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MASSACHUSETTS ASSOCIATION OF HEALTH BOARDS, INC.

IN HARM'S WAY: TOXIC THREATS TO CHILD DEVELOPMENT

Summary of A Reportt
by Greater Boston Physicians for Social Responsibility
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This report examines the contribution of toxic chemicals to neurodevelopmental, learning, and behavioral disabilities in children. These disabilities are clearly the result of complex interactions among genetic, environmental and social factors that impact children during vulnerable periods of development. Toxic exposures deserve special scrutiny because they are preventable causes of harm.

1. An epidemic of developmental, learning, and behavioral disabilities has become evident among children.

* It is estimated that nearly 12 million children (17%) in the United States under age 18 suffer from one or more learning, developmental, or behavioral disabilities.

conservative estimates, affects 3 to 6% of all school children, though recent evidence suggests the prevalence may be as high as 17%. The number of children taking the drug Ritalin for this disorder has roughly doubled every 4-7 years since 1971 to reach its current estimate of about 1.5 million.

HOARDING: WHAT TO DO ABOUT IT AND WHY IT IS A BOH CONCERN

By Philip Leger; Athol
Health Agent;
Chair Royalston BOH

Dr. Randy Frost, a professor of psychology at Smith College who is studying this issue, defines hoarding as "the acquisition of, and failure to discard possessions which appear to be useless or of limited value." The collection of materials can range from newspapers, books, magazines, and animals, to equipment, old cars, metal, and tools. Living spaces are often so cluttered as to make passing through difficult. Land and outbuildings such as sheds and garages can be collections areas also.

Boards of Health are made aware of hoarding situations by complaints and referrals from neighbors, family members, public safety officials, social service

Preemption : a Perennial Threat to Board of Health Authority

What would happen if a change in a local charter law took away the authority of the local board of health to hire sanitarians and other staff? What if the state took away the ability of local boards of health to enact local tobacco control regulations or to enact stricter septic system regulations that go beyond the basic protections of Title 5? These are just a few of the ugly scenarios that could transpire some day if we do not remain vigilant to defend against preemption and the other perennial threats to board of health authority.

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Inside This Issue page

This year marks the first ever celebration of April as Public Health Month. As a sponsor of Senator Richard Moore's bill which Governor Cellucci has signed into law, MAHB will be helping to focus attention on local health issues. The program will take place on April 5th in the Great Hall from 11a.m. to 1 p.m. DPH Commissioner Howard Koh and Senator Richard Moore, chairman of the Health Care Committee, will participate in the program.

Special thanks to the Canton Board of Health and Nashoba Associated Boards of Health, and the Massachusetts Public Health Nurses Association for co-sponsoring a health screening at this event.

Paul Revere Award - Given this year posthumously to Randall Swartz (see page x for tribute)

MAHB Public Service Award -Sandra Collins RN BSN, founding president of the Massachusetts Association of Public Health Nurses incorporated in 1998. She has been a leader in making the *Leadership and Resource Guide for Public Health Nurses* a reality. Recognized for her many contributions to local and state wide public health efforts

MAHB Distinguished Service Award: Rose C. Tyburski R.N. in appreciation for 21 years of Service on the Palmer Board of Health and 27 years of work as a dedicated visiting nurse.

Legislator of the Year Awards will be given to Senator Mark Montigny and Representative Michael Cahill. Senator Montigny is recognized for his long support of public health and the tobacco control program and his crucial support in convincing the rest of the legislature that the settlement money should be dedicated to public health and tobacco control with a dedicated portion going to tobacco control.This marks the second time that MAHB has honored Senator Montigny for his work on behalf of public health.

Rep. Cahil is honored for his courageous support for a total workplace ban on smoking thus protecting all workers of the commonwealth, but most especially the restaurant and bar workers who are most exposed to the harmful and deadly effects of ETS

Skin Cancer Prevention Grants

Thanks again to funding provided by the Massachusetts

tion Initiative. Last year DPH enabled us to give local boards $19,000 towards skin cancer prevention projects. This year's awards total $24,000.

The funded comunities are Ashland, Beverly, Billerica, Boston, Brookline, Canton, Dudley, Haverhill, Hopedale, Lowell, Marblehead, Melrose, Northbridge, Sharon, Swampscott, Watertown, Wellesley, Westford and Winchester.

April is Public Health Month in Massachusetts

The MAHB Journal of Local PUblic Health

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The primary purpose of the Massachusetts Association of Health Boards is to assist and support Boards of Health [and related governmental and community organizations/agencies] throughout the Commonwealth in meeting their statutory and service responsibilities, through programs of education, technical assistance, representation, and resource development.

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boards this year was the smashing court victory described on pp 18-19. We are proud of the fact that this was our first amicus brief filing, and Cheryl Sbarra, MAHB's Tobacco Control Program Director did a fantastic job, along with Chris Banthin from the Tobacco Control Resource Center.

Last Winter we transformed the MAHB Quarterly into the MAHB Journal. There were several reasons for this. As more people have Internet access either at work or home, it is much more cost effective and efficient to communicate via the MAHB web site and e list. As the cost of printing and postage escalated and the circulation increased, the cost of putting out a print version on a quarterly basis became prohibitive. Also, now that our staff has grown, we have a much stronger presence throughout the state, and do not need to rely on the flagship MAHB Quarterly as our main identity. Lastly, as the Certification Program and other training initiatives are expanded, it becomes harder to set aside the time for outlining and editing each issue. No longer tied to four issues a year, we can concentrate on providing more in depth coverage of important issues.

Welcome to new MAHB staff and Executive Board!

This has been a busy year for MAHB as we added a new Western Regional office with Melinda Calianos J.D as our Tobacco Control Assistant Program Director representing us in this part of the state. We are also fortunate to have Graham Kelder J.D. join us as our constitutional expert and staff attorney. Mike McClean, a doctoral student at Harvard School of Public Health is filling a needed niche as science advisor. MAHB is the first state or national association of local boards of health to provide this level of technical support. We also welcome two new Executive Board members. Donald MacIver works for DEP and serves on the Littleton Board of Health. He is also on the Board of the Mass. Association of Conservation Commissions (MACC). Claire Maranda teaches nursing at Curry College and serves on the Canton Board of Health. She also hosts a cable tv program devoted to health.

Internet Resources

On page 21 I have tried to convey some of the spirited and informative discussions which have enlivened our MAHB e-list. This endeavor is hosted by the commercial

coverage of events like the Barnstable Supreme Court decision. At least for the time being, however, it remains a top down resource. To provide an opportunity for you to post and reply to each other's questions, create favorite book marks, share files, add to existing data bases, or start new ones, we needed Yahoo's services. Our two Internet locations compliment each other. For example, mahb.org has a huge database of regulations, but it is dependent on me, the web author, to add to this from time to time. By contrast, at http://groups.yahoo.com/group/MAHB each of you can share information by up(or down)loading to the shared files or database folders.

Board of Health Survey

Please take a moment to complete the survey on the last page. We will add this data to that which was collected last year on the membership renewal forms, and place it in the MAHB e-list database, so it can be easily updated as needed. The goal is to eliminate those annoying and repetitive surveys and give you the tools to keep your information fresh.

MAHB Legal Handbook

The long awaited *Legal Handbook*, which has been out of print for a couple of years is available for order once again. This classic reference book belongs on every board of health bookshelf next to the *Guidebook*. Order forms can be obtained from our web site.

How to Conduct a Hearing & Conflict Management CD

This cd was introduced at the Certification Program last fall and is also available. This is a must see if your board is facing a fractious hearing, and it also includes many useful tips for managing difficult situations.

Mass. Association of Public Health Nurses

Contratulations to the nurses who have created a new non-profit organization dedicated to Public Health Nursing. We look forward to working with this dedicated group to promote a healthier Commonwealth.

Every individual involved in local public in Massachusetts is familiar with the term "preemption." But what exactly does preemption mean? The preemption doctrine is rooted in the Supremacy Clause of the United States Constitution: "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. "It is basic to this constitutional command that all conflicting state provisions be without effect." *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981).

This does not mean, of course, that the states may not enact legislation dealing with the same subjects as federal law, or that a particular matter may not be the subject of simultaneous federal and state regulation. The existence of a federal interest in regulating the matter does not exclude the possibility of a legitimate concurrent state interest.

In particular, the states historically have ''exercised their police powers to protect the health and safety of their citizens." "Consideration of issues arising under the Supremacy Clause 'start[s] with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress.'" So, in evaluating what preemptive effect, if any, to give a federal statute, what Congress intended is "the ultimate touchstone."

There are two kinds of preemption: "field" preemption and "conflict" preemption. At the federal level, "field" preemption means that Congress may legislate in a field which the states have traditionally occupied in such a way as to make reasonable an inference that it was Congress' purpose to leave no room for the States to supplement the federal legislation. When Congress does this it is said to have preempted the field of regulation. This might be true, for example, in the case of a field ''[where] the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject."

"Conflict" preemption rests on the sound proposition that the effectiveness of federal statutes as an obstacle to the achievement of the full purposes of the federal law, and so again the state law would be required by the Supremacy Clause to recede.

Similar doctrines apply with state laws vis-à-vis local laws. States sometimes legislate in a field in such a way as to make reasonable an inference that it was the state legislature's purpose to leave no room for local governmental bodies to supplement the statewide legislation. When a state does this, it, too, is said to have preempted the field of regulation. "Conflict" preemption in this arena rests on the notion that the effectiveness of state statutes ought not be undercut or obstructed by inconsistent local legislation. It would be impossible, for instance, to comply with contradictory prescriptions of state and local law. In such a case, the local law must yield to the state law.

As most of you know, In Massachusetts, Board of Health regulations are presumed valid. Druzik v. Board of Health of Haverhill, 324 Mass. 129, 138 (1949); *see also* School Committee of Boston, v. Boston, 383 Mass. 693 (1981). "In determining whether a local regulation or by-law is inconsistent with a state statute , [courts] have given municipalities 'considerable latitude,' requiring a 'sharp conflict' between the [regulation] . . . and the statute before invalidating the local law." Take Five Vending, Inc., v. Provincetown, 415 Mass. 741, 744 (1993) (citation omitted). "[L]ocal communities, through their [regulations] . . . may supplement statutory provisions so long as their [regulations] . . . are not inconsistent with any State law." Marshfield Family Skateland v. Marshfield, 389 Mass. 436, 442, appeal dismissed, 464 U.S. 987 (1983). Accordingly, courts will invalidate Board of Health' regulations as inconsistent with state law in three instances:

1. Where the legislature has specifically limited local action on a subject;

2. Where intent to preempt is inferred from a comprehensive and pervasive statutory scheme; or

3. When the purpose of the statute cannot be achieved because of the local action.

Marshfield Family Skateland *supra* at 441; Take Five

136, 156 (1973); compare Wendell v. Attorney General, 394 Mass 518 (1985) (determining that detailed scheme of regulation restricting pesticide use preempted local regulations). Moreover, "The legislative intent to preclude local action must be clear." Marshfield Family Skateland *supra* at 441 (citations omitted).

By changing local charters, town and city governments can also effectively destroy some aspects of local board of health authority. In the area of hiring authority, for example, 300 years of consistent legislation and court precedent make it clear that Boards of Health have exclusive authority to hire, fire, and establish contracts with the agents and assistants they need to execute and enforce their local health laws and regulations. With a simple change in a city charter, however, a local commissioner of health can be designated to perform the duties once performed by the board. This commissioner is assisted by a local council of health that has only advisory powers. See Mass. Gen. Laws ch. 111, sec. 26A. Local boards of health must be ever vigilant against such a change in local law as it would effectively remove their authority.

Towns are also increasingly being asked to adopt a charter which places the hiring authority over board of health staff in the hands of a town administrator. This is happening now in Tewksbury, where a proposed charter change would transfer the supervisory authority of the health staff to a community development position. Across the state, town managers are urging these changes, which place critical hiring and supervisory responsibilities either directly, or indirectly within their grasp.

Why would the loss of hiring authority be bad for public health? The volunteers who sit on boards of health are responsible for over 60 areas of public health law and regulation. Through annual voluntary certification programs (Primary and Advanced), they have the opportunity to develop significant expertise in local public health policy. They also have access to publications, a *Journal of Local Public Health*, and other information supplied by this organization, the Mass DPH, and Mass DEP. The Board of Health Certification Program provides public assurance that

health nurses and others who work for the board. It is bad management and bad government to establish a system where these employees are not accountable to the elected or appointed board members who develop policies.

