

**U.S. Public Health Service**

**Centers for Disease Control and Prevention**

**National Center on Birth Defects and Developmental Disabilities**

**Records of the Conference Call Meeting of the**

**National Task Force on  
Fetal Alcohol Syndrome and Fetal Alcohol Effect**

**October 24, 2007**

**Conference Call Meeting held at  
Executive Park Building 12  
Centers for Disease Control and Prevention  
Atlanta, Georgia**

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**Centers for Disease Control and Prevention  
National Center on Birth Defects and Developmental Disabilities  
National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect**

**Minutes of the Conference Call Meeting  
October 24, 2007**

A conference call meeting of the National Task Force on Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) was convened on October 24, 2007 in Atlanta, Georgia by the Centers for Disease Control and Prevention's (CDC's) National Center on Birth Defects and Developmental Disabilities (NCBDDD).

**Wednesday, October 24, 2007**

**Call to Order**

Mary Kate Weber, MPH, Designated Federal Official, called the meeting to order at 12:00 p.m. Jean A. Wright, MD, MBA, Chair, welcomed those present. She thanked everyone for giving their time to attend the final conference call for the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect (NTFFAS). Upon determining that a quorum had joined the call, Dr. Wright officially called the meeting to order.

**Introduction of Task Force Members, Liaison Representatives, and Attendees**

Task Force Members Present:

Jean A. Wright, MD, MBA, Backus Children's Hospital, Savannah, GA  
James E. Berner, MD, Alaska Native Tribal Health Consortium, Anchorage, AK  
Carole W. Brown, EdD, Catholic University of America, Washington, DC  
Raul Caetano, MD, PhD, MPH, The University of Texas School of Public Health, Dallas, TX  
Grace Chang, MD, MPH, Brigham and Women's Hospital, Boston, MA  
Mary C. DeJoseph, DO, Philadelphia College of Osteopathic Medicine, Philadelphia, PA  
Lisa A. Miller, MD, Department of Public Health and Environment, Denver, CO  
Colleen A. Morris, MD, University of Nevada School of Medicine, Las Vegas, NV  
Melinda M. Ohlemiller, BA, MA, Saint Louis Arc and parent of a twelve-year-old with FAS,  
St. Louis, MO  
Heather Carmichael Olson, PhD, University of Washington FAS Diagnostic Clinic,  
Washington State FAS Diagnostic and Prevention Network, Seattle, WA

Standing Member:

Kenneth R. Warren, PhD, National Institute on Alcohol Abuse and Alcoholism (NIAAA),  
National Institutes of Health (NIH) Washington, DC

Acting Executive Secretary:

R. Louise Floyd, DSN, RN, Fetal Alcohol Syndrome Prevention Team, DBDDD, NCBDDD,  
CDC

Task Force Members Absent:

Kristen L. Barry, PhD, Serious Mental Illness Treatment Research & Evaluation Center,  
Department of Veterans Affairs, Ann Arbor, MI

Mary J. O'Connor, PhD, ABPP, David Geffen School of Medicine at the University of California, Los Angeles (UCLA), Los Angeles, CA

*Liaison Representatives Present:*

American Academy of Pediatrics (AAP): George Brenneman, MD, FAAP

American College of Obstetrics and Gynecology (ACOG): Robert J. Sokol, MD, Department of Obstetrics and Gynecology, C.S. Mott Center for Human Growth and Development, School of Medicine, Wayne State University, Detroit, MI

The Arc: Sharon Davis, PhD, Health Promotion and Disability Prevention Committee, Silver Springs, MD

Center for Science in the Public Interest (CSPI): George A. Hacker, JD, Alcohol Policy Project, Washington, DC

National Organization on Fetal Alcohol Syndrome (NOFAS): Kathleen T. Mitchell, MHS, LCADC, Washington, DC

*Liaison Members Absent:*

March of Dimes (MOD): Karla Damus, PhD, Washington, DC

*Other Attendees:*

Jacquelyn Bertrand, PhD, Developmental Psychologist, FAS Prevention Team, DBDDD, NCBDDD, CDC

Coleen Boyle, Director, DBDDD, NCBDDD, CDC

Elizabeth Parra Dang, MPH, Behavioral Scientist, FAS Prevention Team, DBDDD, NCBDDD, CDC

