDIES FAS

FAS has often been on the agenda of Parliament through Private Member's Bills dealing with health warning labels on the containers of alcoholic beverages, statements and speeches in the House of Commons and through studies in Committees. The most recent focussed effort was a study by the Standing Committee on Health and Welfare, Social Affairs, Seniors and The Status of Women in 1992. Chaired by Dr. Stan Wilbee, a Health Sub-Committee conducted hearings and in June 1992 tabled its report **"Foetal Alcohol Syndrome – A Preventable Tragedy."** Research at the time indicated that 78% of Canadians were current drinkers; that the use of alcohol was firmly entrenched in Canadian society; and sales of alcoholic beverages amounted to $9.6 billion. Noting that the effect of maternal alcohol consumption on the fetus had been an area of concern for over a century, the report repeats one of the most often quoted statements on the subject:

"Today, there is no question that maternal alcohol consumption can have devastating impacts on the fetus. The basic fact is that when the pregnant women drinks, her unborn child "drinks" also; that is, the alcohol in the mother's bloodstream circulates through the placenta and into the bloodstream of the fetus. It is possible that the blood-alcohol level of the fetus will remain at an elevated level for a longer period than that of the mother because the immature fetal liver metabolizes the alcohol more slowly."



Fetus at two months.

At the Committee hearings, Dr. Oscar Casiro of the University of Manitoba gave evidence about the difficulty of making an early and accurate diagnosis. He stated that FAS is not always evident for the first few months of life. Since there is no clinical test, it takes time to identify the spectrum of abnormalities which can characterize FAS.

One of the consequences of FAS noted in the report is the effect on neonatal mortality rates. This is rarely mentioned in

current literature but clearly the impacts of FAS should not be ignored. The Committee was told that neonatal death rates for FAS babies are higher than normal. This may be due to the fact the mother is intoxicated at the time of birth and the baby then goes through withdrawal, which accounts for the higher mortality. Death rates in early infancy are also higher than normal, usually because of a failure to thrive. This may be due to poor parenting skills and a poor home environment which itself may be the result of parental alcohol use. Other higher-than-normal incidence of health problems include impaired walking, speech impediments, dental problems, vision problems and hearing difficulties.

The Association of Canadian Distillers spoke of FAS only in terms of abusive amounts of alcohol during pregnancy as did The Brewers Association of Canada. They also stated that there were still questions about whether there was any risk associated with the moderate consumption of alcohol during pregnancy. They cited a 1991 paper in the British Medical Journal suggesting that consumption of one drink per day is safe for pregnant women. However, Dr Casiro, testified that the study had methodological flaws. He was concerned that 30% of the children studied were not followed for the full 18-month term and that the diagnostic test used was not sensitive enough to detect subtle alcohol-induced damage in the children.

The report also includes an important section on adoptive children with FAS. Because FAS is not easily detectable during the early stages of life, many affected children are put up for adoption or end up in foster homes because the mother is unable or unwilling to keep them. In most cases, adoptive parents are unaware that the children have been damaged by alcohol until the child is at least several years old. It is not

until that stage that their learning disabilities and their inherent socially dysfunctional traits become obvious. The adoptive parents find themselves faced with a medical and social situation for which they are often totally unprepared.

The Sub-Committee reports correctly that FAE is much more prevalent than FAS and is caused by a lower level of alcohol consumption by the mother. Although FAE children may not exhibit the same physical deformities as FAS children, they can suffer the same problems associated with alcohol induced brain damage. The differences between FAS and FAE may account for the disparity in the numbers of children affected.

Based on their work, the Sub-Committee developed 21 recommendations for the Minister of Health who responded with his own report in December 1992. All recommendations were directed to the Federal Government and, where applicable, in co-operation with Provincial and Territorial Governments or other applicable agencies or organizations. The following is a brief summary of those recommendations and the Government's response:

1. **Create a National Advisory Committee on Alcohol and the Fetus.**
   The Sub-Committee felt that alcohol consumption during pregnancy was a very serious issue and that the potential risks to the fetus merited a higher profile. They wanted it separated from other drugs because alcohol is a legal product.
   The government rejected the recommendation and suggested that the issue is better addressed within the context of broader national policy initiatives aimed at improving the prospects for healthy pregnancies and reducing alcohol and other drug abuse.

2. **Establish a National Resource Centre on Alcohol and the Fetus.**
   The purpose would be to disseminate information across Canada and to develop treatments for victims and drinking mothers.
   The Government rejected this recommendation preferring to leave the role to the Canadian Centre on Substance Abuse and encouraged all other groups to interact to ensure that requests for information are appropriately channeled.

3. **Establish Provincial and Territorial Co-ordinators to focus on prevention, identification of high-risk persons, clinical services and treatment and care facilities.**
   Essentially, they concluded that there was a need for improved co-ordination of Provincial resources, programs and activities.
   The Government rejected the recommendation suggesting that problems could be best addressed by existing service providers.

4. **Organize a National Conference on FAS.**
   The purpose was to promote the exchange of information, to stimulate research and treatment activity, and to raise public awareness.
   Health Canada agreed with the recommendation and hosted a symposium in Vancouver B.C. in October 1992. They also hosted a Workshop in St. John's Nfld. in July 1994.

5. **Require health warning labels on the containers of alcoholic beverages alerting consumers that alcohol**

consumption during pregnancy places the fetus at risk for FAS or FAE.

The beverage alcohol industry opposed this action stating that awareness was already high; that warning labels are not effective in raising awareness; and that it would cost money to print warning labels which could better be used elsewhere. All other witnesses supported the initiative.

The Government rejected the recommendation but invited the Provinces to collaborate with the Federal Government in developing ways of testing the impact of warning labels with a goal of arriving at a "made-in-Canada" approach. This has not happened despite the unanimous support of the Provincial Ministers of Health. Funds were appropriated for the project but it was cancelled by the subsequent Federal Minister of Health.

6. **Health warning labels should be designed with regard to readability, perceptual prominence, colour contrast and impact.**

   See recommendation 5.

7. **Develop appropriate warning signs for establishments serving and selling alcoholic beverages or supplies to alert customers to the risk for FAS or FAE.**

   The objective is to establish a uniform program of warning signs across the country to compliment warning labels.

   The Government rejected the recommendation saying that it was the responsibility of local jurisdictions.

8. **Ban advertising of alcoholic beverages, generally known as "lifestyle advertising" on radio and television in Canada.**

   The concern was that the promotion of moderate drinking and a healthy lifestyle is overwhelmed by the amount of

product advertising by the alcohol industry. They viewed this as a matter of public interest in the context of national health policy.

The government noted that the Association of Canadian Distillers had launched a court action challenging the CRTC's authority to regulate advertising. They committed to continue to examine alcohol advertising and promotional trends and their possible adverse impacts.

9. **Require that appropriate and effective warnings about the serious impacts of alcohol on the fetus be included as part of all forms of advertising of alcoholic beverages in Canada.**
   See recommendation 8.

10. **Regularly review and evaluate current public awareness and education programs on the impacts of alcohol on the fetus. Programs should be maintained, expanded or replaced as warranted.**
    The Committee felt that the issue of public awareness and education was important because prevention of disease is the first line of defense in health care.
    The Government stated that recommendations 10. and 11. are predominantly provincial jurisdiction.

11. **Develop and implement awareness and education programs directed at Canada's primary and secondary school systems, the judiciary, and social and child-welfare services to increase awareness and understanding of FAS.**
    The Committee noted that many institutions and individuals who come into contact with persons with FAS or FAE are not aware of the problems faced by these persons or how to respond to their situations.

See recommendation 10.

12. **Upgrade the curriculum of medical schools, schools of nursing, and other relevant health-care educational institutions with respect to the impacts of alcohol on the fetus in particular and on human health in general.**
    The evidence suggested that health-care professionals, particularly family physicians, were not well enough versed in the impacts of alcohol on the fetus to provide accurate and effective advice and guidance to pregnant women.
    The Government stated that it was up to the health-care professions to set curricula.

13. **Design and carry out an epidemiological study to determine the incidence of FAS/FAE in the general population and in targeted high-risk sub-populations.**
    The Sub-Committee concluded that the incidence of FAS/FAE in Canada was not known with any accuracy and more research is needed.
    The Government said it would be necessary to develop a consensus on a case definition of the adverse effects of fetal alcohol exposure. The Department of Health would then explore the feasibility of the recommended study.

14. **Lead and assist in developing effective diagnostic tools for health-care professionals to identify and assess the special care and treatment needs of children born with FAS/FAE so that early and accurate diagnosis of these conditions might be made and appropriate treatment programs prescribed and applied.**
    This recommendation responds to the view that early diagnosis will mean more timely treatment in the best interests of all.

See recommendation 12.

15. **Initiate a program of research to develop more effective methods for the treatment, care and training of children with FAS/FAE so that these individuals can maximize their intellectual and employment potential.**
    Testimony suggested that treatment of FAS/FAE victims is typically inadequate and not uniform across the country.
    The Government said that this was provincial jurisdiction.

16. **Develop more appropriate, effective, and economical treatment-delivery programs for victims of FAS/FAE.**
    The effectiveness of treatment and training methods will be useful only to the extent that they can be delivered to persons in need. One of the major needs is for financial assistance to parents, particularly adoptive parents of persons with FAS/FAE.
    The Government said that this was provincial jurisdiction.

17. **Develop and implement programs to subsidize adoption of children with FAS/FAE.**
    Many mothers of FAS/FAE children are either unwilling or unable to provide care. Financial assistance would help many foster parents to adopt these children.
    The Government said that this was provincial jurisdiction and that they assist through the income tax system.

18. **Establish a special Aboriginal Committee on Alcohol and the Fetus.**
    Due to the much higher incidence of FAS/FAE among aboriginal peoples, it was felt that a dedicated committee was appropriate.

The Government generally agreed with recommendations 18, 19 and 20. They noted that the Canadian Centre on Substance Abuse has a separate group focussing on aboriginal needs.

19. **Design and deliver an aggressive public awareness campaign for aboriginal communities.**
    Testimony supported an aggressive social marketing plan to make people aware of the risks associated with prenatal alcohol consumption.
    See Government response to recommendation 18.

20. **Develop more effective and appropriate community-based programs to deal with learning disabilities of aboriginal individuals afflicted with FAS/FAE.**
    It was felt that the most effective solutions for aboriginal communities would be derived from the community itself, rather than be imposed from outside.
    See Government response to recommendation 18.

21. **Design and implement a research program to develop diagnostic procedures to identify adults afflicted with FAS/FAE.**
    The concern was that there are many FAS /FAE adults in Canada who have not been properly diagnosed. This research initiative would serve as a first step in a comprehensive program to provide assistance to afflicted adults.
    The Government simply hopes that improved awareness on behalf of social service and criminal justice agencies will increase sensitivity to the existence of FAS/FAE adults.

The Health Sub-Committee had done a good job on getting the pulse of the nation through the experts who have worked extensively on addressing areas related to FAS/FAE.

Furthermore, their recommendations called out for a unified strategy across the country which would make FAS/FAE a true national priority. The Government, represented by the opinions of Health Canada, rejected that call and effectively opted for the status quo.

Health Canada's reluctance to champion any new initiatives is hard to understand. The historic pattern of rejecting a clear consensus of the public, national healthcare experts and health-related organizations is very troubling. Although they did not explicitly support the arguments of the beverage alcohol industry, Health Canada effectively adopted their position that there is no need for new initiatives to increase public awareness of the risks associated with consumption of alcoholic beverages. The burden of proof has not been satisfied and therefore the public interest does not appear to have been served.