Board members are also responsible for developing partnerships with community leaders and other public agencies to promote health education, solve health problems and assure that health care is accessible to all residents. Staff input and cooperation is vital to this effort, but difficult to obtain when they are answerable to another town office.

Enforcement of laws and regulations intended to protect the public and environmental health often brings agents and board members into conflict with special interests. (e.g. slumlords, tobacco companies and polluters). When complaints are received, board of health members have the training and experience determine whether staff are acting inappropriately, or in the public interest.

Local health staffers need expertise which must be constantly updated in order to protect the public health from emerging diseases and other health threats. Informed boards of health are more likely to require adequate training and continuing education for their staff. Experience in smaller communities suggests that when boards lose control over their staff, the level of public health expertise drops significantly. That drop may result in improperly installed septic systems, food poisoning, or failure to provide prevention programs, leading to serious health consequences for the community.

A third area where Board of Health authority is threatened almost every year is in the area of Title 5. For many years, MAHB has issued a standing offer to the homebuilders and realtors to assist in mediating and investigating any local board of health whose regulations were deemed unfair or unreasonable. We would put together a team of engineers and any other required experts, and present our findings to the local board. To this date, nobody has ever presented us with a single verifiable complaint, yet these apocryphal stories proliferate. Under such circumstances, it makes

This year, for example, HB 3156 eliminates board of health authority to enact stricter local controls under Title 5. In addition, SB 1063 sets a dangerous precedent undermining boh authority to regulate by requiring local boards of health to petition and to get approval from DEP prior to adopting any regulations exceeding Title 5. This is an unreasonable proposal which has been promoted for a number of years by Massachusetts realtors and others who have an economic interest, but no background or experience in public or environmental health.

Many of the local regulations adopted today are of an administrative nature, addressing loopholes in the state code regarding system inspections. These local regulations protect both consumers and the environment, but the issues they address are not community-specific, and would not be permitted under this bill. Also, local boards have often lead the way with new regulatory approaches which are later adopted by the state, after they have proven their usefulness at the local level. Example: In 1990, the Towns of Whately and Williamsburg adopted a regulation requiring all homes have systems inspected prior to sale. These regulations resulted in the elimination of a large number of direct sewage outlets. It took DEP years to incorporate the same concept into the revised Title 5.

The Town of Montague developed well regulations in 1988. These included a setback distance of 150 feet to a septic system if the soils had a rate of two inches a minute or less. Today many systems of that age are beginning to fail, but thanks to the additional local setback requirements, some lots have room to install new systems which they otherwise would not (variances are granted to the 100 foot state requirement for repairs). These are but two examples of local regulations which have withstood the test of time. There are many others.

One area in which Boards of Health are already partly pre-empted is pesticide regulation. In 1991 a Federal Supreme Court decision (Wisconsin Public Intervenor v. Mortier, 59 U.S.L. W. 4755) which held that the Federal Insecticide, Fungicide and Rodenticide Act Act (FIFRA) does not pre-empt local government or regulation which imposes additional substantive requirements on pesticide use. In 1985, the Massachusetts Supreme Court upheld this interpretation in Town of Wendell v. Attorney General, 394 Mass. 518.

The tobacco industry tries to achieve technical preemption in two ways: plain old preemption and "super preemption." Plain old preemption means passing a bill on a particular aspect of tobacco control and thereby preempting local action on that particular aspect of tobacco control. Super preemption, a strategy that first surfaced in 1994, means preempting "all local government action on tobacco issues, no matter what the subject of the specific bill at hand." Super preemption bills were introduced in state legislatures in Indiana, South Dakota, Oklahoma and Mississippi in 1994. The typical super preemption clause reads as follows: "The provisions of this law shall supersede any existing or subsequently enacted local law, ordinance or regulation which relates to the use, sale, promotion and distribution of tobacco products."

As of May 28, 1996, 29 states had fallen prey to the tobacco industry's push for preemption:

· 19 states have preemption over various youth access provisions such as vending machines, self-service displays, etc.

· 17 states have preemption over various clean indoor air provisions such as restrictions on smoking in restaurants, public places or work sites;

and

· 8 states have preemption over restrictions on tobacco advertising and promotion.

Where it cannot achieve true preemption, the tobacco industry tries to pass weak, loophole-ridden laws with weak substantive provisions and/or weak enforcement mechanisms at the state level, knowing that even if these bills aren't technically preemptive, they will have a pseudo-preemptive effect, i.e., they will chill local action on the particular subject being regulated. This happened in Massachusetts with the

control the sale, distribution and use of tobacco. The industry achieves pseudo-preemption by aggressively promoting legislation that is "nothing more than window dressing designed to look like tobacco control" or by hijacking and distorting otherwise legitimate tobacco control legislation

The first way to guard against the threat of preemption is to be generally wary of additional state-level initiatives to control the sale and use of tobacco in Massachusetts. The second way is to ensure that any new state or federal laws contain an anti-preemption clause.

Specifically, we strongly suggest adoption of the following (or closely analogous) language:

> Nothing in any of the sections of this Act shall be construed to preempt any existing law, ordinance, by-law or regulation which requires a permit or license for the sale of tobacco products, or which regulates the sale, use, or distribution of tobacco products. Nothing in any of the sections of this Act shall prohibit any city, town, or board of health from enacting or enforcing any law, ordinance, bylaw or regulation which requires a permit for the sale of tobacco products or which regulates the sale, use, or distribution of tobacco products. Without limiting the generality of the foregoing, nothing in any of the sections of this Act shall prohibit any city, town, or board of health from enforcing any law, ordinance, bylaw or regulation which imposes a monetary penalty, permit suspension or permit revocation for a violation of the local law. In cases where the local ordinance, bylaw or regulation is more stringent than the provisions of this Act, the more stringent ordinance, bylaw or regulation shall control to the extent of any inconsistency between such ordinance, bylaw or regulation and any section of this Act.

of health discussed in this article are rooted in the competitive nature of American economic and political systems. That's why they seem to arise anew almost every year. Tobacco companies know that local regulation of the sale and use of tobacco is the biggest threat to their economic viability, so they try to preempt that authority. Municipal officials often want to have more power and control, so city charters are amended to concentrate the power normally exercised by a board of health in the hands of other appointees who they believe they may exercise better control over. A variant of this is transferring the board's hiring authority to a town administrator. Builders don't want to have to comply with the stricter-than-Tile-5 local regulations that boards of health sometimes deem necessary to impose, so the builders' lobbyists try to preempt the ability of boards to pass stricter controls and/or force boards to petition DEP before they can enact such controls.

It's all part of the competitive political and economic system that is the American way. The role of members of local boards of health is to make sure they are informed and capable players of that game so that they are always able to ward off these perennial threats to their independent local authority. It is imperative that boards of health do so, because boards of health are in the best position to gain and exercise the expertise needed to best protect local public health. Safeguarding the public in this efficient and effective manner by preserving the authority of local boards of health is also part of the American way!

-Graham Kelder and Marcia Benes (with some additional material contributed by Marc Boutin)

The clutter can be a safety and public health concern due to the hazards created such as fire, blocked egresses, harborage for insects and rodents, and blocked access to sinks, toilets, and baths. Very often the occupant exhibits significant distress or impairment in functioning. There may be an indication that mental illness is an issue.

Are BOH's responsible to investigate? Yes. BOH's have authority under Massachusetts General Laws Chapter 111, section 122 and related sections and under the State Sanitary Code 105 CMR 400.00 and 410.00. In the State Sanitary Code Chapter 1, 105 CMR 400.100 (A), the BOH's inspection authority is clearly stated. The occupant and or property owner should be given a notification of inspection either by telephone, regular mail, certified and regular mail, or just by stopping by and asking to inspect. If you are refused access you cannot go in. The police and fire departments cannot give you permission. The board of selectmen or mayor cannot give you permission. Relatives or friends cannot give you permission. If refused entry, you will have to develop a record as to why you need to inspect the property and how you attempted to conduct an inspection. This information will be needed when you apply to the courts for an administrative search warrant. You

should consult with the town or city attorney if you never have applied for a search warrant.

When you are allowed to conduct an inspection, be observant of the occupant as well as the condition of the dwelling. Does the occupant own the dwelling? Does the occupant appear to understand there is a health concern? Does the occupant appear to be able to care for themselves? Are there children living there? Are there animals involved? Pay attention to the mental well being of the occupant. The collection of these materials may be an indication of a psychological problem. This issue is a major concern for both the individual and the community. Care must be taken to deal with this situation. When appropriate, referrals should be made to elder services, emergency services, DSS, MSPCA, and other agencies that might be able to make support services available.

Under 105 CMR 410.352 (A), the occupant is responsible to maintain the dwelling free from obstructions. Under 105 CMR 410.352, the occupant is responsible to maintain the dwelling unit in a clean and sanitary manner. And under 105 CMR 410.602, the occupant is responsible to maintain

enforcement order is issued in the absence of contacting support agencies, it will not be enough to break the cycle of complaint, enforcement order, clean up, and then collecting again.

Planning for these types of situations can be very helpful when faced with an actual case. Discussing this issue with members of the community is the first step. Members of elder services, veteran agencies, shelters, housing authorities, substance abuse services, and other social services and community groups should be approached to participate. Setting up a hoarding and social action committee would be the next step. This committee would meet and determine who best or what piece of a solution could be offered in certain situations. A list of what services are available and contact persons and numbers could be created. This would help identify what resources are available and for what situations. Networking is key.

Each case is different and there are no magic formulas that will apply universally. The committee must be willing to be flexible and creative. Use whatever has been successful, but be willing to adapt to the resident and situation. Plan for non-responsive or uncooperative residents. Establishing communication is key. Find the language of the resident in order to communicate more effectively. Honor and respect their home even if it is a "critical mess." Identify the resident's support network whenever possible such as family, neighbors, church, and other community connections. This sometimes is difficult in hoarding situations because isolation is part of the problem. Many hoarders live alone, have never been married, and have a family history of hoarding. Isolation helps perpetuate the situation because the hoarder is not being pressured on a daily basis to clean up.

The enforcement order and the courts can supply

resources in the community that will help such as honor court, church groups, social service agencies, family, and friends. The plan should also continue to work with the enforcement community such as BOH, public safety, building department, animal control, and MSPCA in order to achieve compliance. A lead agency should be designated to work with the resident to facilitate the action plan.

The plan should include phases that are realistic and identify priority areas for clean up. Sometimes the tasks are so overwhelming that people are discouraged to begin. Identify critical areas to clean such as kitchen, bathrooms, egresses, bedrooms. Identify types of material to move first such as organic garbage type waste. If the job is broken into smaller parts, it will seem less daunting.

Often the hoarder does not understand why all the fuss. A man I am working with to clean up his house says that people have, "sore eyes". People look at his place and get sore eyes. He can't understand why people are so bothered by it. BOH's do not have to be alone in helping resolve these types of situations. Networking and identifying resources ahead of time can go a long way in

In the Fall of 1998, Senator Richard Moore filed an amendment to the Uniform Procurement Act that would have extended the existing municipal health department exemption to boards of health. Unfortunately, this bill did not become law. A second bill did become law in the Fall of 2000, however. This second bill raises the threshold set by the Uniform Procurement Act for purchases of services requiring advertised, sealed bids (MGL ch. 30B, § 5) or proposals (MGL ch. 30B, § 6) from $10,000 to $25,000. This means that boards of health have to use the Act's competitive bidding process only in entering into contracts or agreements of $25,000 or more.

Senator Moore's bill was prompted by a ruling from the Inspector General's office that could affect any health board which contracts for the services of registered sanitarians, engineers or other professionals. Until recently, many town counsels and boards of health have assumed that boards of health were exempted from the provisions of the UNIFORM PROCUREMENT ACT because of language in a 1992 amendment, which exempted Health Departments. Unfortunately, the Inspector General has determined that boards of health are not health departments, therefore are not exempt from the provisions of this law.

Senator Moore's bill would clarify the intent of the legislature in 1992, when municipal health departments were exempted. MGL Chapter 30B, Section 1(b)(27), (the Uniform Procurement Act), would be amended to "This chapter shall not apply to (27) contracts or agreements entered into by a municipal hospital or a municipal department of health or a municipal board of health". This bill will be refiled in the near future.