Patricia P. Green, MSPH, Epidemiologist, FAS Prevention Team, DBDDD, NCBDDD, CDC

James Tsai, MD, Epidemiologist, FAS Prevention Team, DBDDD, NCBDDD, CDC

Jacqueline Vowell, Committee Management Specialist, FAS Prevention Team, DBDDD, NCBDDD, CDC

Stephanie Wallace, Writer-Editor

Kimberly Leeks, PhD, RTI International, Atlanta, GA

Alton Dunlap, RTI International, Atlanta, GA

Frank DeStefano, PhD, RTI International, Atlanta, GA

Stephanie Henry Wallace, Cambridge Communications, Atlanta, GA

**Update/Discussion of Task Force Report: *Preventing Alcohol-Exposed Pregnancies***

Mary Kate Weber reminded everyone that the main charge for this conference call was to provide an update on the October 18, 2007 version of the Task Force report titled "*Preventing Alcohol-Exposed Pregnancies*." Following the last face-to-face Task Force meeting on September 12-13, 2007, CDC and RTI staff incorporated the suggested revisions provided during that meeting. Subsequently, a revised draft was disseminated to the Task Force members on October 5, 2007 for review and comment. Ms. Weber thanked the group for the additional feedback submitted following the October 5<sup>th</sup> draft, indicating that it had been incorporated into the most current version. The major revisions since the last Task Force meeting included the following:

- The Executive Summary has been shortened considerably and was revised to reflect the revisions made in the report.
- Several sections were moved to the appendices:
  - Current Federal Efforts section has been moved to Appendix A and is now a timeline of federal efforts and other significant activities contributing to FASD prevention efforts.
  - All of the relevant alcohol screening tools that were originally in the body of the report except for the T-ACE have moved to Appendix B.
  - A brief summary of several recent screening and brief intervention activities are referenced in Appendix C.
- The section on Women at Highest Risk was reworked.
- The recommendations were reworked.
- A new section, *Future Research Directions*, was added, which was essentially based on the discussions that occurred during the last Task Force meeting.
- A number of editorial revisions were made.

Ms. Weber thanked everyone again for their input, and expressed her gratitude to those who assisted in reworking sections and offering editorial comments. The group then engaged in a discussion pertaining to the recommendations and report content.

### **Recommendations Discussion**

- Dr. Berner noted that on line 161 there is a syntax error: “is” should be “are.”
- Dr. Sokol indicated that there was something missing in the wording of Recommendation #3. He suggested revising it to read “examine gender and age effects, as well as pregnancy outcomes where possible.”
- Dr. Wright indicated that they were attempting to make a strong statement that analyses should be included by gender and age, because their experience with the research that was reviewed for the document did not show that this was consistently available where it would have been helpful.
- Dr. Sokol thought the recommendation itself was fine. The wording of it, however, was simply difficult to understand.
- Dr. Olson suggested simply adding the word “examine” before “pregnancy outcomes where possible.” Dr. Sokol concurred.

- An inquiry was posed regarding whether Recommendation #2 was entirely new. Ms. Weber responded that it was. Dr. Floyd added that they were attempting to encourage the use of population-based interventions that the Task Force for Community Preventive Services is currently reviewing. This recommendation was created to show support for the Community Guide in implementation of those recommendations that they make for alcohol use overall for the general population because childbearing age women would benefit from these as well.
- Given that the Task Force for Community Preventive Services recommendations on excessive alcohol use have not yet been published, or seen beyond a presentation during a previous Task Force meeting, Dr. Miller expressed concern that they were recommending something without knowing its actual content.
- Dr. Hacker said he thought they did know the content and that it went back to the presentation they heard from Tom Babor at a previous Task Force meeting about environmental policies that might relate to this area.
- Dr. Caetano agreed, but thought Recommendation #2 would be better worded if they did not make reference to the Task Force for Community Preventive Services, but instead actually gave examples of some of the interventions. It sounded odd to him to have a recommendation identifying another document that people would have to search for in order to find out what the Task Force was recommending. He suggested taking the examples from “Alcohol: No Ordinary Commodity.” They refer to that in the body of the report and refer to the population-level policies that were identified as effective in “Alcohol: No Ordinary Commodity.”
- Dr. Hacker thought it would be more powerful if it was a CDC document that they related to rather than World Health Organization’s (WHO’s) “Alcohol: No Ordinary Commodity.”
- Dr. Caetano thought it was fine from a recommendation perspective to refer to another report but not be specific enough that they would identify the policies.
- Dr. Hacker thought they could do both—mention the report and then include perhaps the top three or four policies that the report will contain.
- To make the document as strong as possible, Dr. Sokol thought it should be clean and simple. If they wanted to say they would like to promote population-based interventions that educate on alcohol harms the general population, including women of childbearing age, this can be done without mentioning the Task Force for Community Preventive Services. If they want to know what to implement, they can go into the body of the report, and there are plenty of people who are experts in universal prevention. He would keep it as a straightforward, bold statement, which would make it more powerful, “Promote the implementation of population-based interventions for reducing alcohol-related harms in the general population, including women of childbearing age.