Chapter 5

MODEL STRATEGY FOR FAS

In February 1998, the State of Minnesota published the report of the Governor's Task Force on Fetal Alcohol Syndrome. Entitled **"Suffer the Children: The Preventable Tragedy of Fetal Alcohol Syndrome"**, the report is an excellent review of FAS and where we are in terms of prevention, diagnosis and treatment. They characterized FAS as a health issue that is totally preventable and conclude that the primary focus should be on community awareness as a whole and not simply on the individual. Their principal findings and recommendations for a comprehensive strategy are as follows:

1. **Low public awareness is impeding prevention efforts.**
   - Conduct public awareness campaigns which use positive messages that appeal to both men and women and reach those of all cultural backgrounds.
   - Establish and publicize a central source of information.
   - Encourage the business community to offer employees incentives for healthy pregnancies.
   - Work with non-profit, civic, religious and service groups on prevention and awareness.
   - Include prevention messages in school-based drug and alcohol awareness programs and in sex education and parenting classes.
   - Fund research to better understand FAS.

2. **A lack of solid data masks the full costs and extent of FAS.**
   - Conduct research to reliably estimate the incidence of new cases and the total number of persons with FAS.
   - Determine the monetary costs attributed to FAS.

3. **High-impact advertising of alcoholic beverages overshadows public messages about responsible drinking.**
   - Involve the beverage alcohol industry in pubic awareness campaigns and education.
   - Ensure that prevention messages are displayed wherever alcohol is served.
   - Restrict number and location of alcohol-related billboards.

4. **Too little is done to identify, warn and help women who are likely to drink during pregnancy.**
   - Train health care professionals to routinely screen for alcohol use during pregnancy. Child protection workers, social workers, correctional officers and people in other related professions should be trained to look for signs of alcohol use during pregnancy and to provide referrals for treatment.
   - Expand maternal-child substance-abuse projects.
   - Develop a specialized chemical dependency treatment program for pregnant women who may themselves have fetal alcohol syndrome.
   - Create a model program to prevent additional births of children with FAS to women who already have such a child.
   - Fund programs to help women at highest risk of abusing alcohol or of having additional children with FAS.

- Require children's mental health programs, family service collaboratives, early childhood screening and other similar programs to provide prevention education about the risk of drinking during pregnancy.
- Develop and support coordinated efforts among public health nurses, community health agencies, health-care providers and social services to identify and help women likely to drink while pregnant.
- Develop a long-range plan to provide chemical dependency treatment services to pregnant women.
- Expand the number and capacity of programs offering comprehensive services (counselling, family planning, parenting skills and support groups) to help women stop drinking during pregnancy, as well as the number of inpatient and outpatient treatment centers and halfway houses serving pregnant women and women with children.
- Change the local dependency assessment criteria so that the use of alcohol during pregnancy is a qualifying factor for admission to treatment.
- Develop a mandatory reporting process for referring a pregnant woman to chemical use screening and assessment.
- Expand the law to allow for a pregnant woman unable to stop abusing alcohol to be placed in the least restrictive alternative necessary to receive appropriate treatment. Revise the definition of "chemically dependent person" to include a pregnant woman who has engaged in acts of alcohol abuse.
- Revise the law to require mandatory reporting of alcohol use during pregnancy. Under a mandatory reporting process, a woman will first have a chance to voluntary receive treatment before involving her in the legal system. A woman would be considered to be

abusing alcohol during pregnancy if she meets one of the following conditions: requires detoxification during pregnancy; habitually consumes three or more drinks at one time knowing of the pregnancy; refuses to stop excessive drinking during pregnancy; appears intoxicated based on two or more of following indicators: odour of alcohol; slurred speech; eyes do not track together; impaired balance; difficulty remaining awake; consumption of alcohol; responding to sights and sounds that are not actually present; or extreme restlessness, fast speech or unusual belligerence.

5. A staggering number of children with FAS are not diagnosed at all, diagnosed late or misdiagnosed.

- Develop a diagnostic clinic network to coordinate services and information among screening programs, diagnosticians, clinics and other centers.
- Ensure that comprehensive screening for FAS includes all age groups and is done by many agencies, as well as the hospitals and outpatient programs.
- Require screening of children the court has found in need of child protection or services, when there is evidence of chemical dependency problems in the biological mother.
- Include FAS as part of chemical dependency assessment process.
- Work to have definitions of FAS included in important diagnostic codes.
- Integrate diagnostic protocols and clinical experience related to FAS exposure into the academic training of physicians and nurses. Provide continuing medical education on screening in diagnosis.

- Raise awareness in the health care profession of the link between early, accurate diagnosis and access to services that can improve outcomes.
- Fund research on methods to quantify the central nervous system impairments associated with fetal alcohol exposure in order to develop clinical diagnostic tools for the intellectual and behavioural problems associated with FAS.

6. There is a dramatic shortfall of services to meet the complex needs of those with FAS.

- Fund pilot projects in school districts to develop "best practices" for educating children and youth with FAS.
- Study extending eligibility through age 18 of funding of services that give money to help infants and toddlers with disabilities.
- Obtain funding for pilot projects that build on effective local initiatives, combine several funding sources and provide a continuum of services for those with the FAS.
- Explore requiring adoption or foster care agencies to fully disclose records of prenatal care, the birth mother's alcohol or drug use and the child's assessment for FAS.
- Offer training to all people raising children with FAS including out-of-home care providers such as foster homes, group homes and child-care providers.
- Require FAS education in child protection case plans where the child or the caregiver has been diagnosed with FAS.
- Provide respite care for parents of a child with FAS and establish group homes for children and adults with FAS whose families cannot care for them or who cannot live independently.

- As children near adulthood, provide transitional services such as housing assistance, vocational training and placement and medication monitoring.
- Fund a long-term residential job-training program for youth and adults with FAS.
- Provide training and support to Family Services programs, children's mental health programs, interagency early childhood intervention teams and other local efforts so they can better address the needs of children with FAS.
- Train youth and adults with FAS to be their own advocates. Encourage communities to recruit and train volunteer advocates for people with FAS.
- Work through school-based clinics to provide early assessment, counselling and referral services to youth with FAS before they are placed in alternative school programs or referred to the courts for truancy.
- Recruit and train mentors for teenagers with FAS.
- Provide summer activity enrichment programs designed for youth with FAS to develop their skills and areas of strength, including theatre, music, visual arts, individual sports and computers.
- Review delinquency and child protection laws to determine the feasibility of allowing the court to order family intervention where it deems appropriate.
- Establish a juvenile assessment center in each judicial district to provide central intake and comprehensive assessment of all youth entering a juvenile corrections system.
- Develop a diversionary program for first-time offenders who are identified as having FAS. Link these youth with trained advocates or mentors.
- Conduct FAS screening of adult and juvenile inmates in state correctional facilities. Use screening to

improve chemical dependency treatment and the transition of inmates into communities.

7. **A child's condition worsens without timely help for the problems associated with FAS.**
   - Expand current efforts to prevent secondary disabilities and expand successful strategies through public and private agencies and organizations.
   - Develop effective substance abuse prevention tactics for children with FAS.

8. **Professionals in key fields have little knowledge of FAS.**
   - Train professionals and government employees who work with people who have FAS or design programs that serve these people.
   - Make FAS training a continuing education requirement for licensing in key professions including all that deal with chemical dependency.
   - Expand substance-abuse education, including education on FAS in medical and nursing schools.
   - Make staff education on FAS a licensing requirement for facilities to serve people with FAS.
   - Review the adequacy of education in key professions and determine whether students in these fields are adequately prepared to deal with FAS.

9. **Lack of coordination hampers prevention, diagnosis and services.**
   - Create a state board, using public and private funding, to coordinate FAS activities.
   - Explore creating a college or university based institute on FAS.

- Provide resources to support and expand community coalitions that deal with FAS to assist children and families in dealing with the condition.
- Establish a surcharge on all alcohol-related court fines with proceeds designated to fund education on FAS.

In conducting the work of the task force, there were a number of concerns expressed by various participants. These concerns include the following:

- Women often stopped using alcohol during pregnancy but not until they know they are pregnant. Referral for chronic alcohol use often happens late in pregnancy.
- Women who want to stop drinking during pregnancy must have immediate and thorough support.
- Prenatal intervention should not be punitive. A judgmental attitude will sabotage the prevention and treatment.
- Many women with alcohol problems move frequently, making it difficult to follow through with services.
- Transportation and childcare are barriers for women seeking help. Many local treatment centers are too far away for a successful transition after treatment.
- Prevention efforts must not overlook males, middle and high-income people, and children as young as preschoolers.
- The cost to local governments is high, especially in larger cities.
- FAS is often part of a package of other serious problems such as abuse, depression and poor nutrition.
- Many children with FAS have IQ levels too high to qualify for services they need.
- Services for children with FAS are better in early childhood than during their school years when the focus of public services shifts from health and development to educational ability.

- Labelling children may add to their shame, guilt and anger.
- Some children are the third generation of FAS.
- Many children and youth in foster care and group homes have been affected by alcohol.
- Children with FAS are more likely to have contact with child protection, legal and corrections systems.
- Teen drinking and teen pregnancy are closely related and on the rise according to public health workers.
- The chemical dependency field and legal system need a better understanding of FAS.
- Mandatory reporting covers illicit drugs but not alcohol. Yet, alcohol use is more common and more damaging during pregnancy. Physicians may be hesitant to report suspected alcohol use because of concerns about data privacy or damaging their relationship with patients. Child protection workers have no legal authority to report alcohol abuse by pregnant women.
- Knowing about all available resources is a critical, unmet need for families and professionals.

Considering the range of concerns identified by participants, it is apparent that the needs involve not only prevention and awareness but also support services, training and funding. The task force noted the following needs as a result of their work:

- Early, accurate diagnosis and reliable standards for assessment
- Local prevention, treatment and training to meet certain needs, along with other training.
- Ongoing support and reliable information for those who care for, teach or otherwise serve children with FAS.
- Immediate, thorough support for pregnant women who want to stop drinking, with forced commitment to a treatment program for women who cannot stop drinking during pregnancy as a last resort.

- Long-term support groups and respite services for birth, adoptive and foster parents who are raising children with FAS, especially teenage or adult children.
- Outreach clinics and better access to resources and experts, especially in rural areas.
- Follow-up care for teenagers after alcohol treatment.
- Childcare and transportation for women seeking treatment for alcohol, along with chemical dependency treatment programs that allow women to bring their children and include training in parenting, relationships and life skills.
- Solutions that keep families intact.
- A consistent and clear prevention message repeated in many creative ways to different audiences.
- Use peers for prevention training.
- Inclusion of FAS information in sex education classes.
- A media campaign emphasizing it is not “cool” to drink.
- Involvement of local government, aboriginal leaders and bar owners.
- Better collaboration between social services, public health nurses and child protection.
- Advanced training and curriculums for health professionals and preschool, elementary and special education teachers.
- Training for law enforcement and corrections personnel, along with juvenile justice practices that lead to immediate action rather than long-term involvement with the system.
- Long-term assisted living or transitional help for people with FAS as they reach adulthood.
- Incentives and rewards for women who participate in prevention programs before and during pregnancy.
- Coordination and health insurance coverage for prenatal intervention and treatment services.
- More funding for preventing unplanned pregnancies.