-Graham Kelder

*The number of children in special education programs classified with learning disabilities increased 191% from 1977-1994.

*Approximately 1% of all children are mentally retarded.

*The incidence of autism may be as high as 2 per 1000 children. One study of autism prevalence between 1966 and 1997 showed a doubling of rates over that time frame. Within the state of California, the number of children entered into the autism registry increased by 210% between 1987 and 1998.

These trends may reflect true increases, improved detection, reporting or record keeping, or some combination of these factors. Whether new or newly recognized, these statistics suggest a problem of epidemic proportion.

2. Animal and human studies demonstrate that a variety of chemicals commonly encountered in industry and the home can contribute to developmental, learning, and behavioral disabilities.

Developmental neurotoxicants are chemicals that are toxic to the developing brain. They include the metals lead, mercury, cadmium, and manganese; nicotine; pesticides such as organophosphates and others that are widely used in homes and schools; dioxin and PCBs that bioaccumulate in the food chain; and solvents, including ethanol and others used in paints, glues and cleaning solutions. These chemicals may be directly toxic to cells or interfere with hormones (endocrine disruptors), neurotransmitters, or other growth factors.

Lead

*Increases in blood lead levels during infancy and childhood are associated with attention deficits, increased impulsiveness, reduced school performance, aggression, and delinquent behavior.

*Effects on learning are seen at blood lead levels below those currently considered "safe."

Mercury

*Fetal exposure to methylmercury, primarily from regular maternal fish consumption, have been implicated in language, attention, and memory impairments that appear to be permanent.

Manganese

*Unlike many other metals, some manganese is essential as a catalyst in several critically important enzymatic processes. However, several studies report a relationship between excessive childhood levels of manganese exposure and hyperactivity or learning disabilities.

Nicotine

*Children born to women who smoke during pregnancy are at risk for IQ deficits, learning disorders, and attention deficits.

*Children born to women who are passively exposed to cigarette smoke are also at risk for impaired speech, language skills, and intelligence.

Dioxins and PCBs

*Monkeys exposed to dioxin as fetuses show evidence of learning disabilities.

*Humans and animals exposed to low levels of PCBs as fetuses have learning disabilities.

*Children exposed to PCBs during fetal life show IQ deficits, hyperactivity, and attention deficits when tested years later.

Pesticides

*Animal tests of pesticides belonging to the commonly-used organophosphate class of chemicals show that small single doses on a critical day of development can cause hyperactivity and permanent changes in neurotransmitter receptor levels in the brain.

*One of the most commonly used organophosphates, chlorpyrifos (Dursban), decreases DNA synthesis in the developing brain, resulting in deficits in cell numbers.

*Some pyrethroids, another commonly used class of pesticides, also cause permanent hyperactivity in animals exposed to small doses on a single critical

Solvents

*Exposure to organic solvents during development may cause a spectrum of disorders including structural birth defects, hyperactivity, attention deficits, reduced IQ, learning and memory deficiencies.

*As little as one alcoholic drink a day by a mother during pregnancy may cause her offspring to exhibit impulsive behavior and lasting deficits in memory, IQ, school performance, and social adaptability.

*Animal and limited human studies show that exposures to common chemicals like toluene, trichloroethylene, xylene, and styrene during pregnancy can also cause learning deficiencies and altered behavior in offspring, particularly after fairly large exposures.

3. A deluge of highly technical information has created communication gaps within the field of child development.

*The recent explosion of research in the many sciences related to child development has produced a glut of highly technical information not readily understood by those outside the field in which the research was performed.

*A communication gap has resulted, dividing fields of research and separating the domains of research, clinical practice, and the public.

*Behavior and cognition can be described using clinical disorders, such as ADHD or Asperger's syndrome, which are categorical and qualitative. Alternatively, behavior and cognition can be described using abilities/traits, such as attention and memory, which are continuous and quantitative. Abilities/traits cluster into disorders in various ways and are emerging as an important bridge among the scientific disciplines focusing on child development.

4. Although genetic factors are important, they should not be viewed in isolation.

Certain genes may be susceptible to or cause individuals to be more susceptible to environmental "triggers." Particular vulnerability to a chemical

example, a gene coding for the enzyme, delta aminolevulinic acid dehydratase (ALA-D), can influence lead metabolism, bone storage of lead, and blood lead levels.

*Two genes increase susceptibility to organophosphate pesticides. One, carried by 4% of the population, results in lower levels of acetylcholinesterase, the target enzyme of organophosphates. The other, carried by 30-40% of the population, results in reductions in paroxonase, an enzyme that plays an important role in breaking down organophosphate pesticides.

*Antibody reactions to infections is another important gene-environment interaction. For example, studies suggest that "PANDAS" (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection), that may affect patients with obsessive compulsive disorder, Tourette's syndrome and tics, result from streptococcal antibodies that cross react with critical brain structures in genetically susceptible children.

5. Neurotoxicants are not merely a potential threat to children. In some instances, adverse impacts are seen at current exposure levels.

*According to EPA estimates, about 1.16 million women in the U.S. of childbearing years eat sufficient amounts of mercury-contaminated fish to risk damaging brain development of their children.

*Breast-fed infants are exposed to levels of dioxin that exceed adult exposures by as much as a factor of 50. Dioxin exposures of this magnitude have been shown to cause abnormal social behavior in monkeys exposed before birth through the maternal diet. (While breast milk contaminants may compromise some of the cognitive benefits of breast feeding, breast milk remains strongly preferred over infant formula due to numerous important benefits to infant health.)

*Prenatal exposure to PCBs at ambient environmental levels adversely affects brain development, causing attention and IQ deficits, which remain detectable years later and may be permanent.

*Neurotoxicants that appear to have trivial effects on an individual have profound impacts when applied across populations. For example, a loss of 5 points in

by over 50% (from 6 to 2.6 million).

6. Vast quantities of neurotoxic chemicals are released into the environment each year.

*Of the top 20 chemicals reported by the Toxics Release Inventory as released in the largest quantities into the environment in 1997, nearly three-quarters are known or suspected neurotoxicants. They include methanol, ammonia, manganese compounds, toluene, phosphoric acid, xylene, n-hexane, chlorine, methyl ethyl ketone, carbon disulfide, dichloromethane, styrene, lead compounds, and glycol ethers. Over a billion pounds of these neurotoxic chemicals were released directly on-site by large, industrial facilities into the air, water, and land.

*Vast quantities of neurotoxic chemicals are also used in industrial processes and incorporated into products. For example, according to 1997 data from the Massachusetts Toxics Use Reduction Act, over half of the top twenty chemicals in use (over 500 million pounds), and half of those incorporated into products in Massachusetts, are known or suspected neurotoxicants.

*Use of lead in manufacturing increased 77% in Massachusetts between 1990-1997.

*An additional 1.2 billion pounds of registered pesticide products are intentionally and legally released each year in the United States.

*Mercury contamination of our waterways is so widespread that 40 states have issued one or more health advisories warning pregnant women or women of reproductive age to avoid or limit fish consumption. Ten states have issued advisories for every lake and river within the state's borders.

7. Environmental releases often lead to human exposures with potential for harm. Dispersion of these chemicals is global.

*One million children in the US exceed the currently accepted threshold for blood lead level exposure that affects behavior and cognition (10 micrograms/dl).

in the urine of over 80% of adults and 90% of children from representative population samples.

* Inuit mothers in the Arctic, far from sources of industrial pollution, have some of the highest levels of PCBs in their breast milk as a result of a diet rich in marine mammal fat.

8. The historical record clearly reveals that our scientific understanding of the effects of toxic exposures is not sufficiently developed to accurately predict the impact of toxicants, and that our regulatory regime has failed to protect children.

a. As testing procedures advance, we learn that lower and lower doses are harmful.

The historical record shows that "safe thresholds" for known neurotoxicants have been continuously revised downward as scientific knowledge advances. For example, the initial "safe" blood lead level was set at 60 micrograms/deciliter (ug/dl) in 1960. This was revised down to 10 ug/dl in 1990. Current studies suggest that lead may have no identifiable exposure level that is "safe." The estimated "toxic threshold" for mercury has also relentlessly fallen, and like lead, any level of exposure may be harmful.

Such results raise serious questions about the adequacy of the current regulatory regime, which, by design, permits children to be exposed up to "toxic thresholds" that rapidly become obsolete.

b. Most chemicals are not tested for their general toxicity in animals or humans, not to mention toxicity to a child's developing brain specifically.

Nearly 75% of the top high production and volume chemicals have undergone little or no toxicity testing. However, the EPA estimates that up to 28% of all chemicals in the current inventory of about 80,000 have neurotoxic potential. In addition:

* Testing for developmental neurotoxicity is not required even in the registration or re-registration of pesticides, one of the strictest areas of chemical regulation

c. Even when regulated, the risks from chemical exposure are estimated for one chemical at a time, while children are exposed to many toxicants in complex mixtures throughout development. Multiple chemical exposures often interact to magnify damaging effects or cause new types of harm.

With the exception of pesticides used on the food supply, current regimes regulate only one chemical at a time and do not take into account the potential for interactions. Since real world exposures are to multiple chemicals, current regulatory standards, based on single chemical exposures, are inherently incapable of providing adequate margins of safety.

*New studies in humans and in the laboratory show that PCBs and mercury interact to cause harm at lower thresholds than either substance acting alone.

*A recent 5-year pesticide study suggests that combinations of commonly used agricultural chemicals, in levels typically found in groundwater, can significantly influence immune and endocrine systems, as well as neurological function, in laboratory animals.

d. Animal studies generally underestimate human vulnerability to neurotoxicants.

*Animal studies of lead, mercury and PCBs each underestimated the levels of exposures that cause effects in humans by 100-10,000-fold.

*Regulatory decisions that rely largely on toxicity testing in genetically similar animals under controlled laboratory conditions will continue to fail to reflect threats to the capacities and complexity of the human brain as well as important gene-environment interactions.

9. Protecting our children from preventable and

·The inability of the current regulatory system to protect public health is not surprising, considering the disproportionate influence of special interests in the regulatory process. When there is evidence for serious, widespread and irreversible harm, as described in this report, residual scientific uncertainties should not be used to delay precautionary actions. Actions should include reduction and or elimination of exposures as well as further scientific investigation of developmental neurotoxicity.

References can be found in the full report (140 pgs.) To obtain a copy of In Harm's Way for $10, please contact Greater Boston Physician's For Social Responsibility, 11 Garden St., Cambridge, MA 02138 617-497-7440 – The report can be viewed and downloaded for free at the web site www.igc.org/psr/

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A training program for health professionals on In Harm's Way is being offered for CME/Contact Hour credits on April 26, 2001 at the New York Academy of Medicine in New York City. For more information on the conference or other In Harm's Way training materials, e-mail psrmabo@igc.org. To register, go to the NYAM web site at http://www.nyam.org/meded/regform.html.

CDC Releases Assessment of Chemical Exposure

The National Report on Human Exposure to Environmental Chemicals is the first of its kind, using biomonitoring to measure 24 chemicals or their metabolites in human specimens such as blood or urine.This study shows unexpectedly high amounts of mercury and diethyl phthalate, which is used in the perfume and cosmetics industry. This chemical has been linked in animal studies to abnormal hormone function and birth defects. Its effect on humans is unknown.

The study will be conducted annually and expanded it to more than 100 chemicals, with e reports broken down by demographic categories. For the complete report, go to www.cdc.gov/nceh/dls/report

State Supreme Court Hands Boards of Health a Victory

On January 19, 2001, the Supreme Judicial Court of Massachusetts, in a unanimous decision, upheld the authority of Boards of Health to enact secondhand smoke regulations as reasonable health regulations. The name of the case is **Tri-Nel Management, Inc., et al v. Board of Health of Barnstable et al, 433 Mass. 217, 741 N.E.2d 37(2001),** (hereinafter referred to as "the Barnstable case.") While the decision represents a huge victory for tobacco control, its implications extend beyond tobacco. The Court upheld the broad authority granted to local boards of health to enact reasonable health regulations pursuant to Mass. Gen. Laws ch. 111, § 31.

Background

In February of 2000, the Barnstable Board of Health, an appointed board, voted unanimously to adopt an environmental tobacco smoke (ETS) regulation completely banning smoking in all restaurants and bars. The Board passed the regulation pursuant to Mass. Gen. Laws ch. 111, § 31, which permits Boards of Health to adopt "reasonable health regulations."

