Their Approaches to Meeting the Needs of People with Mental Illness. Washington, DC: Bazelon Center for Mental Health Law; 1996.
6. National Advisory Mental Health Council. *Health Care Reform for Americans with Severe Mental Illness.* Rockville, MD: National Advisory Mental Health Council; 1993
7. Helf C. *Medicaid Managed Care and Mental Health: An Overview of Section 1115 Programs.* Washington, DC: Intergovernmental Health Policy Project; 1994.
8. Trabin T, Freeman MA. *Managed Behavioral Healthcare: History, Models, Strategic Challenges and Future Course.* Tiburon, CA: CentraLink Publishers; 1995.
9. Mechanic D, Schlesinger M, McAlpine D. Management of mental health and substance abuse services: state of the art and early results. *Milbank Q.* 1995;73:19–55.
10. Durham ML. Healthcare's greatest challenge: providing services for people with severe mental illness in managed care. *Behav Health Sci Law.* 1994;12:331–349.
11. McFarland BH. Health maintenance organizations and persons with severe mental illness. *Community Mentl Health J.* 1994;30:221–242.

9605: Cessation of Nuclear Testing and Abolition of Nuclear Weapons

The American Public Health Association,

Recognizing the public health hazards created by nuclear-weapons production and explosive testing, whether conducted in the atmosphere or underground;[1,2]

Recalling that the Governing Council of the American Public Health Association has adopted public policy statements opposing the production of nuclear weapons[3] and opposing explosive nuclear-weapons testing by France in the islands of the South Pacific Ocean,[4] by the United States at its Nevada test site, and by other nations;[5] and

Noting that on September 10, 1996, the United Nations, by an overwhelming margin, adopted and opened for ratification by the world's nations the Comprehensive Nuclear Test Ban Treaty, which contains a "zero-yield" testing threshold and bans "peaceful nuclear explosions"; and

Noting that other weapons of indiscriminate mass destruction have been banned by the Biological Weapons Convention of 1972 and the Chemical Weapons Convention of 1993;[6] and

Noting that an increasing number of countries and of international and national medical and public health associations, including the Canadian Public Health Association,[7] have urged the timebound abolition of nuclear weapons; and

Noting with concern the US, 1996 funding through the Department of Energy for the development and testing of a new generation of nuclear weapons at the national-weapons laboratories; and

Noting that the International Court of Justice ruled on July 8, 1996, by a unanimous vote that nations have "an obligation to pursue in good faith and to bring to a conclusion negotiations leading to nuclear disarmament in all its aspects"; and

Noting that the Canberra Commission on the Elimination of Nuclear Weapons, composed of prominent physicians, political leaders, generals, and scientists from both the nuclear weapons states and other nations, released on August 14, 1996, a report outlining a plan for the total abolition of nuclear weapons and reaffirming disarmament as the world's only option; therefore

1. Calls upon all nations of the world to respect the moratorium on explosive nuclear-weapons testing currently being formally observed by the declared nuclear-weapons nations, and informally observed by the undeclared nuclear-weapons nations; and

2. Calls upon all nations of the world to ratify promptly the Comprehensive Test Ban Treaty;

3. Calls upon the United States to join all nations in negotiating promptly a comprehensive treaty banning new weapons development at the national weapons laboratories, banning the production of all weapons-usable fissile material, and placing existing stockpiles of such material under international safeguards; and

4. Calls upon all nations to initiate immediately and conclude by the year 2000 negotiations on a nuclear-weapons convention that requires the phased elimination of nuclear weapons within a timebound framework under strict and effective international control.