- Funding for research on the most effective actions to take after diagnosis.

The report concludes that many professional skills are needed to prevent FAS. That involves physicians and nurses, health care plan providers, education providers, justice system professionals, the beverage alcohol industry, social workers and child protection personnel. Each of these segments has the opportunity to be part of the solution and each should be encouraged to establish and implement constructive action plans.

There are, however, potential conflicts of interest and ethical concerns related to certain types of collaboration with the beverage alcohol industry. The fact is that any program that actually works would be detrimental to the alcohol industry because sales would decline. It is unlikely that they would support any program initiative which might be detrimental to business. However, they would likely support program proposals which were not likely to have any significant effect. This satisfies the corporate responsibility requirement without jeopardizing business objectives.

Program decisions should not be subject to compromise or undue influence either in appearance or in fact. Strategically, it may therefore be best to keep the alcohol industry at arms length. Governments should encourage them to run their own programs rather than risk becoming addicted to their funding. They don't want programs to fail. They just don't want them to work very well.

Chapter 6

HEALTH WARNING LABELS

Beverage alcohol is the only consumer product in Canada that is known to cause harm if misused that does not alert the consumer to that fact. When someone is harmed by a consumer product, the courts have come down hard on the producers who did not have warnings or other safety information to caution the user. That is why today, virtually every consumer product which could even remotely cause harm if misused carries a clear and understandable warning or appropriate messaging. Many of those products also carry labelling because of legislative requirements. Under the circumstances, how is it that alcohol, which kills over 19,000 Canadians each year, has eluded social and political pressures to put health warnings on its products? Most answers to this question would be anecdotal or speculative. However, we can get some clues by examining the historic record. In most cases, you will find that there have been public and private interventions by the beverage alcohol industry.

The initiative of having health warning labels on the containers of alcoholic beverages is not a recent subject in Canada. It was first raised in Parliament in 1976 by the then Minister of Health, the Honourable Marc Lalonde. In 1988, the U.S. passed legislation requiring health warning labels to be placed on the containers of alcoholic beverages effective in 1989. In response to the initiative, the 1988 meeting of all

Canadian Provincial Ministers of Health unanimously passed a motion to ask the Federal Government to mandate labelling in Canada. Despite the unanimity, Minister of Health, Jake Epp overruled the 10 Provinces and his Ministry took no action.

In June 1992, the Health Sub-Committee issued a report entitled **"Fetal Alcohol Syndrome - A Preventable Tragedy."** One of their recommendations was that the Minister of Health should amend the Food and Drugs Act to require that containers for beverage alcohol sold in Canada carry an appropriate warning label alerting all consumers that the consumption of alcohol during pregnancy places the fetus at risk for FAS/FAE. They further recommended that the form of a warning label on beverage alcohol containers should be designed with proper regard for readability, perceptible prominence, color contrasts and impact. The design and content of the warning label would also be subject to the approval of the Minister of Health.

According to the report, the issue of health warning labels was the most contentious issue that the Sub-Committee had to deal with during their hearings. The witnesses were sharply, but not evenly, divided on this matter. The two industry groups who offered testimony, the Brewers Association of Canada and the Association of Canadian Distillers, opposed the inclusion of warning labels on bottles and other containers. Virtually every other witness supported the proposal. The witnesses from Health and Welfare Canada stated that the department was reviewing the available evidence on the effectiveness of warning labels, before making any decision.

The industry's position was that the general public awareness of Fetal Alcohol Syndrome was already very high; that warning labels were not very effective in raising awareness in

any case; and that the funds necessary to develop and print warning labels on containers would be better spent on other, more useful, programs for preventing alcohol-related problems. The witnesses also testified that the industry was already very active in promoting the responsible use of beverage alcohol and in alerting the public to the dangers of alcohol consumption while driving or working, or by pregnant women.

The brewing industry estimated that they collectively spend about $10 million per year. Notwithstanding, the Committee pointed out that the $10 million per year the brewing industry spends on “responsible use” campaigns was less than 10% of the brewing industry’s expenditure on product advertising which promotes consumption of beverage alcohol. Health and Welfare Canada also estimated that the entire alcohol industry spends $250 million each year on advertising, promotion and sponsorships.

Almost all the non-industry witnesses testified that warning labels on alcoholic products should be a part of the overall strategy to raise public awareness of the risks posed to the fetus by maternal alcohol consumption. Most witnesses based their support for warning labels on the consumer’s right to know that the use of a product carried certain risks. It was also noted that in 1989, the Canadian Medical Association passed a resolution to urge governments in Canada to enact legislation requiring that all alcoholic beverages sold in Canada be labelled with warnings on the hazards from the consumption of alcohol during pregnancy. This was in response to the United States introducing warning labels on the containers of alcoholic beverages in 1989 and the fact that Canadian beverage alcohol producers who exported their products to the

United States were required to put such labels on their products.

The Sub-Committee conceded that warning labels on the containers of alcoholic beverages would not, by themselves, completely solve the problem of FAS or FAE, nor would they effectively reach all segments of society. They stated that problem drinkers and alcoholics would probably not be sensitive to label warnings.

Design and presentation of a warning label was considered vitally important to its effectiveness. The Sub-Committee examined several examples of warning labels on alcoholic products from the United States. In all cases, the warnings were found to be generally inconspicuous and difficult to read. It was their view that if warning labels were adopted for Canadian products, it was essential that they not emulate the United States examples, but be carefully designed for maximum visibility and impact. They concluded that warning labels, properly designed and printed, would be an essential part of a comprehensive strategy for increased public awareness and education about the risks that maternal alcohol consumption poses for the fetus.

In September 1992, Health and Welfare Canada sponsored a two-day symposium in Vancouver on Fetal Alcohol Syndrome and Fetal Alcohol Effects. This marked the first time representatives from across the country had been able to address FAS/FAE in a Canadian context. With key sectors and all of Canada's regions represented, participants from Provinces, Territories, professionals, industry, non-government organizations, First Nations, as well as foster and adoptive parents, were able to share information and discuss new directions and priorities in a comprehensive manner.

At the opening of the symposium, the Honourable Benoit Bouchard, Minister of National Health and Welfare expressed his concern about the issue of FAS/FAE and announced that negotiations were underway with provincial and territorial colleagues about a shared pilot project on warning labels for alcoholic beverages. He said that the pilot project would help to determine if mandatory warning labels would be **"an effective public information strategy."**

Health warning labels, as part of a comprehensive strategy, were discussed in the workshops. While there was no consensus on the efficacy of labelling as a deterrent to FAS/FAE, there was general agreement that it could be very effective as an awareness tool. Many suggested that labelling of alcoholic beverages should proceed and that its impact should be studied. The use of labels in the United States was cited as a possible direction for Canada. Furthermore, it was noted that many Canadian firms currently manufactured products for the U.S. market with warning labels. In 1993, $65,150 was appropriated for the initial phase of a warning labels pilot project. However, before the project got started, Mr. Bouchard was replaced as Health Minister and his successor, the Honourable Paul Ramsey, scrapped the project. In related correspondence, he stated that the Ministry of Health was in the process of reviewing the most appropriate action to take with respect to labelling alcohol beverage containers; that labelling strategy involves other ministries; and that he was continuing to explore the issue with his cabinet colleagues. The layman's translation is that notwithstanding the health imperative, we are dealing with the alcohol industry and we should be very careful.

In December 1992, the Health Minister issued his response to the Health Sub-Committee's report. Concerning

recommendations five and six on health warning labels, he conceded that in 1989, three-quarters of Canadians (80% of female respondents) agreed that all containers should display warning labels. He also acknowledged that most of the witnesses that appeared before the parliamentary Sub-Committee called for warning labels while the beverage alcohol industry remained opposed. At the symposium in Vancouver, the industry's representative outlined their position with respect to warning labels as follows:

"The beverage alcohol industry's concern over labels on bottles and warnings in advertising is that the introduction of such warnings will shut the door to other more effective measures. . . We will not voluntarily put warning labels on any alcohol produced in Canada for consumption in Canada because such a measure, ***although easy enough to implement****, is not effective and, therefore, does not satisfy our sense of responsibility. We would rather be a partner in providing sound alcohol education to those who need it. Education is the action required. . . We have faced this challenge before with drinking and driving. The concerted efforts of government, law-enforcement, interest groups and the beverage alcohol industry have made drinking while driving socially unacceptable. . . The alcoholic beverage industry is committed to working to reduce the incidence of FAS/FAE. We are willing to work with a coalition of groups on the development of effective and focussed preventive programs to reach those who are of risk. . ."*

The minister also noted that other observers, outside the alcohol industry, have pointed out that the drinkers at highest risk for FAE/FAE, may be unlikely to be influenced by warning labels, whether due to their own alcohol abuse or to lack of literacy. In the U.S., which has had warning labels

since 1989, results from impact evaluation studies have been mixed. Nevertheless, small but significant positive changes in public awareness were reported in the American studies, even though the U.S. label was criticized with regard to its prominence and readability. He also noted that at the symposium there was similarly a mixed message. Many believe labelling could improve public awareness, but there is no consensus on its efficacy as a means of **"changing attitudes or as a deterrent to inappropriate drinking behaviour."** His position was therefore to invite the provinces and territories to collaborate with the federal government in developing ways of testing the impact of a warning label, with the goal of arriving at a "made-in-Canada" approach.

In my experience, whenever anyone uses phrases like "made-in-Canada approach" they are buying time. Let's recap what happened. In June 1992, the Health and Welfare Sub-Committee on FAS recommended that health warning labels be placed on the containers of alcoholic beverages. In September 1992, the Health Minister addressed the symposium in Vancouver and announced negotiations for a pilot project with the provinces and the territories to determine whether health warning labels would be an "effective public information strategy". Then in December 1992, the Health Minister responded to the report saying that he has invited the provinces and territories to collaborate with the federal government to determine if health warning labels are an effective **"means of changing attitudes or as a deterrent to inappropriate drinking behaviour."** The change in language is subtle but the effect is as different as night and day.

Who or what happened between September 1992 and December 1992? Who made the Minister change his mind? All the discussions at the Sub-Committee and the symposium where in the context of public awareness and there was no disagreement that health warning labels would be an effective tool in this regard except for the view of the beverage alcohol industry. All of a sudden, the Minister shifts the focus from public awareness and public education to whether labels could effectively change attitudes or be a deterrent to inappropriate drinking behaviour. Warning labels have always been talked about as an instrument of public awareness and as part of a comprehensive strategy to address the tragedy of FAS. It is highly unlikely that you could find anyone who could provide research evidence that a label, in itself, changed behaviour. The phenomenon of a Health Minister changing his mind on FAS repeats itself again in 1997 and the issue again is whether the label is intended to promote awareness or change behaviour. Similarly, you could not find research evidence that labelling would not change behaviour. The fact is that no credible research evidence currently exists.

The next discussion on FAS came on July 23, 1994 when Health Canada sponsored a workshop in St. John's Newfoundland on the subject of pregnancy and Fetal Alcohol Syndrome / Fetal Alcohol Effects. On the question of **Prevention of FAS/FAE: What Works?,** a presentation was made by Dr. Robin Walker. In his material, Dr. Walker referred to research by Dr. J. R. Hankin concerning a 1993 time series analysis of the impact of the alcohol warning label on antenatal (pregnancy) drinking. The following is an extract of Dr. Walker's presentation:

"In my opinion, Hankin (1993) has done the best evaluations of the effect of labels on bottles warning of the dangers of

alcohol; these were done in the state of Michigan in the U.S. Two recent studies by Hankin looked first at when knowledge increased; Hankin look specifically at pregnant African-American women, over 5000 of them. One interesting outcome was a very high false-positive rate before labelling started. The question asked was the following: "Are you aware of alcohol beverage warning labels?" About 30% of people were aware of it before it actually existed! However, after the label appeared, there was increased awareness of labels among pregnant women as time passed.