The Windjammer Lounge (the Windjammer), a local bar, sued the Town of Barnstable and the Board of Health claiming that the Board of Health did not have the authority to adopt an ETS regulation banning smoking in restaurants and bars.

The suit was filed in Barnstable Superior Court, along with a Motion for a Preliminary Injunction that would have prohibited the Board of Health from implementing and enforcing the regulation. The Superior Court judge ruled in favor of the Board of Health. The Windjammer appealed the ruling directly to the highest court in Massachusetts, the Supreme Judicial Court (SJC). The SJC granted the Windjammer's request for direct appellate review. Because the case involves only state issues of law, the decision of the SJC is final in this case.

MAHB co-authored an amicus (friend of the Court) brief in support of the Barnstable Board of Health.

The Supreme Judicial Court's Decision

On January 19, 2001, the SJC issued a unanimous decision that upheld the authority of the Barnstable Board of Health to enact an ETS regulation that banned smoking in all food service establishments, lounges and bars. The Court's written decision rebuts every argument the Windjammer made in support of its claim that the ETS regulation was not legal.

First, the Windjammer argued the § 31 alone did not grant a local board of health broad authority to adopt any reasonable health regulations. The Court held that § **31 did authorize local boards of health to make reasonable health regulations**. The plain language of § 31 allows boards to "make reasonable health regulations." In support of its decision, the Court stated that the " . . . language itself . . ." is clear**.** Tri-Nel Management, Inc. & others vs. Board of Health of Barnstable & another, Id at 219, quoting from Hoffman v. Howmedica, Inc., 373 Mass. 32, 37 (1977). § 31 "'was passed as legislation of broad and general scope . . . '" Id at 221. § 31 is "'a comprehensive, separate, additional source of authority for health regulations.'" Id at 222.

Second, the Windjammer argued that the regulation was unreasonable because there was no evidence that exposure to ETS in restaurants and bars was

the board's expertise in this subject matter, we conclude that the board's regulation is within the standard of reasonableness." Id at 220. The Court said, " . . . we have previously recognized the ill effects of tobacco use . . . as a legitimate municipal health concern . . . " Id at 222. In addition, the Court stated that "[w]e have repeatedly observed that this statute [§ 31] has granted boards of health plenary [absolute] power to issue reasonable, general health regulations**."** Id at 222.

Third, the Windjammer argued that the state law requiring restaurants with over 75 seats to reserve 25% of its seating for nonsmoking (The Clean Indoor Air Act) prevented local boards from enacting a stricter ban on smoking. The Court held that **the Clean Indoor Air Act did not prevent (preempt) boards of health from enacting stronger ETS regulations.** When the legislature passed the Clean Indoor Air Act (Mass. Gen. Laws c. 270, § 22), "it provided that nothing in the act prevented municipalities from regulating smoking more strictly in public places . . ." Id at 224. "General Laws c. 270, § 22, sets forth minimum [s]tatewide restrictions on smoking in restaurants to protect and accommodate the nonsmoking public. The board's ban placing additional restrictions on smoking, furthers, rather than frustrates, this intent." Id at 224.

Fourth, the Windjammer argued that the board of health is not the legislative body of a city or town and, therefore cannot pass a law prohibiting smoking in restaurants and bars. The Court held that **boards of health, as well as the legislative body of a municipality (city council or town meeting) can pass laws prohibiting smoking.** The Court concluded that the Board of Health has the legal authority to make rules and regulations pursuant to Barnstable's town charter as well as pursuant to § 31. Id. at 226.

Fifth, the Windjammer argued that the Court should

local boards of health pursuant to § 31. "The plaintiffs have invited this court to reconsider the degree of deference accorded to health regulations. We decline to do so; the rationale behind this rule has maintained its vitality and the rule itself remains 'consonant with the needs of contemporary society.'" Id at 218, n.6.

Sixth, the Windjammer argued that § 31 is an impermissible delegation of legislative power to local municipalities. The Court held that § **31 is not an impermissible delegation of legislative power because public heath matters have historically been delegated to local boards by the legislature.** "[T]he legislature made the policy decision that public health matters affecting local communities may be the subject of reasonable health regulations. G.L. c. 111, § 31." Id at 226.

Lastly, the Windjammer argued that the smoking ban would cause economic loss. The court held that **the Windjammer failed to show any economic loss. Also, economic loss alone would be insufficient to prove irreparable harm. In addition, the Windjammer did not prove that implementation of the smoking ban would be against the public interest.** "[I]n light of the scientific support linking ETS to adverse health effects, the Superior Court judge properly determined that the issuance of an injunction would not serve the public interest." Id at 227.

Conclusion

Local Boards of Health frequently rely on § 31 as the legal authority for adopting health regulations. The Supreme Judicial Court has, once again, upheld the validity and legality of this broad authority granted to local Boards of Health by the state legislature. The full decision of the Court can be read on the MAHB website, www.mahb.org.

The foregoing is intended as educational assistance and not legal advice. Cheryl Sbarra, JD, Massachusetts Association of Health Boards,

by Michael McClean
MAHB Science Advisor

Environmental Tobacco Smoke (ETS) is a combination of exhaled smoke and sidestream smoke, and has been classified by the Public Health Service's National Toxicology Program as a known human carcinogen. In fact, ETS exposure has been found to be associated with an increased risk of numerous health effects that include lung cancer, coronary heart disease, emphysema, asthma, stroke, and other respiratory illnesses.

Exposure to ETS is often misperceived as a nuisance issue that may *bother* some people and not *bother* others. Exposure to ETS is not a nuisance issue - it is a health issue. When cigarettes are burned, the hundreds of chemicals that are present in cigarettes become more than 4,000 chemicals in ETS. Of these 4,000 chemicals, approximately 60 are known or suspected to cause cancer and 47 are actually regulated by the government as hazardous waste. Accordingly, efforts to reduce ETS exposure in restaurants and public places can result in considerable public health benefits.

The most efficient and most effective method for controlling indoor exposure to ETS is to eliminate it completely. The ban of smoking in restaurants and public places:

♦ eliminates ETS exposure for all employees and customers,

♦ is very inexpensive to implement,

♦ is easy to administer and enforce, and

♦ complies with all current and future secondhand smoke regulations and laws.

Completely eliminating smoking is far more efficient and effective than a measure that allows variances for separately ventilated smoking areas. The American Society of Heating, Refrigeration, and Air-Conditioning Engineers (ASHRAE) is a professional organization of ventilation engineers that establishes ventilation guidelines, which are recognized by the American National Standards Institute (ANSI) as the industry-wide standards for this field. ASHRAE has removed their guidelines for designing restaurant-based smoking areas based on the fact that ETS is a known human carcinogen

If a city or town is considering allowing separately ventilated smoking areas in an ETS regulation, it is critical to enact an ETS regulation that is sufficiently detailed with respect to ventilation requirements. The following ventilation requirements should be specifically addressed in a regulation that allows for ventilation:

♦ Smoke-free and smoke-permitted areas should be physically separate areas (solid walls, floors, ceilings and doors) with separate ventilation systems.

♦ All spaces must be clearly identified as either smoke-free or smoking-permitted areas.

♦ Air from smoking sections should be exhausted directly to the outdoors. Air-handling systems should not recirculate or transfer air from a smoking area.

♦ Smoking areas must be at negative pressure with respect to adjacent or connected non-smoking areas to prohibit the flow of contaminated air into the non-smoking areas.

♦ The ventilation system should provide the smoking room with approximately 60 cfm of supply air per smoker.

If the ventilation system includes air-cleaning components, or if other filtration devices are being used in the restaurant, there should be a routine maintenance schedule in place such that filters and/or activated carbon are replaced regularly.

An engineering firm that specializes in the installation and maintenance of ventilation systems should be hired by the establishment to ensure that these requirements are met. The regulation should require a letter of verification from the ventilation engineers following installation, as well as some mechanism for verifying that the ventilation system is being routinely checked and maintained throughout the year.

Under ideal conditions, a ventilation system can be used to contain ETS to the smoking area; however, ventilation is not capable of maintaining acceptable levels *within* the smoking area, which likely results in an increased health risk for employees. For these reasons, in addition to considering the costs associated with installing and operating a ventilation system, a regulation that bans smoking is the most effective and efficient method of

The Massachusetts Coalition for a Healthy Future (MCHF) – the statewide coalition formed to promote Question 1, the initiative petition that funds the Massachusetts Tobacco Control Program – has applied for a SmokeLess States grant from the Robert Wood Johnson (RWJ) Foundation. Since 1992, MCHF has acted as the guardian of Question 1 tobacco control monies, which are subject to annual legislative appropriation. MCHF also promotes local and statewide tobacco control legislation, and the Coaliton has successfully promoted numerous "first in the nation" laws and regulations such as Massachusetts' cigarette ingredient disclosure law.

Although MTCP is one of the best funded state tobacco control programs in the nation, MCHF – currently a statewide coalition of some 22 organizations – is largely volunteer driven and has resources insufficient to the tasks with which it is charged. MCHF has asked RWJ for $500,00 per year for three years to bolster MCHF's protection of MTCP funds, and to increase the Coalition's capacity to promote innovative local and statewide policies.

The top priorities the RWJ grant would fund are to: 1) raise the tobacco excise tax in Massachusetts to further reduce the demand for tobacco products in the Commonwealth and to fund public health initiatives; 2) redirect Multistate Master Settlement Agreement (MSA) funds in Massachusetts to tobacco control initiatives; 3) develop and implement innovative local and statewide tobacco control policies; 4) foster changes in Medicaid and state employee health insurance, and encourage private health insurers and managed care providers to cover tobacco dependence treatment and nicotine replacement therapy as part of normal and routine coverage.

MCHF will achieve these goals by using SmokeLess States grant funds to 1) diversify and strengthen its active membership base; 2) build its organizational, technical, and leadership capacity; 3) greatly expand its innovative grassroots organizing capabilities; 4) develop a comprehensive plan to improve the tobacco policy environment in Massachusetts; and 5) educate the public about tobacco control.

The American Cancer Society would be the lead agency on the project. The grant proposal was drafted by new MAHB attorney Graham Kelder. Part of the grant funds would be used to fund policy work that

much.

-Graham Kelder

MCHF Top Legislative Priorities

In a retreat it conducted in late September of last year, the Massachusetts Coalition for a Healthy Future (MCHF) set out its top priorities for the current legislative year. These are: 1) the passage of the statewide ETS bill introduced by State Representative Mike Cahill; 2) the restoral of more than $10 million in Master Settlement Agreement (MSA) funds to tobacco control; 3) the passage of a new $.50 tax on cigarettes that would fund health insurance for the underinsured in the Commonwealth; and 4) the passage of a bill raising the minimum legal sale age for tobacco products in Massachusetts to age 19.

The new cigarette tax is being promoted in the Commonwealth by Health Now! Massachusetts, which is part of a regional tobacco tax increase campaign being promoted by the Alliance for a Healthy New England. The Health Now! Massachusetts campaign brings together consumer health care, tobacco control, and public health advocates. The campaign also includes physicians, other health care providers, insurers, labor unions, and grassroots supporters. The campaigns primary goal is to provide affordable health care to the substantial portion of Massachusetts' residents living without health insurance through an expansion of MassHealth and other public initiatives aimed at uninsured low- and middle-income workers and other residents.

In FY2000, MCHF had been able to persuade the legislature to allocate $22.8 million in MSA fund to new tobacco control initiatives. This virtually doubled the annual budget of the Massachusetts Tobacco Control Program (MTCP). This funding was slashed by $10 million in FY 2001. Restoring that funding is a top priority for the current fiscal year, FY 2002.

Rep. Cahill's ETS bill is discussed in detail in another article in this issue.

-Graham Kelder

I am very excited to be MAHB's Assistant Director for Tobacco Control and Staff Attorney. When I joined MAHB in June I was immediately thrilled to have the opportunity to work with Marcia Benes, Cheryl Sbarra and Marc Boutin on an issue as important as tobacco control in Massachusetts. Two months into my tenure with MAHB I have discovered my excitement has multiplied as I get to meet and collaborate with so many wonderful people in so many communities working on this critical issue.