References

1. International Physicians for the Prevention of Nuclear War and Institute for Energy and Environmental Research. *Radioactive Heaven and Earth: The Health and Environmental Effects of Nuclear Weapons Testing in, on and above the Earth.* New York, NY: Apex Press; 1991.
2. Makhijani A, Hu H, Yih K, eds. *Nuclear Wastelands.* Cambridge, MA: MIT Press; 1995.
3. American Public Health Association Policy Statement No. 8917: Public Health Hazards at Nuclear Weapons Facilities. *APHA Policy Statements, 1948 to Present, Cumulative.* Washington, DC: American Public Health Association; current volume.
4. American Public Health Association Policy Statement No. 8307: Nuclear Testing and Dumping of Nuclear Waste Materials in the Pacific Ocean. *APHA Policy Statements, 1948 to Present, Cumulative.* Washington, DC: American Public Health Association; current volume.
5. American Public Health Association Policy Statement No. 8715: End to Nuclear Weapons Testing and the Strategic Defense Initiative. *APHA Policy Statements, 1948 to Present, Cumulative.* Washington, DC: American Public Health Association; current volume.
6. Sidel V. The End of the Beginning: Progress towards the Abolition of Nuclear Weapons. *Med War.* 1995:11(3):71–78.
7. Canadian Public Health Association 1996 Resolution No. 9: The Abolition of Nuclear Weapons. Ottawa: Canadian Public Health Association.

9606: The Precautionary Principle and Chemical Exposure Standards for the Workplace

The American Public Health Association,

Understanding that the "precautionary principle" that was adopted internationally as a starting point for environmental policy in 1992 at the global United Nations Conference on Environment and Development (UNCED) in Rio de Janeiro, Brazil, states that "where there are threats of serious or irreversible environmental damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent degradation,"[1] that chemicals that are carcinogenic or genotoxic and those that have toxic effects on reproduction have potentially serious or irreversible effects and thus must be considered in the application of the precautionary principle to the workplace environment; and

Recognizing that 75% of current occupational exposure limits (OELs) were established 15 to 40 years ago; that historically, these values have been set near the maximum acutely tolerable level, with

little regard for the risks of long-term serious or irreversible damage for men, women, and children such as cancer or reproductive health effects, effects on growth and development, and toxic illnesses;[2] and that for many substances to which millions of workers are exposed, working at current exposure limits is expected to cause death rates from occupational cancer greater than 1 per 100;[3] and

Knowing that in the United States and other countries, since 1946, workplace chemical exposure limits have been substantially based on the threshold limit values (TLVs) established by a private organization (the American Conference of Governmental Industrial Hygienists or ACGIH); that TLVs historically have tended to represent long-existing levels of exposure to toxic substances in industry, rather than guidelines to control exposures to levels below those shown to cause harm;[4] that the minutes of the TLV committee show that, starting in 1970, employees of various multinational chemical companies have played central roles as committee members in developing TLVs for over 120 chemicals;[5] and that this company role was not balanced by those representating of workers' interests, such as union representatives; and

Recognizing that an alternative approach to setting standards for occupational exposure to chemicals has been proposed, which reverses the burden of proof in that every chemical is considered potentially dangerous until the extent of toxicity is sufficiently known;[6] that this alternative approach reflects an attitude of risk avoidance, instead of the attitudes of risk regulation or risk acceptance implicit in the TLV concept; that for substances with adequate available experimental toxicological data, a precautionary exposure limit is derived from the lowest observed effect level, by the use of a defined set of safety factors (for example, by the use of existing environmental airborne reference concentrations as a starting point);[7] that these health-based exposure levels' (HBELs)[8] may be derived from existing environmental risk values published by governmental agencies, where available and that (for example, about 100 chemical compounds have California Office of Environmental Health Hazard Assessment [OEHHA] cancer potency numbers; that there are over 40 USEPA Airborne Reference Concentrations (RfCs); and that OEHHA is currently developing chronic reference exposure levels for 120 substances); If no such toxicological data are currently available, an interim precautionary occupational exposure limit of 0.1 mg/m3 is established;[6] therefore

1. Finds that current US workplace chemical-exposure limits often fail to adequately protect the health of workers;

2. Encourages the development of a workplace chemical-exposure, including pesticide-exposure, prevention policy based on the UNCED precautionary principle; and

3. Encourages regulatory agencies responsible for setting workplace health standards to evaluate the effects on more sensitive populations not previously considered in standard development.