- Dr. Miller reminded the group that they said they were focusing on interventions that are evidence-based that affect women of childbearing age who are at risk for an alcohol-exposed pregnancy. It was not clear to her that Recommendation #2 met that criterion.
- Dr. Caetano disagreed. He thought it did meet the criterion and that there is very strong evidence that population-based policies affect alcohol consumption in the whole population. For example, a sexually active 21 year old woman drinks, but does not go to the OB/GYN or a family practice. How is she going to be affected by any prevention intervention? The only way is through population-based strategies. Otherwise, she will not see a physician, be screened, or be asked by anyone about how much she is drinking.
- Dr. Sokol said that there was no evidence that this worked. He was fine with keeping the recommendation, but taking out “Task Force for Community Preventive Services.”
- Dr. Caetano disagreed that there was no evidence. There is evidence that reducing alcohol availability reduces population problems. As he reviewed the report, he thought they were doing a disservice to universal prevention.
- Dr. Miller thought Recommendation #1 was saying that more evidence is needed for universal prevention strategies. However, currently there is no evidence.
- Dr. Caetano responded that the evidence exists that the policies reduce alcohol problems in the general population, and FAS falls under the large umbrella of an alcohol problem. The evidence is never specific around reducing X, Y, and Z.
- With that in mind, Dr. Miller suggested that they consider changing what they said they were going to do in this document.
- Dr. Floyd said that her sense from the Community Guide was that they would be seeing some recommendations that related to alcohol in the near future. She agreed with the notion that with an evidence-based population-based intervention, by de facto, childbearing age women would be affected. However, for the time being, they do not have the recommendations of the Task Force on Community Preventive Services, and they did say that evidence-based would be the litmus test. While her hope was that they would receive something from the Community Guide, it did not appear that they would have it in time for this Task force document. Therefore, she suggested removing Recommendation #2.
- Dr. Hacker did not think the recommendation should be removed entirely. There are substantial grounds to do more than just ask for more research. He thought there was substantial evidence that population-based approaches will reduce overall consumption, including among the target population. He did not support eliminating a recommendation that actually stated this. However, if they did decide to remove Recommendation #2, he suggested that they also remove the entire discussion of universal policy activities.
- Dr. Miller disagreed, saying she did not think they needed to remove that at all, and that it was an important discussion.