I have been an attorney for nearly nine years. During most of that time I served as a prosecutor for the Northwestern District Attorney's Office. As an Assistant District Attorney I tried cases primarily in Hampshire and Franklin counties. In 1997 I was appointed Special Prosecutor for Domestic Violence in Hampshire County. . I enjoyed my years as an A.D.A., particularly because I got to work with the public and give an understanding ear and a hand and to victims in need of support. In addition to my work as an A. D. A. I served as Chairperson for the Northwestern District Attorney's Civil Rights Advisory Board. In this capacity, I had the opportunity to lead and organize many educational efforts to promote civil rights and respect throughout the Pioneer Valley

Prior to moving to Western Massachusetts I worked in legal services offices in Cambridge, MA and Juneau, AK. My interest in public health issues is longstanding. While attending Boston University School of Law I studied public health law. In 1986 I was a researcher in a University of Michigan-based research project documenting the incidence of undiagnosed substance abuse in a hospital population and testing a series of questions meant to help busy practitioners determine which patients might be abusing alcohol.

In my spare time I enjoy photography, taking in the beauty of Western Massachusetts and hugging my squirmy newborn son.

Graham Kelder

Graham E. Kelder, Jr., Esq., formerly the managing attorney at the Tobacco Control Resource Center, has joined MAHB's legal staff as its Federal and State Tobacco Control Legal Policy Analyst. Graham is a member of the Massachusetts Tobacco Control Program's Community Assistance Statewide Team (CAST), a policymaking and advisory committee on which he has served since 1995 and which he chaired from 1998-2000. In 2000, he directed an extensive updating and expansion of the Massachusetts Tobacco Control Program's *Controlling the Sale and Use of Tobacco Products in Massachusetts: A Legal Policy Manual for Municipal Officials and Public Health Officers*, a manual originally edited by him in 1994.

Graham was named as the new chair of the legislative committee of the Massachusetts Coalition for a Healthy Future (MCHF), a statewide tobacco control coalition of over 47 organizations, in March 2001. In January 2001, he authored MCHF's Smokeless States grant proposal.

In 1999, Graham co-directed a study, commissioned by the national office of the American Cancer Society, of the Multistate Master Settlement Agreement (MSA). That same year, Graham co-authored *An Action Plan to Protect the Health of Massachusetts Citizens and Their Children: Using Tobacco Settlement Funds to Reduce the Health/Economic Costs of Tobacco-Related Disease in the Commonwealth*, the tobacco settlement blueprint that enabled tobacco control advocates to persuade the state legislature to almost double the multimillion dollar annual budget of the Massachusetts Tobacco Control Program in FY2000. In July 2000, Massachusetts Attorney General Thomas F. Reilly appointed Graham to the Commonwealth's 27-member Advisory Committee on Health and Tobacco Control.

Graham has published numerous articles on tobacco control and tobacco litigation in journals such as the *Stanford Law and Policy Review*, *Trial* magazine, the *American Public Health Association Journal* and the

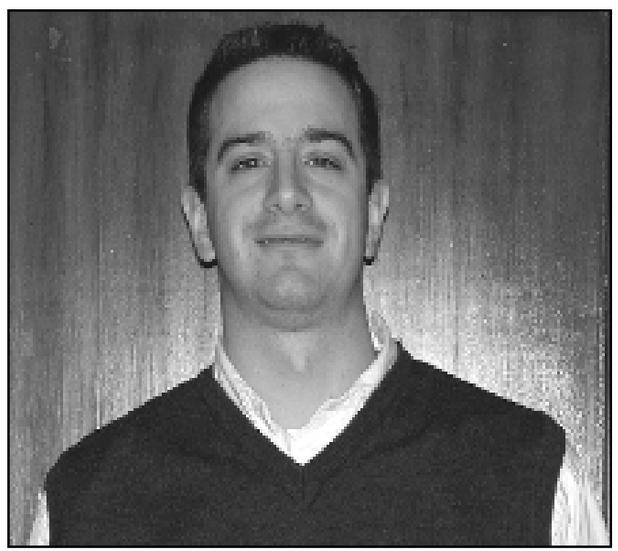
Reducing Tobacco Use: A Report of the U.S. Surgeon General (2000).

Described by the *Columbia Journalism Review* as a key press contact in tobacco litigation and tobacco control law, Graham has been quoted in legal periodicals such as the *National Law Journal* and the *ABA Journal*, foreign periodicals such as the *Daily Telegraph* (U.K.) and the *Financial Times* (U.K.), news magazines such as *Business Week* and *U.S. News & World Report*, and domestic newspapers such as the *Boston Globe* and the *New York Times*. He has appeared on the BBC, National Public Radio's *All Things Considered* and *Morning Edition*, WBUR's *The Connection* and *Marketplace*, CNBC's *Inside Opinion*, and MSNBC's *Dayside*.

Michael McClean

MAHB Science Advisor

Michael McClean is the Science Advisor and Ventilation Consultant for the Massachusetts Association of Health Boards. His primary responsibility is to provide information to local Boards of Health regarding the effective control of environmental tobacco smoke (ETS) in restaurants and public places. While there is no question that a Smokefree Policy is the most effective and most efficient way to control ETS exposure, the use of ventilation systems as an alternative control is an important and complicated issue. As a result, Mr. McClean has been providing technical support to local Boards of Health by attending public hearings, designing and presenting ventilation workshops, and responding to specific questions regarding ETS and/or ventilation.



Mr. McClean is currently a doctoral student in the Department of Environmental Health at the Harvard School of Public Health where he is conducting a large-scale study of asphalt

is associated with an increased risk of cancer.

Prior to the doctoral program, Mr. McClean obtained a M.S. in Environmental Science and Engineering from the Harvard School of Public Health. During the master's program, he was selected by the Department of Energy as an Industrial Hygiene Fellow and spent three months conducting beryllium research at the Lawrence Livermore National Laboratory in California. Also during this time, Mr. McClean worked as a consultant for the Environmental Protection Agency to develop QA/QC protocols for a greenhouse gas emissions inventory.

Prior to graduate school, Mr. McClean spent three years working as an environmental consultant at a firm that specializes in human health and ecological risk assessment. His primary responsibilities were to conduct human health risk assessments and develop risk-based cleanup strategies at state and federal hazardous waste sites. Michael has a B.S. in Environmental Science from the University of Massachusetts in Amherst.

The MAHB elist provides an opportunity for people to post questions and benefit from the accumulated experience of 141 other people including board members, staff, DEP and DPH and faculty at Schools of Public Health and MAHB staff. The answers to almost any question (except where the stock market is headed) can be found within this diverse forum, yet fewer than 10% of all board members have joined. We also have a growing database of information about boards of health, and the ability to store and share files in a central location. Here is just a sampling of the 239 messages which were posted since last June.

At what level of food sales do most of you require a temporary food permit and inspection for a weekend fair: cooked meat products, obviously. But - cotton candy? bake sale? fried dough? Thanks - Lee Edelberg, Shelburne BoH

In Leicester (1990 pop. 10,200), we require a permit for just about any food sales (that we know about), without regard to what is being sold. We waive the fee for any charity events. We feel that if people are required to get a permit, there's a better chance that we can catch anything that might be a problem. We ask that they present a list of all foods to be sold, then offer advice where we feel it's necessary. We do not ask for permits when the schools are selling candy bars.

Hi everyone, Our town has distributed 2 rounds of loans through the Mass. Water Pollution Abatement Trust Septic Betterment Loan program with the support of Northbridge Environmental Co. in administering the program...reviewing loan applicaitons, preparing loan documents, drawdown requests, and other program materials. Northbridge is no longer interested in providing these services. We do not have either the staff or the expertise to run this program on our own, but would like to continue to help out homeowners who do not qualify for the state-run MHFA program. Is anyone aware of any other firm or individual who has been assisting communities with this program? Thanks. Sharon BOH

Duxbury is on our third round of the Septic Loan Program. We use South Shore Housing Development Corporation, 169 Summer Street, Kingston, MA 02364 - Joan Maney is our contact person 781-585-3885 (ext. 250). They have handled all the necessary paperwork since the beginning. They charge a fee for each homeowner that is included in the loan. Becky Chin, Duxbury Board of Health

For Wrentham, I administered both loan programs, without help from third party consultants. All of the forms and legal documents are available from DEP (or were available from OECD in the case of the older program) and staff at both agencies was very helpful. Once you understand the procedure, and have it set up properly, (for example, the DEP legal forms should be reviewed and approved by Town Counsel), it takes about an hour or less to go through the entire process for each successful application. It helps if you have the BOH Secretary check the forms for completeness and to ask the applicants to send in the missing information. The steps include the following: evaluate a loan application, approve it, fill out the loan documents and sign the documents along with the homeowners. In terms of DEP interactions, you have to fill out a one-page form to drawdown funds from the loan and give them quarterly reports. I have help from the Town Accountant in certifying the quarterly report to DEP and the Treasurer/ Collector also assists in this report and has to sign the drawdown form, which take about 15 minutes or less each quarter. The Assessor's office is now taking care of filing the executed loan documents at the Registry of Deeds. In the previous programs, I filed 3 to 4 loans at a time, thereby minimizing the number of trips I had to make to the Dedham Registry. If you are comfortable dealing with the paperwork, by all means do it yourself. You now have the templates to follow which were prepared by Northbridge. If you are not comfortable doing this, I suggest you, i.e. the Board of Health, take the responsibility for approving the applications and then get any small accounting or tax accounting firm to help you with the rest. This work is very similar to what they do all the time. About 6 months ago, I was able to sit down with the BOH Agent from a Town northwest of Boston and explain this procedure in detail. I would be happy to do so again if anyone is interested. Ravi Nadkarni

....We have a Health Agent and the town has decided to combine our Health Agent and our Animal Inspector into one job (we have never been able to find anyone to fill the Animal Inspectors position) We need to budget this new combined position and need some help on fees. Are there any fees associated with the Animal Inspector? Do any other towns have a list of fees? (crow pick ups etc etc) We really appreciate any feedback anyone could give us.Thanks Wendy Lonstein Boylston BOH

The Town of Abington Animal Inspectors receives $5.00 per animal, and the cost to the Town is about $2,500 a year

prohibit "any reference to his or her license in advertising or promoting any method of hair removal other than electrolysis", so that one is excluded. I have been asked if there is a regulation requiring a physician's presence on the premises when laser hair removal is being done. (I would hope that there is!) Thank you for any help. Carol Looney, Milton

Carol: As far as I know, it is not necessary for a physician to actually be on the premises. In fact, you do not need to be a physician to actually do laser hair removal. Many Nurse Practitioners and Nurses are working in this field now. I believe oversight needs to be provided by a physician. In many cases this means that the MD is present on paper only, and not actually in the room when the service is conducted. I have forwarded your email to my brother who actually works for a company that manufactures these lasers in their Sales Dept. We have discussed this many times, and perhaps he can shed better light on this issue than I can. Good Luck, Stephanie J. Wilkie, FNP

There is a movement in the Town of Tewksbury to make a transition from an elected Board of Health to an appointed one. The town manager has suggested the appointment of a Community Development person, who in turn would oversee not only the Board of Health, but also the Building Inspectors and other town offices as well. I would be interested in hearing from Board Members relative to their opinion of this issue, both pro and con. It seems to me that the Board of Health needs to remain as free from political influence as possible, and that the appointment of a Community Development person who is accountable to the Town Manager, who is accountable to the Board of Selectmen who are fraught with political influence and motivation would not be the way to go. Your thoughts on this?? Stephanie J. Wilkie, FNP Board of Health, Tewksbury

...In Somerville we have a Health Department and a 3 member appointed Board. The Board members are not responsible for provision of services, they mainly advise & support the Health dept and approve and pass regulations. I am the Director of the Health dept and do not have voting privileges on the BOH. I have always assumed they are different entities. Tho a year ago, a staff person insisted our dept is the BOH. ..What actually is our legal situation... I always thought most cities/towns had a hlth dept & a separate BOH except for the smaller places that had a combination. Genita

munity that has created a "Health Department," ...Boston has a Public Health Commission created by statute with the essentially same authority as any other board of health. ...Springfield also has an entity with the authority of a board of health. Marc Boutin, Esq.

Hi Genita,

1. Boards of health are either elected or appointed, and they are the governance, or policymaking (i.e. regulations) part of the local health equation. They are also ultimately responsible for the both hiring and performance of staff, although this is sometimes delegated to the health directors. Some boards are very small and have no staff, some are very large, and have full time professional health directors. Nonetheless, all of these boards have the same authority by law. All directors and agents who work for the board of health or health department are serving under the governance of the board of health.