The time lag found in this case should be noted. The awareness did not even start to increase until about four months after the introduction of the label and increased gradually thereafter. Hankin speculates that people did not see the label on the bottles, nor did they read it. How many smokers actually read those quite obvious labels on tobacco packets, for example? However, it may just be that this is another example of public education, that if there is a lot of publicity surrounding bottle labels, the awareness that alcohol consumption as a problem during pregnancy may increase, i.e. the awareness of the label may be based on the media coverage rather than on the label itself.

For the period preceding the introduction of labels, the monthly percentage of those aware of the warning labels zigzags, but is essentially quite flat. The first point at which an increase in knowledge is actually shown above the baseline occurs approximately four months after the label was introduced, and then knowledge progressively increased. Hankin did not stop at evaluating whether people knew about the label.

The second study looked at an analysis of the impact of a label on drinking during the antenatal period; this, after all, is what matters. Again, the study looked at African-American women. This time the study was even larger: 12,000 women took part in it.

A decrease in drinking during pregnancy was noted overall. A decrease in drinking was particularly noted in those described as non-risk drinkers. Here, the "risk" level is exactly the same as in some of the other studies; the level was defined as less than .5 of an ounce of alcohol per day, which is one drink per day. Unfortunately, those who drank more than one drink a day did not change the behaviour during the course of this study. Therefore, the question raised is the following: notwithstanding the effect of this protective measure on the drinking habits of lower-risk drinkers (I will not call them non-risk), would this actually affect the rate of FAS? Based on this, the answer, of course is "probably not." The overall drinking rate does decrease. There is a lot of variation in the samples, but there is a downward trend. In the non-risk drinkers, the downward trend is perhaps a little more obvious; it appears to be significant. In terms of the so-called risk drinkers, no change whatsoever took place. In their case, the zigzag still follows the same baseline.

In that case, what other approaches are there? Another method to follow, of course, would be to deliberately try to identify the drinkers at most risk and attempt to change their behaviour. I widened my search beyond the literature on FAS and alcohol consumption during pregnancy and took a look at literature on substance abuse and tobacco as well. The literature in this case, however, is bedeviled once again with programs that are elegantly described and look beautiful but have not been evaluated. As well, there is a surprising

scarcity of well evaluated programs that examine the effects of these factors on the behaviour of those who took part in the programs. As a result, there are many programs, and they may work. The problem is that, for most of them, we do not know whether they actually do work or not."

At the same workshop, a presentation was also made by Dr. Oscar Casiro on Community Prevention Strategies. One of the strategies he addressed, which could be used to prevent the adverse effects of alcohol, was the introduction of health warning labels on the containers of alcoholic beverages. The following is an extract from Dr. Casiro's presentation:

"We see warning labels everywhere. If one looks around the house, one will find warning labels on household cleaning items, plastic bags, paint, medicine, and batteries. All have some sort of warning label, e.g. "For external use only", "Keep out of reach of children", "Do not put over the head; suffocation may result." Thus, alcohol labels serve as reminders of already known hazards. To my knowledge, there has not been significant controversy regarding the use of these labels.

There is no beverage-container label legislation in Canada at this time. In the United States, after 20 years of controversy, a labelling law was enacted at the end of 1989. Alcoholic beverages were labelled at the point of bottling starting in November 1989. There are two components to the U.S. label. The first is a warning by the Surgeon General that women should not drink alcoholic beverages during pregnancy because there is a risk of birth defects. The second component relates to the ability to drive a car or operate machinery, and to health problems in general. These labels started to appear in the U.S. in November 1989.

Have they been effective? Little research has been conducted on labels for us to know yet. A warning must be noticed, read, and understood; it must also be believed and remembered before it can affect behaviour, which is the ultimate goal of any warning. Is this happening with U.S. labels? Do we know that people are noticing, reading, believing and remembering them? Some studies have attempted to look into this matter.

First, are labels being noticed? The study by Kaskoutas focuses on this issue. Six months after the enactment of the law, 33% of the people surveyed had seen the label and 27% knew what the labels said. It is interesting to note that, in the case of the abstainers, 17% had seen the labels and 12% knew what the labels said. For the moderate drinkers, the numbers were 35% and 28%; for the heavy drinkers, results stood at 46% and 39%. No significant difference in knowledge was found to be associated with seeing the warning label. However, women who had seen the label were 1.4 times more likely to report having conversations about drinking during pregnancy. Therefore, the labels are being seen; as well they are seen more by people who drink more.

Another study examined the important characteristics of labels. The conspicuousness of health warnings on all containers tends to influence their possible effect. Placement is an important characteristic. Placed vertically, the label would be read by tipping the bottle and spilling some of the contents. It can also be placed horizontally, which allows for it to be easily read. The size and color of labels are also important. In an interesting study by MacKinnon, a label that says "Poison", "Toxic", or "Causes cancer" on a beer can was shown to have substantial affect on self-reported choice behaviour. The alcohol label currently used did not have nearly as powerful an effect. Therefore, when we speak of the

effectiveness of labels, we must pay attention to the characteristics of the label.

A study by J.R. Hankin et al focused on when knowledge increased; it showed a decrease in drinking during the antenatal period, beginning seven months after the label law was implemented. Let us not forget that there was a four month lag between enactment of the law and the increased awareness of the label. We must remember that, because labels were placed at the point of bottling, there was a lag until those bottles appeared on the shelf. Women under age 30 and women who predominately consumed wine coolers and beer were more likely to know about the label.

What is the impact of alcohol warning labels on drinking during the antenatal period? Again, the study by Hankin on 12,000 inner-city African-American women in Detroit found a decrease in drinking during the antenatal period, which began seven months after the label was implemented. There was a differential impact on respondents who drank different amounts. Light drinkers reduced their intake by approximately one ounce of beer per week. No reduced consumption of alcohol was noticed in the case of heavy drinkers.

We can then ask what effect alcohol warning labels have on the adolescent population during the first year. Let us remember that these are very preliminary studies. MacKinnon randomly selected grade 12 students and surveyed them in September 1989, i.e., before the enactment, and then in October 1990, a year after the enactment. He surveyed all schools in Marion County, Indiana. After the enactment of the law, more adolescents had seen the labels; more knew whether it existed and whether to recognize the risks stated on the

label. However, no substantial changes in alcohol use or beliefs about the risks written on the label were noticed. We can conclude that adolescents did not believe what was said to them.

Thus, what can we conclude about labels? In general, labels are being noticed, read, and recalled by consumers. They serve as a reminder of already known hazards. According to studies, previous levels of awareness that alcohol can cause damage to the baby seem to be quite high. Can labels alone decrease or eliminate Fetal Alcohol Syndrome? It would be naive to think so. No single strategy will be effective in itself.

I believe it is important to expose the drinking public to a multiplicity of health messages, as the results of the European study by Ihlen from Oslo, Norway, published last year have shown. The focus of the study was the social acceptability of drinking alcohol during pregnancy. The authors undertook a campaign called Intoxication and Pregnancy which consisted of training and providing information to health care workers on a number of issues regarding alcohol and pregnancy and a multi-media public-awareness campaign aimed at the general public.

A survey of the general population and a large number of pregnant women was conducted in 1985, before this campaign, and again in 1990. They found an increase in the number of people with a restrictive attitude towards alcohol use during pregnancy. After the five-year campaign, they found a significant reduction (50%) in alcohol consumption during pregnancy. The average alcohol consumption was 12 drinks a month and this decreased to six drinks a month after the campaign. Although a cause-effect association cannot be established between the social acceptability of alcohol

consumption during pregnancy and the reduction in drinking, the authors firmly believe that there was a connection. As Skog stated in 1960, society is a highly organized system of interactive persons in which an individual's drinking behaviour is closely related to that of others. I strongly believe that all possible direct and indirect means must be used to encircle and finally control the problem of antenatal alcohol abuse. No single strategy will be effective by itself. There is a need to expose the drinking public to a multiplicity of messages."

The workshop did not make any recommendations, but the fact that more people were sharing information on a variety of topics related to FAS was positive. We can only hope that this kind of professional interaction will help in the further development of public policy.

The next discussion on health warning labels came in June 1995 when I introduced a Private Members (Bill C-337) in the House of Commons. There was very strong support throughout the House of Commons but the Bill was going nowhere without the Minister of Health. I did not realize it at the time but there was much discussion about the Bill going on behind the scenes. Health Canada officials did not support the Bill for reasons that were not fully disclosed. On reflection, this had much more to do with keeping the peace and funding support of the beverage alcohol industry who pay about $7 billion per year in alcohol taxes and who provide partial funding for other Health Canada programs.

In the end, Health Minister Diane Marleau told Health Canada "thank you for your opinion" and threw her support behind the Bill. Her Parliamentary Secretary, Hedy Fry, was then instructed to speak in favour of the Bill. Equally gratifying

was the fact that all parties indicated they would support the Bill. Although Second Reading of the Bill normally requires three hours of debate spread over about a 3 month period, all parties agreed to collapse the debate during the first hour and call for a vote. With unanimous support of all parties, the vote was carried and the Bill was sent to committee for public hearings. The 35th Parliament prorogued its first session and the normal practice was that all Bills died on the Order Paper and would have to start all over again. Fortunately, the government brought forward a special resolution which allowed Bills which had passed Second Reading to be reinstated at the same point in the legislative process that they were at when the House was prorogued. Bill C-337 was reintroduced, became Bill C-222 and was referred to the Health Committee for public hearings. This Bill sought to require that containers of all alcoholic beverages sold in Canada display the following message: "Consumption of alcoholic beverages impairs a person's ability to operate machinery or an automobile and may cause health problems or cause birth defects during pregnancy."

As with any Bill, the key is to develop and present convincing arguments and to seek support not only in Parliament but also from the public at large. Finding solid argument was not the problem. Taking on the beverage alcohol industry was quite another matter as I would eventually discover.

There are many reasons why we should have health warning labels on alcoholic beverages. The costs and other impacts of the irresponsible use of alcohol are far too great to ignore. At a time when all governments are seeking to reduce the costs of health, social, justice and lost productivity, we need to pursue an appropriate balance of preventative and remedial strategies. We need to let the consumers know that health experts

recognize the hazards of alcohol use and we need to inform consumers about the risks of alcohol use.

Failure to label alcohol beverages when medical drugs, foods, cleaners, solvents and other dangerous products all carry health warnings falsely assures consumers that alcoholic beverages are safe at all times. All levels of governments and the alcoholic beverage industry itself have a social, moral and societal responsibility to reduce the misuse of alcohol. Labelling is a reaffirmation in the ability of consumers to make responsible decisions. Labelling would also promote consumer consistency and indeed would help to change drinking behaviour.

Labels are an integral part of any comprehensive strategy to promote the responsible use of alcoholic beverages. Any prevention program would be incomplete without these health warnings. In the words of Denny Boyd, columnist for the *Vancouver Sun:* "The intended purpose of warning labels on alcoholic containers is to act as a consumer lighthouse sending a signal of impending danger." Labels represent an efficient way to continually remind consumers of the need to drink responsibly. As one element of our overall preventative strategy, it could be implemented quickly and efficiently with the potential of reaching all consumers and with a repeated effect.