- Dr. Brown said she interpreted lines 146 through 148 as offering future research directions, but her impression was that the sentence was not confining those research directions to everything that has been proven.
- Dr. Miller clarified that these lines related to a practice not a research direction.
- Dr. Warren said that supporting universal-based preventions was a worthy goal, regardless of whether any evidenced-based universal preventions currently existed. However, endorsing recommendations not yet published did not seem prudent.
- Dr. Floyd suggested the following rewording, “Promote the implementation of population-based interventions for reducing alcohol-related harm in the general population, including women, as they are validated.”
- It was noted that there is a paragraph in the Executive Summary on universal interventions, so it is highlighted.
- Dr. Caetano suggested reversing Recommendation #1 and #2. It seemed to him that #2 was more general than #1, and #1 was slightly more specific because it discussed testing methodological approaches, which is a very specific research focus.
- Dr. Sokol pointed out that hidden in Recommendation #1 was exactly the concern that there really is not an evidence base for this population that works. He thought the order was acceptable.
- Dr. Hacker indicated that the Center for Science in the Public Interest (CSPI) is planning to repeat their efforts to promote health warning signs on FAS and drinking during pregnancy at the point of purchase, which is what they did long ago in 22 states across the country. There is very little evidence that this is effective to change the amount of drinking among pregnant women or for reducing fetal alcohol syndrome. If they limit Recommendation #2 to “as the validity becomes established,” that kind of program would be interpreted as having no support from this document.
- Dr. Miller said that while it may not be in the recommendations, they do say that universal prevention activities are important and people do need to pay attention to them. It is just that they do not rise to that level of evidence.
- Dr. Floyd suggested, “Promote the implementation of effective population-based interventions for reducing alcohol-related harm in the general population, including women of childbearing age, as they are validated.”
- Dr. Hacker inquired as to whether “validation” meant that the outcomes are specifically related to the target audience.

- Dr. Floyd responded that it did not, but that what they were saying was that it is clear that interventions for reducing alcohol harm in general populations have a direct impact on childbearing age women as well.
- Dr. Caetano said that for the other target audiences they are validated. They cannot say that population strategies are not validated because they are. They have different levels of validation (e.g., taxation, reductions on alcohol availability, control of outlets) that are very powerful. Others may not be as powerful, but there is very strong evidence for these.

### **Motion**

A motion was made to revise Recommendation #2 to read, “Promote the implementation of effective population-based interventions for reducing alcohol-related harm in the general population, including women of childbearing age, as they are validated.” Dr. Miller seconded the motion. The motion carried with 10 Task Force members voting “yes,” 1 voting “no,” and 0 abstaining.

- Referring to Recommendation #2, Dr. Caetano suggested changing the word “misuse” to “use” because it would enlarge the number of studies that they could recommend. Others agreed.
- It was noted that the word “brief” was omitted from Recommendation #4.
- Dr. Sokol thought they should leave the word “brief” out because “brief interventions” are getting connotations and denotations, and it could be argued that some of the interventions found to be effective are barely brief. They are actually fairly intensive. The attempt to intervene is what is important. While Dr. Boyle suggested using the word “behavioral,” Dr. Sokol pointed out that someone might develop a pharmacological intervention.
- Ms. Weber pointed out that primarily brief interventions are referred to in the report. The U.S. Preventive Services Task Force (USPSTF) uses the term “brief.” She thought it would be better to include the word “brief.”
- Dr. Warren agreed with Dr. Sokol that some of the most effective interventions which are called “brief” are four sessions or even longer, and that perhaps they should leave out the word “brief.” Given that this was her area, he requested Dr. Chang’s input.
- Dr. Chang agreed that it would be more encompassing and inclusive if they left out the word “brief.” Leaving it as “evidence-based intervention strategies” would certainly include brief interventions and it would also open the door to other interventions that have been demonstrated to work. The text already includes a definition of what is meant by “brief intervention” [line 571].

- Dr. Floyd noted that some investigators use the term “extended brief interventions” in their quest to define what brief interventions are. She agreed that leaving out “brief” would probably be sensible.
- Ms. Weber noted that there was agreement to leave Recommendations #4 and #5 as they were.
- For Recommendation #7, it was suggested that a comma be added after “age” and that the word “including” be replaced with “as well as” or “such as.”
- With respect to Recommendation #8, Dr. Olson expressed concern that they are not pulling out adolescents. Women who are not adolescents have a whole set of problems, and there are high-risk adolescents who are pregnant. However, in the new version, adolescents are not pulled out at all and she wondered if they could put it back.
- Dr. Sokol said he like the new version better because this was needed regardless of age.
- Dr. Floyd suggested “assuring alcohol treatment for all childbearing age women.”
- Dr. Sokol said he liked Recommendation #9, but he did not know whether there was very much evidence.
- Dr. Caetano did not think that the word “treatment” was appropriate in Recommendation #9.
- Dr. Floyd thought this was connected to their discussion of Phil May’s approach, which looks at the community and includes individual-level interventions and case management.
- Dr. Olson responded that the rewording was intended to embrace the two types of efforts that have been aimed at this particular group. These are community-wide approaches at all levels, including prevention all the way up to having the community focus on someone who is at the highest risk. Multi-level is how Phil May describes what he is doing, but it really is community-wide. She was not trying to get at residential treatment, versus intensive outpatient, versus short-term outpatient treatment.
- Dr. Warren thought it was appropriate to have a statement, but was not clear what it should be. He also wondered if it was possibly redundant with Recommendation #7.
- Dr. Floyd thought it was talking about an individual-level intervention with just one type of individual level intervention, which would be case management. It is very broad and gives the person just about everything they need (e.g., treatment, job field training, tangible help with where to live, etc).
- Dr. Olson thought it would be dangerous to pull out the focus that they tried to include on placing special focus on those women who are at the highest risk of producing the outcome in which the Task Force is interested. It was also noted that the text explains this multi-level approach. Others agreed.