References

1. United Nations Conference on Environment and Development (UNCED). Principle 15. *Declaration of Rio.* Rio de Janeiro, Brazil: United Nations, 1992.
2. Stijkel A, van Dijk F. Developments in reproductive risk management. *Occup Environ Med.* 1995;52:294–303.
3. Alvanja MCR, et. al. Risk assessment for carcinogens: a comparison of approaches of the ACGIH and the EPA. *Appl Occup Environ Hyg.* 1990;5:510-519.
4. Tarlau ES. Industrial hygiene with no limits. *Am Ind Hyg Assoc J.* 1990;51:A-9.
5. Ziem GE, Castleman BI. Threshold limit values: historical perspectives and current practice. *J Occup Med.* 1989;31:910–918.
6. Stijkel A, Reijnders L. Implementation of the precautionary principle in standards for the workplace. *Occup Env Med.* 1995;52:304–312.
7. World Health Organization. *Environmental Health Criteria 170: Assessing Human Health Risks of Chemicals: Derivation of Guidance Values for Health-Based Exposure Limits.* Geneva, Switz: World Health Organization; 1994.
8. Cunningham K. *A Comparison of PEL's and TLV's to Health-Based Exposure Limits Derived from the IRIS Data Base. Report to OSHA by the New Jersey Department of Health.* October 5, 1988. (Annual updates of these HBELs are published by the Santa Clara Center for Occupational Safety and Health, 720 N 1st. St, San Jose, CA 95112, and on the internet: [http://152.3.65.120/oem/chem-exp.htm].)

9607: Prevention of Dioxin Generation from PVC Plastic Use by Health Care Facilities

The American Public Health Association,

Noting the conclusion in the 1994 Draft Dioxin Reassessment by the US Environmental Protection Agency that medical waste disposal is a major source of dioxin contamination;[1,2] and

Also realizing, as did APHA resolution #9304, "that virtually all chlorinated organic compounds that have been studied exhibit at least one of a wide range of serious toxic effects such as endocrine dysfunction, developmental impairment, birth defects, reproductive dysfunction and infertility, immunosuppression, and cancer, often at extremely low doses";[3] and

Recognizing that scientific and policy attention and concern have, for several years, been directed at the potential public health threat from dioxins, which, in addition to their carcinogenic effects, can disrupt the endocrine system;[4–7] and

Understanding that dioxins are created by the disposal of synthetic chlorinated organic compounds,[1,2] and that though the factors that determine dioxin formation during incineration are not fully understood, they are released into the environment during combustion of chlorinated plastic products;[1,2,8–10] and

Observing that chlorinated plastic products—predominantly polyvinyl chloride (PVC)—represent, on a tonnage basis, the largest and fastest growing class of synthetic chlorinated organic compounds;[11] and

Observing that the use of PVC products by the health care industry, which began after World War II and has grown rapidly, especially for single use or short-term use applications, accounts for most of the organically bound chlorine in medical waste;[12] and

Confirming that a prime ethical principle of health care providers is "First, to do no harm"; and

Understanding, as did APHA resolution #9304, "that the only feasible and prudent approach to eliminating the release and discharge of chlorinated organic chemicals and consequent exposure is to avoid the use of chlorine and its compounds in manufacturing processes";[3] and

Understanding that appropriate alternative products composed of nonchlorinated materials are currently available for many, but not all health care uses of chlorinated plastics (e.g., blood bags);[8–10] and

Affirming that any substitution for a chlorinated plastic product must provide a less toxic alternative with concern paid to the full public health implications of the replacement, including infectious considerations; and

Observing that highly effective programs for the reduction of