The confusion arises in part because many larger communities with full time agents or health directors call them selves ""health departments". This is an imprecise term, especially in the context of governance models.2. There are also several (the number is somewhat unclear at this moment, but Newton is one example) communities which have opted to do away with the board of health, except in some vague advisory capacity. These communities have invested all authority, including policy making, to the Health Director.3. Then there is the Health Commission category, which Marc Boutin described. This includes Boston and Springfield, and essentially, it is the same as the Board of Health (#1), except it is called by a different name. 4. Lastly, because Massachusetts laws allow towns to reinvent town government into any form they wish under the Town Charter Provisions, we have recently seen the adoption of new forms of governance where the appointed board of health still has a policy role, i.e. they can still pass regulations, but the hiring of health directors/agents is transferred to another entity. This can be the town manager, or more recently, a new office - the development director.

Needless to say, it is bad news for the public whose health we all work to protect, the board members and the staff when this last option is adopted, because the connection with public health is broken, and there is greater opportunity for mischief by special interests. Marcia Benes

MAHB Executive Board

I only knew Randy for a few short years, but it felt like a lifetime. I don't even remember the first time we met, in large part because his acquaintance seemed much more like a re-acquaintance.

Randy was my best friend in my newly adopted home of Winchester. Randy attracted me for so many reasons: his commitment in his beliefs; his love of learning; his unassuming, forgiving, accepting manner towards people. Randy also had a mischievous side: he would stir things up not so much for resolution of an issue but simply to raise the issue. He got under people's skin with his tenacity and perseverance, but he never personalized any issue. He had the gift of transcendence. Maybe because he was so smart. Maybe just because he cared so much.

Randy was a quintessential public health servant. His view of public health was about as broad as Lynn Margulis' view of Gaia. He might even call the Gaia concept limiting. Though he always downplayed his accomplishments, I came to learn a few things about Randy. He was a physicist by training and received his Ph.D. from the prestigious Rensselaer Polytechnic Institute. He held an associate professor position at UMass/Lowell and taught biotechnology courses in the Department of Chemical Engineering. He was compelled to serve on the local board of health in part due to his daughter's tragic drowning in a neighbor's pool. But his interest didn't stop there. From swimming safety, he became a pied piper of people's issues, and he cut a wide swath. School immunization and substance abuse programs, sewer issues, flooding issues, hazardous waste problems. Randy was on the beat nearly around the clock. He was known to visit the local newspaper at all hours of the night. He was driven to inform the public about community issues, and his gift of gab earned him weekly sound bites.

My own personal intersection with Randy's life was far too limited. I would see him regularly on my early morning run, and I would stop at his house and chat as he puttered around his yard. I never asked why he was up at such an ungodly hour of the morning, but it was clear he enjoyed the peacefulness of it all. We would always end up hatching some new idea for the flood study committee on which we both served.

The other place I would regularly encounter Randy was on the banks of the Aberjona River during any sort of that river, at that very moment. I always said no. Now I wish I had said yes.

Unfortunately, I didn't realize how much Randy meant to me, and how much he meant to so many others, until he died. I thought I was one friend in his circle of a couple of dozen or so. I was wrong. At his calling hours, a line of people wrapped around an entire block. Town police were called out to direct traffic. I suddenly felt like a minuscule bit of his life. I wondered where all those people came from. After three hours waiting in line, I found out.

People from all walks of life were drawn to Randy for many different reasons. Each person there, I thought, must represent a facet in Randy's wonderfully multifaceted life. Some people knew his family for years; others recounted that they were there because of his generosity – as the story goes, Randy offered to contribute personally to children's school programs for those who couldn't afford them (by doing so, he probably shamed local officials into coughing up the funds, but his generosity was legendary). Another person I met was a Town Meeting member who barely knew Randy but learned everything he knew by watching Randy in action on Town Meeting floor. Another person met Randy at the train stop on the way to work and was struck by how compassionate Randy was about his child's asthmatic condition and how much Randy's advice helped. Randy had a massive extended family, and a very special family of his own, with his truly equal partner Paula (who also graduated from RPI) and two incredibly talented and loving sons.

As we chatted in line and exchanged stories, we all agreed that Randy's reach was indeed very far. His compassion for life made it impossible for him to say no. He got involved in so many things, he was, not surprisingly, chronically overcommitted. As we thought about all the things Randy left undone, we all realized that the best tribute we could ever give Randy would be to carry on where he left off.

Everyone who knew Randy, or even those who didn't but who can admire his spirit, will keep Randy's spirit alive by just taking a little more time to get to know people, or making a little more effort to work on a project, or be just a little more forgiving of a different point of view, or get involved in just one more issue.

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Gary S. Moore, Dr.P.H., School of Public Health and Health Sciences
University of Massachusetts, Amherst

Introduction

It's both exciting and apprehensive, much like sitting at the apex of a thrilling coaster ride ready to be hurled and twisted into the next phase. We can hang on for the ride but much of it seems beyond our control. Despite the concerns and reluctance to the new technologies making this education e-Volution possible, it is happening. It is happening at a dizzying pace. New Web services, programs and technologies relevant to the public health field are developing faster than many can realize.

Distance learning opportunities for the public health workforce are suddenly appearing in several different forums. The purpose of this article is to acquaint you with some of those efforts. If you are looking for distance learning opportunities, use the newly developed trainingFinder.org site, or go to the Association of Schools of public Site (ASPH) site at www.asph.org. There is a nationwide program launched by the Health Resources and Service Administration (HRSA) to create a network of Public Health training centers at eight academic institutions to deliver at-a-distance training to the public health workforce. The University of Massachusetts is an academic partner in the New England Public Health Workforce Development Alliance that was established with the other academic partners being Boston University, Yale, Harvard, and Tufts.

In addition to the courses offerings and other learning opportunities, there is a wealth of new Web technologies appearing that will add substantially to the capabilities of providing interactive and exciting Web-based courses. For instance, "Brainmatter" is an intelligent Web application that is a full-featured spreadsheet written in dynamic HTML and delivered right to your browser without the need for other plug-ins. You can easily convert your own Excel 2000 documents or access hundreds of interactive pre-designed spreadsheets and calculators and put them directly on your Web page.

You could also benefit from "KeeBooks" that is an innovative way to organize, package, and distribute the Web. The students can be tracked in their use and it is interactive.. The student can electronically mark in them, highlight pages, tear out interesting content, and pass them along to other students. I will say more about these new technologies in upcoming articles.

TrainingFinder.org

There has been an explosion in Internet technology that has made possible new initiatives in the provision of courses offered at-a-distance to the public health workforce. Recognizing the need for simplifying the search for such learning opportunities, the TrainingFinder.org Web site was created. Public health professionals in all disciplines may search what may be the most comprehensive database available of distance learning opportunities for the public health workforce. This is a free service for those who seek information on courses, and also free to those who wish to submit materials for consideration that may be placed on the site. All courses that are submitted by registered organizations are placed in a temporary holding bin until they are approved for listing by PHF. Submitters will be notified by e-mail upon acceptance or denial of a course. Furthermore, courses will automatically be deactivated at a date provided by the submitter.

Funding for this site is provided by the Health Resources and Services Administration, the Office of Disease Prevention and Health Promotion, the Office of Minority Health, and the Public Health Foundation.

TrainingFinder.org helps you find information about the latest public health distance learning programs from one central location. There are three ways to find the courses you want: You may perform a Quick Search that finds course offerings by a single category (subject, target audience, or credit type) or keyword You may also click on any "Advanced Search" link on the Search page. Advanced Searches work in the same manner as quick searches, except an Advanced Search permits you to use multiple categories and keywords to yield a more specific search. You may also use a Browse function that displays the entire list of active courses in the database 10 listings at a

audience, or credit type) or keyword.

Distance Learning at Schools of Public Health

There are 12 accredited schools of public health offering degree programs at-a-distance and in differing formats leading to a Master of Public Health, credit courses, graduate certificate programs, or continuing education credits in public health. The at-a-distance programs or courses enable students to participate at any time and any place. Distance learning may come in a variety of forms including the World Wide Web (online courses), videotapes, audiotapes, audio conferences, print-based courses, satellite broadcasts, e-mail list serves, or a combination of any of these. The programs each have a different but flexible format that intends to meet the unique needs of the adult learners they serve.

The following is a summary of the Master's degree programs offered through distance learning within the accredited schools of public health. (At this time, no accredited school of public health offers a doctoral program) This information was obtained from the ASPH Web site at www.asph.org. Visit this site to learn more specifics on each of the programs listed.

Distance Learning Opportunities

California

Loma Linda University School of Public Health

Through its extended campus programs, Loma Linda University School of Public Health offers MPH degrees in the following areas: community wellness, health education, maternal and child health, health administration, and international health. Students must be on-campus for 3-5 days per quarter. All other coursework is done at the site location.

Florida

College of Public Health, University of South Florida

The school offers two MPH programs through distance learning. The Masters of Public Health in Public Health Practice is offered at host sites throughout the state of

Georgia

The Rollins School of Public Health at Emory University offers a Career MPH program through distance learning. Within the Career MPH program, students may choose the prevention science option and the management option. Students in the CMPH program are required to attend on-campus sessions only twice per semester (Sunday through Tuesday).

Louisiana

The Tulane University School of Public Health and Tropical Medicine offers an MPH program through distance learning. The Internet-based MPH program in Occupational Health and Safety Management is offered through the Center for Applied Environmental Public Health (CAEPH). All credits may be earned through distance learning.

School of Hygiene and Public Health, Johns Hopkins University

Maryland

The Johns Hopkins School of Hygiene and Public Health Distance Education Division and the School of Public Health offers an Internet-based Master of Public Health. The program requires the completion of 80 credit units, with a maximum of 60 earned via the Internet. The remaining 20 credits must be earned in a face-to-face environment.

Massachusetts

The Harvard School of Public Health offers a Master's in Public Health that uses both on-campus and distance education methods. The program consists of a three-week summer institute, five 4-day weekends per year, and monthly teleconferences. Students earn 40 credits over the course of two years

The School of Public Health and Health Sciences at the University of Massachusetts at Amherst offers a Master's Degree in Public Health (MPH). Through distance learning technologies, including online classes and teleconferencing, the MPH degree in Public Health Practice will allow you, as a health professional, to

On-Campus (OJ/OC) program: Health Management and Policy, Occupational Health, Industrial Hygiene, Clinical Research Design and Statistical Analysis, and Environmental Health. As an OJ/OC student, you attend classes in Ann Arbor for an intensive 4-day weekend (Thursday through Sunday), once a month, for approximately two years.
Joseph L. Mailman School of Public Health, Columbia University

New York
Through its Division of Socio medical Sciences, the school offers an MPH Program in Health Promotion and Disease Prevention in distance learning format. The purpose of the program is to make the MPH degree accessible to the public health workplace. Using videoconferencing, courses are transmitted live to off-site classrooms. No time is required on campus.

North Carolina
The University of North Carolina School of Public Health, offers two degree programs: The Executive Masters Program in Health Administration (EMP) is designed to provide the skills and competencies critical for leadership in upper-level management positions in all areas of health services.

Texas
The Outreach Education program at UT-Houston School of Public Health and its campuses in San Antonio, El Paso and Dallas delivers courses to students using the University of Texas system-wide videoconference network.

Washington
School of Public Health and Community Medicine, University of Washington: The Extended MPH Degree Program is a partial distance learning, partial on-site program for professionals who wish to earn a Master's degree in Public Health through the School of Public Health and Community Medicine at the University of Washington.
Its integrated curricula concentration is in health services management. The onsite commitment is for 1 month during the summer for 3 years, plus 4 weekend seminars per year for 2 years. Studies continue off-site via web and email. Most electives are offered by

(HRSA) launched a new, five-year $15.4 million program to create a nationwide network of Public Health training centers at eight academic institutions. The Public Health Training Center (PHTC) program grants will establish training centers at Boston University, Tulane University, the University of North Carolina, the University of Michigan, the University of Texas health Science Center, and the University of California, Los Angeles. A New England Public Health Workforce Development Alliance was established with Boston University, Yale, Harvard, Tufts, and the University of Massachusetts. The alliance will:

- Create a learning culture promoting strategic public health workforce development in each New England State
- Develop strong collaborations among New England academic public health programs with state and local public health leaders and practitioners who provide services to underserved areas and populations.
- Support 6 dynamic academic-practice partnerships that will assess, plan, and employ flexible formats and distance learning modalities to deliver competency-based training and education to the currently employed public health workforce. Each of the New England states is partnered with one of the five schools.
- The alliance will identify ways for the academic programs and health agencies to collaborate efficiently and share training education modules, distance learning strategies, workshop formats, certificate programs and resources to strengthen the New England public health workforce.