- It seemed to Dr. Floyd that the multi-level concept was encompassed in the case-management. She suggested rewording it to state, “Conduct further research aimed at implementing and evaluating treatment and case management approaches for women at highest risk of having a child with FASD.” She thought perhaps they were getting tripped up with “multi-level.”
- Dr. Olson agreed, but said she would add the modifier “intensive” to “case management” so it would read, “Conduct further research aimed at implementing and evaluating treatment and intensive case management approaches for women at highest risk of having a child with FASD.” Everyone agreed.
- Dr. Warren was not sure where Recommendation #10 came from in the text. It looked like they were switching from alcohol to substance abuse. He did not remember seeing a discussion on abuse of substances other than alcohol in the text.
- Dr. Olson responded that she was trying to get at the children of alcoholics literature and literature of treatment for women who are chemically dependent. She perhaps stepped into another literature on this one. The way they are going to get at the children who are most likely to abuse later is to go into the larger population of substance abusing women, find their children, and work with them before they get involved in getting pregnant and having exposed children. She said perhaps she had roamed too far.
- Dr. Sokol thought there was very little data on transgenerational effects.
- Dr. Olson suggested moving this to Future Directions, but she said she was convinced that they must address the issue of transgenerational problems. Others agreed that it should be left with alcohol, given that this is what the text discusses, and that it should remain as Recommendation #10 rather than moving to Future Directions. Clinical wisdom would support that further research is needed in this area.
- Dr. Floyd suggested the following rewording, “Promote research investigating potential interventions for women at risk for an alcohol-exposed pregnancy with special focus on potential intergenerational effects of alcohol on their offspring.”
- An inquiry was posed about whether to leave in the phrase “substance abuse,” but Dr. Warren suggested that without overt evidence for anything beyond alcohol, he would leave it at just alcohol. He suggested the following wording, “Promote research investigating the potential intergenerational effects of alcohol exposure on offspring.”
- Dr. Olson pointed out that this would raise the issue of paternal alcoholics, which is where most of the intergenerational literature is. Therefore, she suggested “alcohol use during pregnancy on their children.”
- The revised “Promote research investigating the potential intergenerational effects of prenatal alcohol use on offspring” was agreed upon by the group.

### **Motion**

Dr. Morris made a motion to accept the Recommendations as they currently stand. Dr. Sokol seconded the motion, which carried unanimously. See *Appendix A* for a list of the Approved Recommendations.

### **Content Discussion**

- An inquiry was posed regarding whether, in the Prevention Report's Appendix A, there was a plan to include the American College of Obstetrics and Gynecology (ACOG) toolkit.
- Ms. Weber responded that she could add it, and that she would be happy to add any other significant dates here. She noticed that most of the ones in the body of the document were federal agency related, but she was open to including other suggestions. She said if the Task Force members were open to CDC adding significant prevention efforts from other agencies, they would do so.
- Dr. Olson suggested cross-checking Appendix A with the "Call to Action" to determine whether anything in it needs to be added to this document.
- Dr. Caetano said he had several wordsmithing suggestions, but thought it would be easier to send Ms. Weber a marked up version with the changes tracked.
- Ms. Weber said that would be fine. She also noted that the document would ultimately go through the CDC clearance process, which would include an editorial process.