As part of my research on Bill C-222, I took the opportunity to speak with representatives of the Association of Canadian Distillers, the Brewers Association of Canada and the Canadian Wine Institute. I found that their position was very consistent. They all support and promote responsible use of their products, to their credit. Industry representatives also noted that alcohol has been shown to have health benefits in

certain circumstances. I was given examples of programs they already fund and which they felt had better value in terms of the effectiveness of warning labels. **They also expressed concern however that warning labels may alarm pregnant women who may have consumed some alcohol and that the resulting fear or stress would result in consequential and negative health problems or even miscarriage.** I found this latter point to be incredulous and despite my requests, no supporting documentation was ever provided for the representation.

The alcohol industries all held the same view that health warning labels would not work and that there was no evidence that could prove that they could work. Finally, they all specifically stated that they would not voluntarily comply with any recommendation to have warning labels on the containers of alcoholic beverages. Indeed, they said it would have to be legislated.

The industry's position is clear. It fundamentally rests on the argument that health warning labels will not work. I believe this argument is fundamentally flawed primarily because the proof of effectiveness is indeed in the precedents of Canada, the U.S. and the entire world. Warning or caution labels directly on the packaging of products have been used for years for virtually every potentially harmful product except alcoholic beverages. Research and long term monitoring have proven the effectiveness repeatedly. That is why this element of every preventative strategy continues to be used today. Why? Simply because it works.

This is a matter of common sense and practical reasoning. It appears that the industry insists on empirical evidence which it says does not exist. In fact, the evidence does exist. In 1988,

the U.S. government passed legislation requiring health warning labels to be placed on the containers of alcoholic beverages. Implemented in 1989, a series of studies have been conducted to detect the impacts on knowledge, attitude and behavioural changes. Although early studies showed little effects, as the years went by literally dozens of research studies have started to show progressively improving results. Here are three examples:

- In the December 1993 *Journal of Public Policy and Marketing,* a report on public attitudes toward alcohol control since the warning labels were mandated in 1988 said: "It is concluded that the label is serving the goal set out for it, to inform the public of the hazards associated with alcohol consumption."

- In the1993-94 *International Quarterly of Community Health Education,* a report on the awareness and knowledge of alcohol beverage warning labels among homeless persons stated: "Age and level of alcohol consumption were each associated with label awareness and content familiarity suggesting that alcohol beverage warning labels may be reaching homeless persons."

- The final example comes from the March 1994 International Conference on the Reduction of Drug Related Harm. In the research paper **"Mandated Container Warnings as an Alcohol Related Harm Reduction Policy"** it finds: "Within the U.S., results indicate an association between seeing the label and displaying behaviours relevant to limited drunk driving. With regard to limited drinking before driving, 68% of the cases had seen the label in the last 12 months. In cases where there

> was limited driving after drinking, seeing the label was even more significantly associated".

Once the hearings on Bill C-222 were concluded, the Health Sub-Committee was to vote on the Bill. But something had happened. The beverage alcohol industry hired a lobby firm to mount an aggressive campaign against the Bill. Two pieces of literature were sent to all Members of Parliament. Gifts were reportedly given to 40 key M.P.'s. The Brewers Association announced that if the Bill went through, they would withdraw their $10 million annual contribution to prevention programs that they jointly funded with Health Canada. Despite support from all the witnesses except the beverage alcohol industry, there was no reason why the Bill should not proceed. However, the new Minister of Health had made a statement that he was not sure that warning labels was the way to go. That was a severe body blow to the Bill.

In an unusual move, the Committee decided not to vote on the Bill but rather voted to continue studying it as part of the Health Committee's review of Canada's Drug Strategy. That took long enough for the next General Election to be called and the Bill died.

There is no doubt that the alcohol industry killed the Bill. They reportedly spent over $100,000 on lobby efforts and the threat to withdraw from joint programs simply scared off a budget conscious Health Canada. Parliament subsequently dealt with the issue of delaying Bills in Committee and now they are required to report Bills back to the House within six months.

Timing is everything and I would like to believe that the Bill would have passed if Parliament had a chance to vote at third

reading. The Bill has been reintroduced in the 36th Parliament but it is unlikely that it will be successful. When I raised it with the new Minister of Health, he simply said that I would have to have proof that warning labels work. What form that would take and whether it would be possible to establish so-called "proof" is not readily discernible. I suppose the proof is the same proof the government has for health warning labels on tobacco products or any other consumer.

For every hypothesis or proposed initiative, there exists the frustrating response "Prove it". For some, proof of anything virtually requires 100% knowledge which is actually impossible. As such, there will always be debate. The last two Ministers of Health have simply dismissed health warning labels on the containers of alcoholic beverages as part of the solution to FAS because you can't prove they would work. The first issue is "What exactly do you have to prove?" to satisfy the challenge. If it is just awareness levels, studies have clearly indicated increased awareness. However, if the issue is "Does the increased awareness change behaviour?" there is an impasse. First, you have to implement an approach so that over time you can study the impacts. However, if you cannot prove it, then we will not implement it. This is the classical circular argument. There is also the problem that if you implement an approach, the only way to get definitive proof of anything, is to hold all other variables, factors and conditions constant at the same time. This is simply not possible. Therefore, it is arguable that you cannot prove anything definitively. That is why the challenge "Prove it!" is so terminal.

If we had to wait for perfect knowledge before we made any decisions, nothing would get done. However, we do have numerous examples of initiatives which did not require proof.

Tobacco warning labels have been in place for some time and for me the real proof of effectiveness is the reaction of the tobacco industry. They do not want labels and they took the Government of Canada to court. The labelling undoubtedly has increased awareness but it is questionable whether it has changed behaviour. The reality is that it is unreasonable to expect a warning label to change behaviour by itself. It must be part of a more comprehensive strategy with a multiplicity of approaches.

There are two other examples of initiatives which raise the reverse issue of whether an initiative should be ceased if the trends deteriorate. Needle exchange programs were introduced as part of a dubious harm reduction drug strategy. Recent studies have found that the incidence of HIV is higher for needle exchange users than for those who do not use a needle exchange. Similarly, distribution of condoms to youth has become a general strategy of health departments and yet the research shows growing sexual activity among youth and an increase in the incidence of teen pregnancies and sexually transmitted diseases. The debates on these issues are complex and usually involve the impact of other factors rather than just the impact of the initiative in isolation.

The evidence supporting health warning labels is mounting and very powerful. That is why the U.S. started to use warning labels in 1989. That is why indeed in Canada, the Yukon and Northwest Territories started to use warning labels in 1991. That is why 77.5% of Canadians surveyed by the Addiction Research Foundation said they would support health warning labels on alcohol beverage containers. This relatively high level of support has also been confirmed by Health Canada. Why? Because Canadians know that warning labels work.

How do current legislators feel? On May 23, 1995, the B.C. Minister of Health wrote the following to the federal Minister of Health: "I am writing to you in regards to alcohol warning labels. This was a topic of our discussion at the Provincial, Territorial Ministers of Health meeting held in Vancouver on April 10 and 11, 1995. There was unanimous agreement that warning labels should be pursued by the federal government." In addition, the Federal Minister of Health in 1995 clearly stated her strong support for health warning labels for the containers of alcoholic beverages.

The alcoholic beverage industry feels that the consumer has the burden of proof that health warning labels work. On the contrary, the burden of proof that they do not work must fall on the industry. If it cannot provide that burden of proof, then the industry should discharge its social, moral and business responsibility and voluntarily comply with labelling containers of beverage alcohol.

Throughout my research and study on health warning labels on the containers of alcoholic beverages, I came across a number of quotes or comments which I found encouraging. The following are a few examples of attitudes toward warning labels and FAS:

Standing Committee on Health and Welfare, Testimony during special study of Fetal Alcohol Syndrome

> Mrs. Shirley Joiner, adoptive mother of an FAE child, March 26, 1992 – "It's my understanding that all the alcohol produced in Canada and exported to the United States does carry the labelling. Don't we deserve the same education on our alcoholic beverages? Such

legislation could be instrumental in preventing alcohol related birth defects."

Ms. Betty MacPhee, Manager of Vancouver's Crabtree Corner YMCA, April 9, 1992 – " I have great difficulty understanding the reluctance of the alcohol industry to label their products … Every woman has the right to be an informed consumer. Every woman should know there is no known safe amount of alcohol to drink when you are pregnant. It seems ludicrous that alcohol beverages exported from B.C. and the rest of Canada to the USA have had warning labels for two years, but the same bottles in our stores do not."

House of Commons Debates, 35th Parliament on Bill C-337 (Health Warning Labels on the Containers of Alcoholic Beverages)

Hedy Fry M.P., Parliamentary Secretary to the Minister of Health, December 7, 1995 - "I hope everyone here will support the bill. We support it very strongly at Health Canada. We believe if we are ever to prevent the preventable diseases that create a great deal of tragedy in our lives, this is one sure step. We are already half way there. We do it for the United States. Let us do it for Canada."

Standing Committee on Health Sub-Committee, Testimony on Bill C-222 (formerly Bill C-337) – Health warning labels on the containers of alcoholic beverages:

Canadian Medical Association, April 18, 1996 - "Health warnings have appeared on cigarette packages for several decades and this has undoubtedly contributed to public awareness of the health burden of tobacco, and the resulting decline in tobacco consumption. The CMA hopes that, similarly, labelling of alcoholic beverages will alert Canadians to the health and social risks inherent in excessive alcohol consumption."

Canadian Centre on Substance Abuse, April 25, 1996 - "The most compelling argument in favour of warning labels comes not from the field of alcohol policy control, but from the area of consumer rights. Any consumer product that has a consistent proven potential for causing a significant number of deaths and injuries should be appropriately labelled. Consumers have a right to be told clearly what risks are inherent in their use of a product. It is unacceptable to claim exclusion from such a requirement by maintaining that "everybody knows that alcohol can be harmful if you drink too much."

Simone Joanisse, May 9, 1996 - "Modest is still a good word, because if you have one less fetal alcohol kid, believe me, you've saved yourself some bucks, number one. You've given a life some potential, number two."

John Joanisse (concerning extent of public knowledge about FAS), May 9, 1996 - "They know our daughter and they know she has all those problems and they think she's cute and that you bring her everywhere and that's all they know. They don't know about FAS."

Dr. John Guilfoyle (Chair, Council of Chief Medical Officers of Health), May 9, 1996 - "Awareness leads to concern and concern leads to action." Commenting on a health warning label: "It's a symbol ...it's an expression of our shared values. ... It's a commitment to the health of all, that we are not going to let a substance which has injured generations and generations of health now that we have more science, more knowledge, that we will stand by and allow a substance which has created carnage over the centuries to continue to do so." "I think Fetal Alcohol Syndrome is a great area of concern because our awareness of it and even our ability to diagnose it and track it is only in its infancy, to be quite honest."

Dr. George Paterson - Director, Foods Directorate, Health Canada, May 9, 1996, (Commenting on Supreme Court Decision Hollis vs Dow Corning, December 1995) - "The decision indicates that manufacturers have a duty of care to warn consumers about the potential risks associated with the ordinary use of their products. That's to say that consumers must be informed of any dangers inherent in the use of the product, particularly where the product is ingested or implanted in the body."