This program is now being developed with the expectation that new and vibrant endeavors in public health training designed for the public health workforce will soon become available in addition to the ones mentioned above in this article. For more information of the UMass initiative in this area you may contact the academic partner principal investigator (PI) Gary Moore at gmoor@schoolph.umass.edu.

An Overview of M.G.L. ch. 131 s.80A, Threats from Beaver and Muskrat-Related Activities

Beavers play an important role in the Commonwealth of Massachusetts. They help create and preserve wetlands that spawn ecosystems germane to our fragile environment. But when their activities are the cause of a flooded septic system or roadway beavers create hazards for people. The newly amended "beaver law," M.G.L. ch. 131 s. 80A and the related regulations, 321 CMR 2.08 are designed to be a new tool to help communities better handle certain beaver or muskrat created problems. This law empowers local Boards of Health to help solve those beaver or muskrat related problems that pose a threat to public health. Local boards now have the authority to grant emergency permits to trap beaver, breach dams, or alter water flow. (It is important to note that permitting for the latter two activities is authority shared jointly with the local Conservation Commission and will be subject to the local Conservation Commission determinations and conditions.) Boards should not shy away from handily utilizing this new power when a request comes before them. However, boards should also be sure that the problems presented by the applicant are actually caused by beavers or muskrat, and not some other source. While the new law and regulations can appear complicated at first, they can be navigated and be quite helpful to community members. Many individuals and agencies are willing to answer local boards' questions about what to do when confronted with a beaver related question should a problem in permitting arise. A list of resources can be found in at the end of this article.

When the amendments to M.G.L. ch. 131 s. 80A were passed by the Legislature in August 2000, it created a stir. The shift of responsibility about certain beaver problems to local Boards of Health created some furrowed brows. What is important to remember is that the rationale behind the new law is to make solving beaver problems easier. Individuals who believe that their health is somehow threatened by a beaver or muskrat-caused problem now have the ability to alleviate those threats quickly through the use of local government as opposed to the process of making a request of a seemingly far off agency. Despite this many agencies, including Massachusetts Department of Public Health (DPH), the Massachusetts Health Officers Association (MHOA), the Department of Fish & Wildlife (DF&W), the Department of Environmental Protection (DEP), Massachusetts Society for the Prevention of Cruelty to Animals (MSPCA) and others met repeatedly to produce a helpful guide to the new permitting process for local boards. An easy to read, ten-page document entitled, "Guidance for Boards of Health Implementing M.G.L. c. 131, s. 80A, Threats form Beaver and Muskrat-Related Activities," is available from DPH Bureau of Environmental Health Assessment. This guide is a thorough, practical explanation of what the law authorizes and what boards might do in a variety of situations. A sample permit application, sample permit and other related sample paperwork are also available, although local boards can create their own.

Some parts of the law may strike some local boards as unfamiliar territory. Here is a quick overview of terminology and concepts for board members to keep in mind when interpreting the new law.

·Any person can apply to the Board of Health for an emergency permit.

·The use of the word "emergency" means that a permit can be obtained quickly and that the permit is short-lived. "Emergency" does not mean that a public health emergency already exists. In fact, a mere threat to public health will suffice as evidence to obtain a permit.

·M.G.L. ch. 131 s. 80A sets out a list of circumstances that constitute a public health threat. (M.G.L. ch. 131 s. 80A (a)-(i). This list is not exhaustive and a board may learn of other problems that they determine to be a public health threat. Whether or not any situation is a public health threat will be up to the judgement of a local Board of Health.

·If, upon application by a person for a permit, a board determines that a public health threat exists and that beaver or muskrats are the source of the problem, the board shall immediately issue a ten-day permit.

·If a public water supply is involved or in danger, DEP

· When a Board of Health issues a permit, it may fashion each permit to fit the circumstances. The statute and regulation allow for a board to authorize use of Conibear or box or cage traps; breaching of dams, dikes or berms, (subject to the approval of the Conservation Commission before issuance); or use of non-lethal water flow devices (subject to the approval of the Conservation Commission before issuance). The boards may choose to issue a permit for any or all of these activities.

· A permit issued by the Board of Health is good for only ten days.

· A Board is only authorized to issue a permit to use a Conibear trap on an initial ten-day permit.

· If a Board denies a permit, it must immediately specify why it did so in writing. The Board must also inform the permit seeker of his or her appeal options.

· If a permit is denied because the Board finds no public health threat, the applicant may appeal to DPH. If a permit is denied because the Board finds that the source of the problem is not beaver or muskrat, the applicant may appeal the board's decision to DF&W.

· The permit seeker can always apply to DF&W through usual means for a permit to install a water flow device, breach a dam, or trap under different conditions.

· If an initial emergency permit is issued but ten days pass and the problem is not solved, the applicant, in conjunction with his or her local board, may apply for a thirty-day extension permit from DF&W. While awaiting the decision from DF&W on that thirty day permit, the applicant may request up to two additional ten day emergency permits from the local Board.

Here are some commonly asked questions about the new law:

What will the permitting process be like for our Board of Health?

The Board of Health receives a permit application from a person who fears beaver-caused flooding may soon impact his septic tank. Since the problem is on private property or public property that is not a public water supply, the Board of Health investigates. The

Board of Health may choose at this point to advise Board may find the circumstance before them mirrors an example in the law, or the Board may find the circumstance is not one of those enumerated. If the Board determines a threat to public health exists and that threat is the result of beaver activity, the Board shall issue a permit. If the Board authorizes a permit to trap, the approved applicant must secure a licensed trapper. If the Board issues a permit to breach a dam or install a water leveling device the applicant must also seek an Emergency Certification from the local Conservation Commission. The Board of Health permit is good for ten days. If the problem is not resolved, the applicant may, in conjunction with the Board apply to DF&W for a thirty-day permit. In the meantime, the board may not issue more than two ten-day extensions. These additional permits shall not allow the use of Conibear traps.

Is a threat to agricultural land reason for a local board of health to issue an emergency permit? Answer: Yes. In fact such a circumstance is enumerated in the non-exhaustive list of examples appropriate for emergency permitting in M.G.L. ch. 131 s.80A (a)-(i)

What if the beaver dam on a neighbor's property is creating flooding on an applicant's? Answer: If the applicant for the permit is not the person who owns the property where the beaver dam is located, the applicant must get permission from the landowner before any remediation of the beaver problem may begin. Without this initial permission the applicant is facing a trespassing problem. It will be good practice for the Board of Health permit to have a signature line for such permission incorporated into its permit application, or to have an appropriate protocol set up to ensure the landowner has given permission. Hopefully the landowner and the applicant have a relationship such that they are willing to help each other in times of need. If the landowner cannot be reached, or the landowner refuses to give permission to the applicant to access the source of the public health threat, the Board of Health could possibly decide, if the circumstance was appropriate and only as a last resort, to use their authority to alleviate nuisances and gain access onto the property. This type of remedy was not cited in the new law and Boards could be using this remedy at their own peril.

For questions regarding public health issues:

Michael Celona

DPH Bureau of Environmental Health Assessment

(617) 624-5757

For issues regarding wildlife issues:

Sue Langlois

DF&W Field Headquarters

(508) 792-7270 x 123

The District Wildlife Manager for each region across the Commonwealth is also listed as an available resource.

Representatives of the MSPCA are also listed as an available resource.

Beaver management issues will be a "different animal" to Boards of Health this season. M.G.L. ch. 131 s. 80A calls upon local boards to make judgements about a subject relatively new for them. But no doubt once local officials have a chance to thoroughly examine the new law this process will likely become second nature.

-Melinda Calianos

Wading into the New Bathing Beach Regulations

In August 2000 House and Senate members passed legislation regarding the testing of all bathing beaches in the Massachusetts. Legislators created M.G.L. ch. 111 s. 5S to enumerate the expectations and requirements they determined to be necessary to keep beach bathing safe in the Commonwealth. The legislation sailed through the House and Senate without any opposition and was supported by the Environmental Collaborative.

When the bill containing M.G.L. ch. 111 s. 5S came up for vote, the new law was passed unanimously by all present for the vote and then became known as Chapter 248 of the Acts of 2000. The regulation of bathing beaches is not new to the Commonwealth, however. Over the past forty years, bathing beaches

Massachusetts Department of Public Health (DPH), to the agency now known as the Department of Environmental Protection (DEP) and back to DPH. Since 1986 local Boards of Health have been responsible for implementing the State Sanitary Code in regard to bathing beaches. Under the new law pertaining to bathing beaches, local Boards remain responsible for monitoring the bathing beaches in their communities. What is new for Boards lies in an expected increase in the number of beaches to be tested, an increase in the frequency of testing, and the type of testing that must be conducted.

The new law is two-part: it revises and clarifies existing regulatory requirements to better promote public health and safety at more beaches in the Commonwealth and it mandates DPH to promulgate minimum sanitation requirements for bathing beaches. Howard Wensley, Director of the Division of Community Standards whose department in conjunction with others has been working to carry out this mandate, has said that the regulations will likely be completed and available to local BOHs in April.

To do this work, 105 CMR 445.00, " Minimum Standards for Bathing Beaches, State Sanitary Code Chapter VII," is currently being amended. Much of the proposed DPH regulation amendments mirror the new statute. Public hearings about these amendments have included discussion of new water testing standards, requirements for lab analysis and reporting, procedures for notifying the public about unsafe beaches. These hearings were slated for several dates in early March throughout the Commonwealth.

The statute sets minimum standards upon which the regulations will expound. The major changes to the bathing beach laws, such as the increased frequency of testing and the types of organisms the tests seek to discover, are part of the statute. That is, these requirements were voted on by the legislature and are now the law of the Commonwealth and cannot be changed by DPH or a local Board. It is the means to those ends, the details and the "how to's" of the

What bathing beaches will need to be tested. The new definition of bathing beaches breaks out categories into public, semi-public and private beaches. Semi-public beaches, which include beach associations, country clubs, hotels, motels, and other beaches with limited public access will need to be tested under the same regimen as public beaches.

Increased frequency of testing: The statute sets out a minimum standard that public and semi-public bathing beaches be tested once every week throughout the bathing season. The statute further requires that this testing be performed at times that the results will provide a meaningful reading of the safety of the water when bathers would be swimming. DPH may choose the sites and times for testing at particular sites. The older (thought still current at the time of this writing) law requires testing only once every two weeks.

What indicator organisms are the focus of these tests: The tests to be performed will determine the presence and density of enterococci and E.coli in the bathing beach waters. Previously "total coliforms" were used as indicator organisms for determining bacterial quality of beach water, but it has been determined that such a count did not accurately portray the safety of a beach. In addition, the statute was created to protect bathers from sludge deposits, solid refuse; floating solid, grease or scum wastes; oil, hazardous material and heavy metals; and the bacteria listed above.

Paying for testing: Under the new statute and regulation the operator of the beach will pay for testing of the related beach water. For example, if a municipality owns a beach and the Recreation Department of the municipality operates it, the Recreation Department will need to pay for the testing. For a semi-public beach, (e.g. a country club) the testing, monitoring and analysis must be paid for by the owner or operator, not the local board or municipality.

Posting of signs: The statute requires that once an unsafe level of organism is recorded, the operator MUST post a sign that swimming may be dangerous to your health and that the water should not be entered.

from the time of the discovery of the unsafe levels of bacteria.

Laboratories acceptable for testing: The statute is silent on this issue, but lab use is an issue that DPH is grappling with in its efforts to create regulations. It is likely that the requirement will be that any lab performing testing for the bathing beaches will have to be certified by DEP for water quality testing.

Reporting: Local Boards of Health are required by the statute to report results of their testing back to DPH, which will then take those results and ultimately create an annual report on the state of the Commonwealth beaches. DPH is especially interested in the speedy reporting of readings indicated contaminated beach waters to DPH. A requirement that DPH be notified by the local board when a beach is posted as unsafe within 24 hours of its discovery/posting is being considered.