### **Motion**

A motion was made to approve the report as written, with the understanding that there may be additional minor editorial revisions made prior to publication. Dr. Morris seconded the motion, which carried unanimously.

### **Update of the "Call to Action" Report**

Dr. Olson reported that they had an interesting and productive presentation at the FASD Leadership Institute that Claire Coles orchestrated. She disseminated an approved draft of the recommendations to the participants at that Institute that Ms. Weber and Ms. Vowell graciously put together, and she requested that the participants identify other potential recipients for the "Call to Action" upon its publication. She also approached Kathy Mitchell about specific bullet points under Recommendation #8 about grassroots family efforts, and Ms. Mitchell has provided those to Dr. Olson. She plans to have an email exchange with Ms. Mitchell, Ms. Weber, and the other members of the Post Exposure Workgroup to ensure that they simplify and make the grassroots family efforts match the level of the recommendations in the rest of the document.

Two ideas arose at the Leadership Institute that could be made specific bullet points under Recommendation #10 with respect to maintaining a national forum. One is to convene meetings around specific topics of interest, such as FASD intervention, on a regular basis without specifying who would convene them or the logistics. That would be one way to continue the dialogue about FASD. The second, which was somewhat more controversial, regarded establishing a policy institute around FASD. While it is an interesting idea, Dr. Olson said she had been thinking hard about it and was apprehensive about including it as a specific action step. Thus, she decided to put the idea out to the Task Force for input.

### **“Call to Action” Discussion**

- An inquiry was posed regarding whether policy institutes were typically privately funded.
- Dr. Bertrand responded that these would have to be privately funded. She clarified that what Callie Gass suggested was a policy research institute that could address many of the policy and cross-systems issues that were being discussed a lot at the FASD Leadership Institute. It was made clear at that meeting that there is a chasm that must be bridged between what researchers know, what federal officials can do, and what legislators and policy people need. A policy institute is one approach to bridging that divide.
- Dr. Sokol wondered if there was anything in the body of the “Call to Action” about this type of forum. He did not recall seeing anything and thought it would be difficult to include it at this point.
- Dr. Olson responded that there is not anything included at this point, but she could write something. Given that the text of the document is very short, she would only be able to add a few sentences pertaining to that issue. The additions to the other two recommendations are already addressed in the text as it stands, so she will not have to add anything there. The document has been approved as it stands, so it was also not clear to her whether it was appropriate to modify the text in minor ways and proceed.
- While Task Force members found the Policy Institute to be an interesting and compelling concept, because it was a new idea and the document had already been approved largely as it stood, there was agreement that it should not be added at this point.
- Dr. Bertrand thought the concept of influencing policy was within the document itself. While this particular phrase was not included, the spirit seemed to be there.
- Dr. Olson said that while no one seemed to have made a strong statement against a Policy Institute, she was attempting to keep recommendations tied to the text and not complicate matters. She concluded that she would review the document to determine whether a Policy Institute action step could be tied to any text, and that she would seek technical guidance from CDC to ensure that she did not violate the standing motion made during the last face-to-face Task Force meeting. This was agreeable to Task Force members and staff present on the conference call.

- Dr. Bertrand reported that the FASD Leadership Institute was an excellent forum and that Dr. Olson did an outstanding job of presenting the “Call to Action.” There was a lot of consensus about the recommendations for affected individuals that the Substance Abuse and Mental Health Services Administration (SAMHSA) published in 2006 and what the “Call to Action” says. Everyone knows what needs to be done. The Leadership Forum is turning out to be a great next step after the Task Force ends which can also use and promote the products that the Task Force has developed in very productive ways.
- Dr. Olson added that the momentum really did feel like it was going to be sustained, and she felt like the Task Force’s efforts were absolutely a reason for that.

### **Proposed Timeline for Task Force Products/Next Steps**

With respect to the timeline for the Task Force products, Ms. Weber noted that the process for each document differed slightly. The “Call to Action” does not include CDC authors so it will not have to go through CDC’s formal clearance process. Upon making the final edits, it will go to Dr. Wright who will be responsible for delivery of the document with a formal letter introducing the report to the Secretary of Health and Human Services (HHS). This will be sent to Committee Management from where it will move forward to go through a vetting process with HHS. It will remain there for 30 days to ensure that anyone interested has an opportunity to review it. With that in mind, the hope is that it will be out and ready to disseminate by January 2008. Given that there are several CDC authors on the “Prevention Report,” it will have to go through CDC clearance first, but the rest of the process will be the same. The “Prevention Report” is anticipated to come out approximately one to two months after the “Call to Action.”