Claudette Bradshaw, Co-Chair National Crime Prevention Council, May 7, 1996 (Responding to how many women she encountered in her work that were aware of FAS) -"My sad thing I have to tell you is not a lot."

Research Study of Public Opinion Concerning Warning Labels on Containers of Alcoholic Beverages (Commissioned by U.S. Bureau of Alcohol Tobacco and Firearms, December, 1988):

"... 80% of persons surveyed nationally would vote to require warning labels..." "...public believes that warning labels could benefit all consumers of alcohol, especially youth and pregnant women."

"...public believes that warning labels should target specific health warnings..." "...public believes that the warning labels should be placed on all types of alcoholic beverages"

"...if warning labels helped only one person, they are worth having..."

"...public has the right to know if the use of a product exposes them to a health hazard."

"...as soon as it is SUSPECTED that a product created a health hazard, a warning label should be required"

"...higher priority on warning labels on alcoholic beverages for hazards that expose not only the consumer, but also other innocent people."

"...primary objective of warning labels should be to provide information to make people aware of the hazards and give them the option of changing their behaviour or not."

"...labels provide a constant reminder of the hazards and could help create support mechanisms to assist in changing behaviour."

"...most participants were relatively unaware of suspected alcohol related health hazards such as alcohol poisoning, cancer and Fetal Alcohol Syndrome."

> "...warning labels are required to counter the misdirection and over-glamorization of the advertising for alcoholic beverages."

U.S. National Institute on Alcohol Abuse and Alcoholism (Volume 17, Number 1, 1993):

> Rice et al (1991) - "The total economic cost of alcohol problems in the U.S. was estimated to be $85.5 billion. This tremendous societal burden, together with the low cost of intervention, provides a prima facie case that even a small positive effect of warning labels would be valuable."

Health Canada - "Pregnancy and Fetal Alcohol Syndrome / Fetal Alcohol Effects Workshop Proceedings - St. Johns Newfoundland, July 23, 1994:

> Page 23 - "Have they been effective? Little research has been conducted for us to know yet."
>
> Page 24 - "Labels are being seen; as well they are being seen more by people who drink more. Women who had seen the label were 1.4 times more likely to report having conversations about drinking during pregnancy."
>
> Page 25 - "No single strategy will be effective by itself. There is a need to expose the drinking public to a multiplicity of messages. I believe that all possible direct and indirect means must be used to encircle and control the problem of antenatal (pregnancy) alcohol abuse."

First Effects of Warning Labels on Alcoholic Beverage Containers (Alcohol Research Group, California, February 1992):

> "Six months after introduction of warning labels, over one fifth of the respondents reported having seen the labels. Greater proportions of key target groups, such as heavy drinkers and young men at risk for drunk driving, reported seeing the warnings."
>
> "... respondents who probably saw the warning labels were significantly more likely to report several behaviours indicative of heightened awareness of, and caution regarding, the hazard of drinking and driving and of drinking during pregnancy..."

U.S. National Institute on Alcohol Abuse and Alcoholism (Volume 17, Number 1, 1993):

> Kaskutas and Greenfield (1993) - "In 1990, 6 months after labels were implemented in the U.S. 21% of American adults were aware of the label, while in 1991, 18 months after implementation 27% were aware of the label. The highest rates of seeing the labels were among the groups most targeted: young men 18-29 years 41%; women 18-39 years 35%; heavy drinkers 54%. Respondents who saw the labels were more likely to report not driving because of drinking, and not drinking because of driving. Analyses of respondents in 1991 indicated continued association between seeing the label and displaying behaviours relevant to limiting drunk driving. 18 months after implementation, 61%

of the respondents believe the warning label an effective way of changing people's behaviour."

Gallop Survey (Analysis by Mazis et al) 1991 - "...awareness of the label and its specific messages were highest among those consumers for whom the message is most relevant - younger adults and those drinking more heavily."

Research Summary - "The research findings to date are promising. Bear in mind the low cost and very high and sustained level of public acceptance of warning labels, with a majority believing in their effectiveness, the intervention would need to demonstrate only modest effectiveness for its benefits to outweigh its costs. Research indicates the warning label messages are reaching the target population of young and heavy drinkers."

CN Pacific Institute for Research and Evaluation - Berkeley California, Research Study 1994 (Impact of Alcohol Beverage Container Warning Labels on Drivers and General Population):

"Evidence from a multivariate analysis of post-introduction data indicate that both drinking drivers and impaired drivers were more likely to recall labels and their content, an indication that warning labels are reaching "at risk" individuals. In addition, increases in the perceived risk of drinking and driving are consistent with the notion that warning labels, as one part of a larger social movement, are helping to create

an atmosphere in which drinking and driving are less acceptable.

Janet R. Hankin - Clinical and Experimental Research Study, Detroit, May 1992 (The alcohol Warning Label: When Did Knowledge Increase?):

"While the label law was implemented in December 1989, a significant increase in knowledge of the label did not occur until March 1990. Women who predominantly consumed wine coolers and beer, and those under age 30 were more likely to know about the label than their counterparts."

Journal of Public Policy & Marketing - Clinical Research by M. Hilton, Volume 12 Spring 1993 (An Overview of Recent Findings on Alcohol Beverage Warning Labels):

"Some progress has been made toward achieving awareness. Awareness rates have grown over time and awareness appears to be greater among targeted risk groups. Not only was support for the warning label policy high, but it also grew over the first 18 months after the advent of the label. This finding bodes well for the potential effectiveness of the label. Not enough time has passed for the effects to have taken hold."'

Standing Committee on Health Sub-Committee Testimony Bill C-222 (formerly Bill C-337) – Health warning labels on the containers of alcoholic beverages:

> Addiction Research Foundation, April 25, 1996 - "Research in the U.S. indicates that, even though the warning labels have been criticized for being very small, very cluttered, often written sideways and in very small convulcated ink, over the first 18 months after their appearance they were seen by many consumers. 27% of Americans surveyed could remember seeing them. More importantly, the labels have proven to be a targeted education method.... Because the warning labels represent minimal public expenditure they can be a cost effective prevention tool even if their impact is small."
>
> Floyd Rolland (NWT Government commenting on their labelling program), May 9, 1996 - "Our experience in this program has been positive. We have found that the labelling is effective in raising consumer awareness of risks associated with the consumption of liquor and that has been an important, if not essential component, of our health promotion efforts with regard to alcohol."

Internationally, nine countries currently have national laws mandating health warning labels on beverage alcohol containers. These countries are: Brazil, Colombia, Costa Rica, Ecuador, Honduras, Mexico, South Korea, the United States of America and Zimbabwe. The issue is also emerging at the national level in Australia, France, Japan, New Zealand, Taiwan, Thailand and South Africa. The following is a sample of the text of the labels in some of these countries:

- Avoid the risks of excess of alcohol consumption.
- Excess alcohol is damaging to your health.
- Drinking liquor is harmful to your health.
- The abuse of liquor is harmful to health.

- Warning: The excessive consumption of alcohol causes serious harm to your health and endangers your family.
- Excessive consumption of this product is hazardous to health.
- Warning: Excessive consumption of alcohol may cause liver cirrhosis or liver cancer and is especially detrimental to the mental and physical health of minors.
- Warning: Excessive consumption of alcohol may cause liver cirrhosis or liver cancer, and especially, women who drink while they are pregnant increase the risk of congenital anomalies.
- Excessive consumption of alcohol may cause liver cirrhosis or liver cancer, and consumption of alcoholic beverages impairs your ability to drive a car or operate machinery and may increase the likelihood of car accidents or accidents during work.
- Excessive drinking may cause cirrhosis of the liver or liver cancer and increase the probability of accidents while driving or working.
- The abuse of alcoholic beverages can damage the health.
- Excessive consumption can be harmful to health.
- Alcohol may be hazardous to health if consumed to excess.
- Operation of machinery or driving after the consumption of alcohol is not advisable.

The United States label is more substantial and reads as follows:

"GOVERNMENT WARNING:

(1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risks of birth defects.

(2) Consumption of alcohol impairs your ability to drive a car or operate machinery, and may cause health problems."

Legislation on health warning labels was adopted in the United States based on the conviction that the public needed to be reminded of the potential risks associated with drinking alcohol. The labels were intended to remind the public of these risks, particularly the dangers of consuming alcohol while pregnant, driving a car or operating machinery with the goal of reducing alcohol related harm. Though not all testimony agreed that warning labels would be the most effective conveyer of such information, it was felt that when used in conjunction with other prevention efforts, and given the significant public approval, warning labels could contribute to the public's knowledge at minimal cost. It was also argued by some that the public had the right to know about the risks associated with consuming alcohol, just as they had been informed about the risks associated with a variety of other consumer products.

Health warning label legislation was implemented in the United States in 1989. Thereafter, and for the next several years, the National Institute for Alcohol Abuse and Alcoholism (NIAAA) funded a research study on the impact of such alcohol warning labels. These studies considered a number of different approaches to assessing this impact such as testing the public's awareness of the label, individual perception of risk, label design features and behavioural change. Seven years later in its October 1996 edition of Alcohol Alert, NIAAA summarized the research on alcohol beverage warning labels as follows: "Public support for warning labels is extremely high; that awareness of the label's content has increased substantially over time; that perception of the described risks was high before the label appeared and has not generally increased; and that the label has not had important effects on hazardous behaviour, although certain facts may be indicative of the early stages of behavioural

change." This view is echoed in an editorial in a recent edition of Addiction which stated: "Research on the effects of alcohol warning labels is inconclusive, with only limited evidence of a positive impact on consumer knowledge, attitude and behaviour."

Whether one believes alcohol warning labels are effective is very much dependent on what one believes the labels are supposed to achieve. One goal frequently cited in the U.S. Senate hearings held in 1988 was awareness and education and the need to remind the public of specific risks associated with alcohol consumption. A second goal is behaviour modification. As a result of this education, consumers will avoid certain situations that lead to harm, especially those who are at most risk for such harm.

Studies, which focus on the issue awareness, have shown that awareness of the label has increased over time. A telephone research survey was conducted six months before labels were placed on containers and then again six months after, to study label recognition and changes in relevant knowledge. Out of the sample of approximately 6,000 respondents, over one-fifth of them reported having seen the warnings. The researchers also found that strength of belief in the truth of the actual label content "increased significantly while for several spurious potential warnings, it declined somewhat."

In another study, among the sample of 2000 respondents, telephone surveys showed that approximately one quarter of the sample noticed the label six months after its introduction and 16% recalled the specific message which was related to driver impairment. Research that tested awareness of the alcohol and pregnancy message on alcohol containers also showed some evidence of increased awareness of the message

by respondents after the introduction of the label. Increases in the awareness of labels have been slow, but steady, among other sub-groups thought to be at higher risk.

Some reports show that in national household telephone surveys of adults in the United States in 1989, 1990 and 1991, awareness of the labelling increased to 27% of respondents. It is also reported that men, 18 to 29 years old, heavy drinkers (five or more drinks a day a week), and the more educated were most likely to have seen the label. The second goal, that of changing behaviour as a result of awareness and education, has, for the most part, not been achieved based on studies conducted to date.

It should be noted that the quality of labels in the U.S. has come under much criticism, not for their content but rather for their quality. Since there are few regulations regarding the labels, the alcohol industry has used small print, low contrasting colours and often positioned the message on a vertical edge which is awkward to read. Needless to say, the beverage alcohol industry has no interest in having the warning labels work. If they do work, that means that the sale of their products goes down. Quite simply, the objectives of the alcohol industry are not consistent with the health objectives of labelling. Is it any wonder that the beverage alcohol industry opposes warning labels in Canada?