Proposed variance structure: The statute allows for variances under certain circumstances displaying no pollution. A beach where the pollution has been completely remediated could also qualify. The granting of variances will be within the jurisdiction of the local boards. The model for the variance procedure is still under consideration in the regulatory process. It appears likely that a two-year window of no sources of pollution will be required for a variance if requested. A variance would probably allow for less frequent testing, (e.g. once a month), not the total absence of testing.

Certain portions of the regulatory plan are still being considered, such as the timing for testing (e.g. when in relation to maximum bathing load, tides etc.) and the specifics of the variance procedure. The final draft of the regulation required by MGL ch. 111 s. 5S should be completed by April 1, 2001. Mr. Wensley has indicated that it is likely members of his department will be planning trainings on these new rules around the state.

Tobacco Bills

MAHB and the Massachusetts Coalition for a Healthy Future (MCHF) support:

- HB 3291 (introduced by Cahill) which would impose a statewide workplace smoking ban. A hearing on this bill was held before the Health Care Committee on April 4, 2001.
- HB 2169 (introduced by Kaprielian) and SB 1703 (introduced by Montigny) which would impose a new $.50 tax on cigarettes that would fund health insurance for the underinsured in the Commonwealth.
- HB 2907 (introduced by Kelly and Murphy) which would raise the minimum legal sale age for tobacco products in Massachusetts to age 19. A hearing on this bill was held before the Health Care Committee yesterday, April 4, 2001.
- Reports on other tobacco bills to be made available on the MAHB web site as the Massachusetts Coalition for a Healthy Future and MAHB make further decisions.

MAHB Supports

- HB 1131 (introduced by Quinn) which would allow a tax credit of up to 40 percent for "the expenditures for design and construction expenses for the repair or replacement of a failed cesspool or septic system pursuant to the provisions of Title V...." (Said expenditures shall be the actual cost or $15,000, whichever is less.)
- HB 1391 (introduced by Stefanini) which would require health warnings for mercury to be placed on fish products. DPH would be required to produce a "fish consumption advisory" that boards of health could distribute to the public and local retail food establishments. Boards of health would enforce this law. This will be heard before the Health Care Committee on Wednesday, April 18, at 10 a.m. in Hearing Room A-1.
- HB 1625 (introduced by Hall and Resor) which would provide loans to elderly persons over 65 who make less than $40,000 per year to assist with Title 5 compliance.
- HB 2224 (introduced by Petersen) which would establish a legislative regulatory scheme for the recycling of used automotive oil. This will be

- HB 2808 (introduced by Hynes) which would allow a tax credit of up to 40 percent for "the design and cost of construction of a subsurface septic system to meet the requirements of Title 5 .... (Such costs not to exceed $6,000 in credit.)
- HB 3627 (introduced by Harkins) and SB 1573 (introduced by Moore, Hodgkins, Parente, and Marcia Benes and Emile Gougen) which would exempt boards of health from the requirements of the Uniform Procurement Act.

MAHB Conditionally Supports

- HB 2943 (introduced by Parente, Lewis, and Linsky) and SB 945 (introduced by Moore, Tarr, and Bunker) which may give boards of health a mechanism to obtain use of the non-criminal disposition process on their own and which provide detailed requirements for the giving of non-crim tickets (pending clarification of the language in the bills).
- HB 3290 (introduced by Cahill, Canavan, Story, Cleven, and Kahn) which would establish a commission to "study the need for minimum requirements for health agents employed by and members of Local Boards of Health in the Commonwealth" (pending the insuring of adequate representation of MAHB on said commission). This will be heard before the Health Care Committee on Monday, April 23 at 10 a.m. in Hearing Room A-1.

of body art (pending the addition of anti-preemption language).

MAHB Opposes

- HB 963 (introduced by Simmons, Verga, and O'Brien) which would allow counties, councils of government, and, where there is no county government or councils of government, two or more cities or towns to "negotiate and contract with cities and towns to provide the same services their boards of health are required to provide…." This could be used by municipal governments to circumvent board of health authority.
- HB 3156 (introduced by Garry, Pedone and Moore) which would prevent boards of health from imposing sewage and septic tank regulations that are more stringent than those set forth in the state environmental code, "and in particular Title 5 thereof…."
- HB 3728 (introduced by Poirier) which would prevent boards of health from promulgating or establishing "any health rule or regulation, unless the legislative body in that city, town or municipality has in the first instance voted its approval to establish said rule or regulation…." The only exception to this would be "health emergencies." This will be heard before the Health Care Committee on Monday, April 23 at 10 a.m. in Hearing Room A-1.
- SB 491 (introduced by Creedon) which would amend Chapter 111, Section 31 so that board of health regulations would not take effect until they are filed with the Department of Environmental Protection. This law would also render ineffective any board of health regulation adopted before the effective date of SB 491, "and required to be filed with the department of environmental protection by section 31 of chapter 111 of the General Laws, …until it has been so filed." This will be heard before the Health Care Committee on Monday, April 23 at 10 a.m. in Hearing Room A-1.
- SB 496 (introduced by Hedlund) which would require that any board of health regulation or amendment "promulgated after January 1, 1998 that exceeds state regulations relative to septic and cesspool systems shall not apply in a city or town unless approved by vote of the town commissioner [of the Department of Environmental Protection? – it's not clear from the bill] to adopt regulations that are more stringent than the state environmental code

MAHB Conditionally Opposes

- SB 535 (introduced by Moore, Murray, Hodgkins, and Simmons) which would regulate the sale and distribution of bottled water and certain other nonalcoholic beverages (pending the addition of anti-preemption language and the clarification of language that appears to remove one form of existing board of health authority). This will be heard before the Health Care Committee on Wednesday, April 18, at 10 a.m. in Hearing Room A-1.

NOTE: Reports on other bills and committee hearing dates to be made available on the MAHB web site as they become known.

Statewide ETS Bill

The statewide workplace smoking ban introduced by Representative Mike Cahill is one of the Massachusetts Coalition for a Healthy Future's (MCHF) top priorities for the current legislative year.

This workplace smoking ban would ban smoking in all work sites, including restaurants and bars! MAHB has successfully urged legislators to make this measure non-preemptive, meaning that it will not remove the power of cities, towns, and local boards of health to pass even stricter workplace and public places smoking bans. Boards of Health should not, therefore, suspend activity on local workplace smoking measures in anticipation of the passage of this state law.

The small business associations have decided to remain neutral on this issue. Major opposition to this bill will, in all likelihood, come from the Massachusetts Restaurant Association.

The focus of discussion on this bill is the fact that ETS is a major health issue, especially for restaurant and bar workers, who are unnecessarily and unfairly exposed to the deadly health effects of environmental tobacco smoke at a far higher rate than other workers in the Commonwealth.

Under MGL 111 Section 127, boards of health have exclusive authority in this area. We believe changing this is a bad idea for public health.

1. The community volunteers that sit on Boards of Health have significant expertise in the development of local public health policy that is workable and meaningful in their respective municipalities. Boards need control over their staff to ensure that the implementation of local public health policy respects the particular needs of each municipality.

2. Boards of Health are responsible for over 60 areas of public health law and regulation. Boards also are responsible for setting and enforcing local public health policies. The day to day enforcement and implementation depends upon the health agents, public health nurses and others who work for the board. It is bad management and bad government to establish a system where these employees are not accountable to the elected or appointed board members who develop policies and work with community leaders to solve health problems.

3. Health Board members are encouraged to obtain annual voluntary certification (Primary and Advanced), so that they are prepared to meet their responsibilities. They also have access to publications, a Journal of Local Public Health, and other information supplied by this organization, the Mass DPH, and Mass DEP. The important task of assuring a competent public health workforce should not be assigned to local officials whose primary responsibility does not pertain to public health.

4. Enforcement of laws and regulations intended often brings agents and board members into conflict with special interests. (e.g. slumlords, tobacco companies and polluters). When complaints are received, board of health members have the training and experience to assess whether staff are acting inappropriately, or in the public interest.

5. Board members are also responsible for developing partnerships with community leaders and other public agencies to promote health education, solve health problems and that health care is assessable to all residents. Staff input and cooperation is vital to this effort, and is much harder to achieve when they are answerable to another town office.

6. Board of Health staff have highly specialized expertise that is necessary to protect the health and welfare of all residents. (Sanitary Code, Title 5 etc.). Boards of Health through voluntary certification are aware of the needs and therefore ensure that staff are highly skilled. Other boards and departments lack public health expertise and therefore are unaware of the need to have staff with highly specialized public health skills. Experience in smaller communities suggests that when boards lose control over their staff, the level of public health expertise drops significantly. That drop may result in declining health indicators.

Copies of this MAHB factsheet may be downloaded from the MAHB eList

2000 Program Evaluations

Overall the comments were very positive. The Primary and Advanced Evaluation summaries are posted at www.mahb.org/certification/ Comparing total numbers from 1998, there has been a gradual shift as people complete primary and move to advanced.

CERTIFICATION ATTENDANCE FROM 1998-2000

1998	primary 109	advanced 86	total 195
1999	primary 97	advanced 126	total 223
2000	primary 84	advanced 144	total 228

The total numbers are slowly heading upward, but they still represent less than 20% of all board members, so we will increase our efforts to encourage greater participation in 2001.

Our Fall 00 Certification Advanced Program expanded to two alternate tracks. This led to some logistical difficulties, but the new format was enthusiastically received.

Most of the negative comments pertained to our Alternative Title 5 workshop, which in fact was an alternative sewer workshop. Extremely well done, but not the advertised topic. We will remedy this by providing the much anticipated Alternative Title 5 workshop this fall. The Taunton program was held during a record cold spell, and the Holiday Inn's heating system was inadequate. According to the conference center management, their heating system is brand new and state of the art - but for one small oversight - the master switch for heating the rooms is controlled by a manager who does not work on Saturdays - hence our repeated pleas for "MORE HEAT" went unattended. We've been promised that this won't happen again. Otherwise, it is a great facility, and the food received high marks for the second year in a row.

Plans for 2001

The Certification Steering Committee met in mid winter to plan the fall program, and boldly decided to expand to three advanced tracks, in keeping with three general themes: Environmental Health, Legal Issues and Policy. Registrants will be free to choose among these topics, but many people may wish to stick with one theme for the day. The program is getting better in every way - more comfortable locations, better presentations, more networking opportunities and focused discussions whenever possible in place of classroom style lectures. We will also be tweaking the Primary Program, to make sure that it is a useful orientation to local public health, and incorporating as many suggestions as feasible.

One new feature that we will introduce is the Networking breakfast from 8-9 am. This will provide an excellent opportunity for everyone warm up to the program by getting to know board members and staff from their region.

Note that the north-east location has moved from Lowell to the Westford Regency. This modern conference facility is located just off Rt 495, and will provide us with a comfortable space for our expanding programs.

SAVE these DATES and LOCATIONS

Oct 20th Inn at Northampton

Nov.3rd Royal Plaza Marlborough

Nov. 10th Westford Regency

Dec. 1st Taunton Holiday Inn

MAHB is seeking information in order to more effectively advocate for stronger state and community support for boards of health. To make the case that better funding mechanisms are needed, we need an accurate measure of local public health. This survey will also help us to protect boards of health from threats of pre-emption and loss of authority through charter measures. Last year we sent out a survey on our membership forms and 156 were filled out and returned. We want to close the gaps and share this information via MAHB elist and web site so that any subscriber can download it, or update it.

This information is being used in part in a report designed to encourage the state legislature to greatly increase its financial support for local public health initiatives.

City/Town_____

check one
Elected_____ Appointed____ (if appointed, by whom?_____)

Annual Board (health department) Budget $_____

Total Number of BOH Employees_____Public Health Nurses_____
Registered Sanitarians_____ Certified Health Officers_____

Does BOH have authority to hire health agents or directors? Y or N_____
If not, who does?_____

How many of your board members have attended MAHB Certification Programs?_____
How many plan to attend this year?_____

If you have Internet access and would like to be subscribed to the MAHB e-list, please give email address (at work or home) For more information, see pg. 21

_____

Thank you for helping us to advocate for more local health resources.
Please return this to:
MAHB

Massachusetts Association of Health Boards
56 Taunton St.
Plainville, MA 02762-2144
tel & fax (508) 643-0234
http://www.mahb.org

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Please send or fax the bill to Marcia Rising:

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Stow, MA 01775 508-897-2466

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If you have any questions, please call Marcia Benes - (508) 643-0234

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