### **Discussion**

- Dr. Brenneman requested that he be provided with drafts, as soon as legally appropriate, to share with the Committee on Substance Abuse of the Academy of Pediatrics. They are very eager to see it.
- Ms. Weber responded that the documents could not be disseminated until they went through the full clearance process.
- Dr. Olson added that as soon as the document was cleared, she would immediately get a copy to Dr. Brenneman. She also noted that while a formal dissemination plan had not been finalized, a list of people who would receive the “Call to Action” had been compiled and she planned to talk to Ms. Weber about how she could initiate making sure that all of the other Task Force members receive it and that it also gets into the hands of the people who can use it.
- Ms. Weber added that they spoke briefly during the last face-to-face meeting about potential dissemination efforts, and that she would review the minutes from that meeting to pull that list together. The Post Exposure Working Group plans to have a conference call in about a month to determine the best way to get both products out. She invited everyone to participate in that discussion.

- Dr. Morris suggested that in the meantime, Task Force members could begin emailing suggestions to Ms. Weber. There is likely to be a lot of overlap, so this would give Ms. Weber a list for those who participate on the call to review.
- Ms. Olson indicated that she received a list of about three pages at the Leadership Institute, which she planned to type and forward to Ms. Weber.
- Ms. Weber said she was looking forward to receiving everyone's ideas, and that once she pulled them all together, she would distribute them to everyone for review.

### **Other Business**

Ms. Weber indicated that new FASD legislation has been introduced in the Senate by Senator Tim Johnson (D) of South Dakota. There is language included in the bill about the Task Force. Kathy Mitchell announced that there will be a NOFAS reception for Senator Johnson on November 14<sup>th</sup>. All are invited to attend.

### **Public Comment / Adjourn**

With no public comments offered or further business posed, Dr. Wright officially adjourned the Task Force meeting at 2:00 p.m.

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Minutes approved on 01/22/2008  
by Jean A. Wright, MD, MPH  
Chair, National Task for on FAS/FAE

## Appendix A: Approved Recommendations (10-24-2007)

### Prevention Recommendations

| <b>Universal Prevention</b>               |  |
|---|--|
| Recommendation 1:                         | Expand and test methodological approaches for assessing the effects of universal prevention strategies on alcohol use patterns and reproductive health outcomes of childbearing-aged women.                      |
| Recommendation 2:                         | Promote the implementation of effective population-based interventions for reducing alcohol-related harms in the general population, including women of childbearing age, as they are validated.                 |
| <b>Selective and Indicated Prevention</b> |  |
| Recommendation 3:                         | Assure that funded intervention studies on alcohol use, abuse and dependence include analyses of gender and age effects and examine pregnancy outcomes where possible.   |
| Recommendation 4:                         | Promote the use of evidence-based intervention strategies tested in primary care, emergency rooms, and college settings for use in populations of childbearing-aged women at risk for alcohol-exposed pregnancy. |
| Recommendation 5:                         | Establish formal alcohol screening, using validated instruments, and brief intervention programs that are culturally and linguistically appropriate for women of childbearing age.                               |
| Recommendation 6:                         | Expand the education and training of health and social service professionals in the areas of screening and intervening with women at risk for alcohol-exposed pregnancies.                                       |
| Recommendation 7:                         | Assure access to appropriate alcohol treatment services for women of childbearing age especially those with treatment barriers, such as pregnant women and adolescents.  |
| Recommendation 8:                         | Assure that alcohol treatment options for all childbearing-aged women take into consideration their unique needs such as pregnancy, co-occurring disorders, and other special treatment needs.                   |
| Recommendation 9:                         | Conduct further research aimed at implementing and evaluating treatment and intensive case-management approaches for women at highest risk of having a child with an FASD.                                       |
| Recommendation 10:                        | Promote research investigating interventions focused on the potential intergenerational effects of prenatal alcohol use on offspring.  |