Health warning labels do increase consumer awareness but we should not expect them to have significant effect on changing behaviour in isolation. Labelling must be part of a comprehensive national strategy to promote responsible use of alcohol. That strategy presently does not exist in Canada.

Chapter 7

DRINK SMART CANADA

In 1994, as a new member of the House of Commons Standing Committee on Health, I first became aware of the 1992 Report of the Health Sub-Committee entitled **"Fetal Alcohol Syndrome – The Preventable Tragedy"**. The report was very informative for me because I had never heard the term Fetal Alcohol Syndrome nor did I know about its severe consequences. One of the important recommendations in the report was to amend the Food and Drug Act to require health warning labels to be placed on the containers of alcoholic beverages. It seemed like a reasonable and constructive initiative to promote public awareness about the risks associated with alcohol consumption. Having seized my interest, I decided to conduct some research and here are a few important facts I found:

- Beverage alcohol was the only consumer product that could harm you if misused that did not alert the consumer to that fact.
- Health warning labels had been introduced in the United States in 1989.
- Health warning labels had been introduced in the Northwest Territories and in the Yukon in 1991.
- The 10 provincial ministers of health unanimously endorsed health warning labels in 1988 and again in 1992.
- Other supporters of health warning labels included the Canadian Medical Association, the Canadian Nurses

> Association, the Association of Medical Officers of Health, the Addiction Research Foundation, the Canadian Center on Substance Abuse and Mothers Against Drunk Driving (MADD) just to name a few.

In June 1995, given the substantial precedent and authoritative support available, I introduced a Private Members Bill to require health warning labels on the containers of alcoholic beverages. With the support of the Health Minister, the Bill was debated in the House of Commons on December 7, unanimously passed at Second Reading and was referred to the Health Committee for public hearings. Virtually every witness except the alcohol industry supported the Bill. However, by the time the beverage alcohol industry had finished its work, the new Minister of Health had questioned whether labelling was the best approach and the Health Committee buried the Bill deep enough to ensure that another election would be called before it could rise again.

Despite all that had transpired with my Private Members Bill C-337/222, I decided to look for ways to carry on the objective of trying to communicate to the public about the risks associated with alcohol consumption. My late father had been a severe alcoholic most of his life and died because of it. That life experience was enough to motivate me. However, the issue of Fetal Alcohol Syndrome was also very influential on my level of interest in the subject. As a father of three, with two university degrees and a professional designation and who had spent almost 10 years on the Board of Directors of the Mississauga Hospital, I was concerned that I had not become aware of FAS until I became a Member of Parliament in 1993. Like most parents to be, my wife and I knew that too much drinking was not something you should do during pregnancy. What we did not know was that moderate or social drinking

could, under certain circumstances, cause harm to our unborn child. In fact, in his December 1992 response to the Health Committee report on FAS, the Federal Minister of Health stated that "Changes in fetal breathing and the reduction of fetal blood flow to the developing brain have been linked to ingestion of a single drink during pregnancy". The fact is that there is no safe level of alcohol consumption during pregnancy.

With all I had learned about alcohol, the risks associated with misuse and the need for public education, more work was obviously needed. I knew that many Canadians simply were not fully informed. Therefore, broad-based public awareness efforts needed to continue. I also knew that for those who are aware of the risks but who still abuse alcohol, their behaviour would not be easily swayed by traditional public awareness approaches of governments and health-related agencies. They might, however, be influenced by an intervention by others for whom they had respect. The timing of such intervention would also be important. Most people do not drink alone and therefore the critical opportunity to make an intervention is at the time the drinking occurs. With these points in mind, I set out to design a public awareness campaign called "Drink Smart Canada". As a first effort, I drafted the following Drink Smart message:

"We all have a vested interest in reducing the number of alcohol-related tragedies. When you are in the company of someone who is becoming at risk of hurting themselves or others, you should intervene in an appropriate fashion. If you care, make sure that your friend, family member or acquaintance does not become just another tragic statistic. "Drink Smart" Canada says: Do whatever it takes!"

The next step was to assemble an advisory group. They included John Bates, Founder of Mothers Against Drunk Driving (MADD), Fred Burford, President of the Council on Drug Abuse (CODA), Edie Harris from St John Ambulance, Christine Tebbutt who worked for a Toronto City Metro Councillor and who was very familiar with FAS and Janetta Lavery, a mother whose son was killed by a drunk driver. After several meetings and consultations, the advisory group agreed upon the following points:

- The Drink Smart campaign should be nation-wide and have a concise and universal message.
- The intent is not to compete with or to contradict other programs but generally to promote responsible use of alcohol.
- It is important to establish that the problems associated with alcohol are very wide-ranging and costly.
- The facts, presented in an appropriate fashion, should elicit the reaction "I didn't know that."
- The emphasis should be on prevention rather than the rehabilitation of alcoholics who required long-term treatment.
- Most who abused alcohol are not alcoholics and therefore their behaviour may be influenced by timely education and support.
- Directly targeting "at risk" groups tends to be negative in tone, which is less likely to be effective in terms of changing behaviour.
- Informative and proactive communications to responsible persons may be viewed in a more positive light thereby promoting action.
- Most persons who abuse alcohol usually do so in a social environment.

- Since most abusers of alcohol are not alone at the time, this presents an opportunity for those in the company to intervene to provide support and to serve as a "reality check."
- It has become socially acceptable to speak up when someone is smoking. The objective of Drink Smart should therefore be to make intervening equally socially acceptable when someone in your company is misusing alcohol.

With those consensus points, the Drink Smart message was rewritten and adopted as follows:

"If you are with a friend, family member or acquaintance who is drinking and becoming at risk of hurting themselves or others, you should intervene in an appropriate fashion to make sure that they do not become just another tragic statistic."

The message alone was a good start but we needed some compelling statistics to establish some dimensions and a sense of urgency. We all had sources and here is the list we agreed upon:

"Did you know that…

- over 19,000 deaths each year
- 45% of motor vehicle collisions
- 30% of fires
- 30% of suicides
- 60% of homicides
- 50% of family violence
- 65% of snowmobile collisions
- 1 in 6 family breakdowns

- 30% of drownings
- 5% of birth defects
- 65% of child abuse
- 40% of falls causing injury
- 50% of hospital emergencies
- over $15 billion of additional costs

…are all directly or indirectly due to alcohol?"

These statistics were a good compliment to the Drink Smart message. Everyone who would read the statistics would be informed about the risks associated with alcohol consumption and therefore better appreciate the urgency for them to be part of the solution. The unique thing about the Drink Smart message was that it did not target the abusers of alcohol but rather those who were in their company. If the alcohol abuser respected the intervenor, it is more likely that they would respond positively to the intervention.

The next step of the Drink Smart campaign was to design a communications strategy. The advisory group considered posters, a brochure, an Internet site, a CD ROM, lapel pins and bumper and window sticker campaigns. Since it would take some time to find sponsors and patrons, we decided to launch Drink Smart with a poster campaign which would note our toll-free number. This would also serve as a pilot project to determine whether our message was resonating with the public. We were also pleased to receive the support of the Canadian Police Association and the Canadian Association of Fire Chiefs. Since so much of their work relates to problems associated with alcohol misuse, they agreed to serve as Honourary Patrons for our first campaign.

On June 18, 1996, Drink Smart Canada was officially launched at a press conference in Ottawa. Flanked by representatives of the Police and Firefighters, the first Drink Smart poster was unveiled and our plans to pursue a broader strategy was announced. The poster was well received and we were very encouraged by the positive reaction from the media and other groups and organizations. Initially the posters were distributed to M.P.'s who were asked to circulate them in their ridings. The Police and Firefighters also assisted with the distribution.

The message seemed to have good support and we were delighted to learn that the idea of targeting persons who could influence those who abuse alcohol was also part of the nationally supported Joint Statement on FAS in October 1996. Their first recommendation was: "Prevention efforts should target women before and during their childbearing years, as well as those who influence such women, including their partners, families, and the community." In my view, this is a particularly important recommendation because it says that we need to educate all Canadians who may be in a position to influence the behaviour of someone who is not drinking responsibly. This is the same premise on which Drink Smart Canada was designed.

It was also interested to learn that the City of Toronto had started a pilot project that involved placing large warning signs near intersections where there was a substantial history of serious automobile accidents. The thinking was that the best time to remind someone to be careful was precisely at the time that they were entering a high risk situation. This is very similar to the logic of the Drink Smart message which recommends intervention at the time that someone is potentially entering a high-risk situation.

The campaign moved forward with a new brochure. A supply of posters and brochures was mailed to the 620 mayors in Canada whose cities were members of the Federation of Canadian Municipalities. They were asked to distribute the materials in their communities and to consider passing a resolution in support of the campaign. Over the next few weeks, 331, or more than 50% of municipalities, had passed resolutions of support. This support came from every Province and from large cities including every provincial capital as well as small communities whose interest was just as strong. Numerous calls for more material were also received on our toll-free line. By the end of 1997, over 8,000 posters and 50,000 brochures had been distributed.

Confident that we had a good message, we needed to find corporate sponsors or patrons to fund the development of the rest of the communications strategy. Given the high level of public support for responsible alcohol use messaging, we were confident that we could find a partner who would benefit from the positive public relations value of associating with the campaign. Meetings and proposals were discussed with a variety of parties including IBM, Microsoft Canada, The Canadian Bankers Association, The Insurance Bureau of Canada and McDonalds. Despite some encouraging expressions of interest, none of the prospects was prepared to have their name associated with the campaign. What was particularly disappointing was that at least in three cases, the reluctance to participate was a concern about bumping up against the beverage alcohol industry. Virtually every major corporation in Canada has some sort of business relationship with the brewing, distilling or wine making industry. This was a major setback but efforts continue to find a champion to help make Drink Smart an effective national campaign.

Chapter 8

WOMEN OR CHILDREN FIRST?

Fetal Alcohol Syndrome may be incurable but it is preventable. The key to that prevention is twofold. Firstly, the mother must be fully aware of the risks of alcohol related birth defects and must understand and believe that there is no safe level of alcohol consumption during pregnancy. Secondly, the mother must accept the advice and abstain from consuming alcohol during pregnancy.

The first element is the responsibility of society. With the leadership and support of governments, health caregivers, social agencies, communities and families all have the responsibility to ensure that mothers-to-be are aware of the risks, understand the consequences and know that the right thing to do is to abstain from consuming alcohol throughout their pregnancy.

We will meet that responsibility by ensuring that, at every reasonable opportunity, the message is conveyed. However, based on all the relevant research studies I have encountered, full awareness levels only range from 40% to 65%. When you also consider that there has not been consistency in awareness messaging, it is very likely that many women do not believe that small amounts of alcohol can actually harm their baby. The medical profession continues to suggest that moderate consumption is acceptable but by whose standards? The Joint Statement on FAS recommends that women be advised that

for small amounts of consumption, the risk to the baby is minimal. The message that there is no safe level of alcohol consumption during pregnancy is not out there fully and for many whom are aware of it, they simply do not believe it. If a mother gives birth to an FAS child but was only a moderate, occasional or social drinker, society is at fault because we did not effectively communicate a clear message.

Today, Canada does not have a comprehensive communications strategy related to FAS. On October 16, 1996, in a press release from Health Canada regarding the Joint Statement on FAS, the Health Minister of the day laid out what the government has done or is doing as follows:

- sponsored the 1992 FAS Symposium in Vancouver;
- integrating FAS prevention strategies into existing programs within Health Canada's broader work around children and families and substance abuse;
- producing and distributing public awareness materials such as the pamphlet "Alcohol and Pregnancy" and a video entitled, "Un drame evitabe";
- providing partial funding to the 1993 FAS Conference in Saskatoon;
- funding 1993 FAS Workshop in Halifax;
- funding March 1994 FAS Conference in Vancouver;
- funding working group to develop health providers manual on FAS for Aboriginal Communities;
- partially funding October 1994 Conference in Vancouver;
- co-funding of a national information service resource centre on FAS which is located with the Canadian Centre on Substance Abuse

No matter what criteria you choose to judge these actions, it is hard not to conclude that FAS is not a national priority.

It is also hard to believe that the government has not been sued for failure to reasonably inform, or to have others inform the public at large that there is no safe level of alcohol consumption during pregnancy.

What is needed is a massive, comprehensive public awareness campaign that will take the full co-operation of all levels of government, the healthcare profession and social agencies. Some elements could include:

- mandatory health warning labels on the containers of all alcoholic beverages
- mandatory health warning signs in all locations serving beverage alcohol to the public
- make it an offence to knowingly serve alcohol to a pregnant woman
- standardize the communications for all governments, health caregivers and social agencies so that there is clear, concise, consistent and correct messaging given at every reasonable opportunity
- in our schools, make the subject of alcohol misuse and its consequences part of the curriculum
- other elements for consideration as outlined in Chapter 4 and Chapter 5.

The second element of prevention is that the mother who is aware of the risks and consequences and who believes that there is no safe level of alcohol consumption during pregnancy, must choose to abstain from drinking to safeguard her unborn child. That is the responsibility of the mother. When you consider the lifelong suffering of an FAS victim, it is hard not to imagine how the mother must feel knowing that her actions during pregnancy were the cause of this tragedy. Under normal circumstances, society's first reaction is not to

condemn the mother. Her pain will also be lifelong and giving birth to an FAS child under these circumstances is tragic. We now know that even small amounts of alcohol taken during pregnancy can harm the unborn child. That is why the experts all agree that there is no safe level of alcohol consumption during pregnancy. However, what about the case where the mother chooses to ignore the warnings and decides to continue to consume alcohol during pregnancy?

The term fetus comes from the latin meaning offspring. However, for some, it is a term to describe not an offspring or unborn child, but rather a thing that is part of the mother's body. It is a very important distinction which has faced the courts of the land for a long time. It is often said that the unborn child has less rights than a dead body because the law protects the dead body from indignities. It is true. The fact is that under the laws of Canada today, the fetus (unborn child) has no rights.

Many have questioned whether society should take any action if a pregnant women chooses to be a substance abuser despite the risks to her unborn child. So far, the courts have said it is none of our business because under current Canadian law, the fetus is not a legal entity. Some would suggest that it is time to make it our business. Most recently in the notorious Winnipeg case of a 22 year old solvent abusing mom-to-be who refused to get treatment voluntarily, the judge resorted to declaring the mother incompetent and forced her into treatment for her own good rather than for that of her fetus. Later, a higher court, the Court of Appeal, overturned that ruling.

In 1997, a Moncton judge ruled that a child, disabled as a fetus in a car accident could sue his mother for her role in the

accident. This case was appealed. In still another case in the United States, a Wisconsin woman was charged with attempted murder after her daughter was born with a blood alcohol level almost twice the state's legal intoxication limit.

What do you do when reasonable prevention efforts fail and a pregnant woman continues to put her baby at risk? We really need to address that issue. Some have argued that forced treatment or even incarceration is necessary. Critics argue that compulsion infringes on a woman's right to control her own body, a right won through long battles around the abortion issue. They further argued that if you make drug and alcohol use illegal during pregnancy, you will drive women underground. They will not seek medical help until going into labor, putting the babies at far greater risk. By extension, you could also talk about nicotine use, unhealthy lifestyles, improper nutrition, dangerous or high stress work environments, risky sports etc. Many things in the mother's life can affect the outcome of the unborn child. The resolution surely lies in balancing a woman's right to control her own body with her obligation to act responsibly once she becomes aware she is pregnant. Some jurisdictions have, or are considering, taking a harder line.

On July 1, 1998, South Dakota became the first state to allow judges to cut the number of cases of Fetal Alcohol Syndrome. The statutes include:

- Allowing relatives or friends to commit a pregnant woman to emergency detoxification centres for up to two days.
- Allow judges to confine them to treatment centers for as long as nine months.
- Makes drinking while pregnant a form of child abuse.

In February 1998, the Governor of Minnesota's Taskforce on Fetal Alcohol Syndrome proposed mandatory reporting of alcohol use during pregnancy. Under a mandatory reporting process, a woman would first have a chance to voluntarily receive treatment before involving her in the legal system. A woman would be considered to be abusing alcohol during pregnancy if she meets one of the following conditions:

- She requires detoxification during pregnancy
- She habitually consumes three or more drinks at any one time since knowing of the pregnancy
- She refuses to stop excessive drinking during pregnancy
- She appears intoxicated based on two or more of the following indicators: odour of alcohol; slurred speech; disconjugate gazed (eyes do not track together); impaired balance; difficulty remaining awake; consumption of alcohol; responding to sights or sounds that are not actually present; extreme restlessness, fast speech or unusual belligerence.

If the pregnant woman failed to follow the recommendations made at the assessment, a report would be made to local welfare agency or maternal-child substance abuse project. If the chemical use assessment indicated that the woman needed treatment, the local welfare agency would arrange for proper treatment. If a woman continued to abuse alcohol and did not comply with treatment recommendations, the local welfare agency could take action including referral for emergency admission to a treatment facility.

Prevention of FAS is a noble objective to shoot for, but in the absence of it being a national priority and the absence of an effective and comprehensive national campaign, it simply is not going to happen. Many groups, organizations and

individuals in Canada continue the battle to promote awareness and diagnosis and some have suggested further initiatives that might be considered such as:

- Introduce a special tax on all beverage alcohol for human consumption with the entire proceeds going to research, treatment and prevention of FAS and for support facilities and proper housing and care for victims of maternal substance abuse.
- A ban on any alcohol advertising in any media.
- Introduce criminal and civil remedies to be available to the victims of substance abusers and their suppliers.
- Introduce a major screening and assessment of offenders in penal institutions to identify those suffering from FAS.

In August 1999, Saskatchewan, Manitoba and Alberta collaborated on a Fetal Alcohol Syndrome prevention campaign which will last for three years. Their initiatives include the development of education packages for health-care workers, addiction agencies and teachers; community development initiatives; the production of posters, brochures and public-service announcements; and the printing of an FAS prevention message on all liquor store bags and sales receipts. These are positive steps but would they not be that much more effective if every province, using the same messaging, did this at the same time and made it truly a national effort that would benefit all Canadians? Why do we not have a co-ordinated national strategy in Canada?

Chapter 9

THE FINAL WORD

Fetal Alcohol Syndrome and other Alcohol-Related Birth Defects are a reality in our society and the victims suffer a lifetime of tragic symptoms which rob them of any reasonable quality of life. Their needs place enormous demands not only on the parents, but on society as a whole. As such, we all have a vested interest to reduce, as much as possible, the incidence of these incurable but preventable disorders.

While it is important to respect individual rights, we cannot ignore the fact that when a woman is pregnant, the birth of a child is a virtual certainty. Consequently, we have both a social and a moral responsibility to do the best we can to balance the individual's rights during their pregnancy with society's responsibility to promote good public health.

Ensuring that all Canadians are properly informed is the responsibility of society, who directly and through agencies which deliver health and social services, provide the necessary initiatives. However, FAS and Alcohol-Related Birth Defects have not become a national priority in Canada. Politically, it appears that the beverage alcohol industry has sufficient influence to effectively restrict responsible use initiatives to those which they are confident will have little impact, but which will suit their requisite need to demonstrate corporate responsibility. It's not personal. It's just business.

Health Canada also appears to be handcuffed. How can they ever hope to have effective programs when their co-funding partner stands to be the big loser if the programs work? The real measure of success of a program will be the reduced consumption of alcohol by women in their childbearing years.

In December 1999, the Minister of Justice announced that the government was suing the tobacco industry and in her press conference, she stated that "the defendant's goal of making money is inconsistent with the government's goal of protecting children's health." The same can be said of the alcohol industry. They are selling a legal product but since that product can cause harm, our health objectives should not be compromised either in appearance or in fact. By relying on the alcohol industry for so much support funding, Health Canada is understandably reluctant to push the envelope or jeopardize that funding which the alcohol industry threatened to withdraw if health warning labels became mandatory. This dependency may also affect other agencies who are dependent on, or who partner with Health Canada. If we are to make any meaningful progress on FAS, it may be desirable to wean Health Canada off its alcohol dependency which has endured for decades.

Another important step will be to create a national focus. There are literally dozens of groups and organizations in Canada who have made FAS their cause and who represent thousands of people all across the country. They are all commited to do whatever they can to promote awareness on a local and regional basis. However, without national co-ordination, they are all doing much the same thing and their impact is not being felt in Ottawa. They need to form a national coalition to standardize their messaging, to establish their priorities, and to develop a political action strategy.

This coalition would then have the critical mass necessary to dialogue with all the players including the alcohol industry and the politicians. Their growth potential would also be enormous since they could build alliances with numerous other groups and organizations across the country who are involved in broader alcohol-related health issues.

The National Action Committee on the Status of Women (NAC) has levered its influence for years on the strength of membership of other groups across the country. This is also similar to how Mothers Against Drunk Driving (MADD) has become so influential and has made such solid progress on the legislative front. They are organized, credible, informed and persistent. Equally important, they have earned respect for going about their business in a professional and non-confrontational manner unlike the more aggressive style often used by other groups.

If we could prevent even a small percentage of alcohol-related birth defects, the savings in health, social program, educational and criminal justice costs would be many times more than the cost of an effective national prevention strategy. More importantly, we could eliminate so much human misery and suffering which is the essence of a caring society.

ABOUT THE AUTHOR

Paul Szabo is a Member of Parliament representing the riding of Mississauga South. A Chartered Accountant by profession, he also holds an M.B.A. from York University and a B.Sc. from the University of Western Ontario. Prior to his election, he worked in the corporate and public accounting sectors for over 23 years. Mr. Szabo's extensive community service record also includes 9 years as a Director of the Mississauga Hospital, 5 years as a Director of Interim Place (community shelter for abused women and children), and 5 years as a Director of the Peel Regional Housing Authority.

He was first elected to the House of Commons in 1993 and was re-elected in 1997. During his parliamentary career, he has introduced over 20 Private Member Bills and Motions emphasizing health and taxation of the Canadian family. One of his initiatives successfully amended the criminal code to provide stiffer sentences for the abusers of women or children.

He also developed "Drink Smart Canada", a national alcohol awareness campaign and he has authored five monographs: "Divorce - The Bold Facts", "Strong Families Make a Strong Country", "Tragic Tolerance of Domestic Violence", "The Child Poverty Solution" and "Fetal Alcohol Syndrome – The Real Brain Drain", all in support of his personal initiatives as a Member of Parliament.

Paul and his wife Linda have been married for 28 years and they have three children, Aaron, Reagan and Whitney.