

Reducing the Risk of Alcohol Exposed Pregnancies Through Fetal Alcohol Spectrum Disorders (FASD) Prevention and Intervention Strategies

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Fetal Alcohol Spectrum Disorders (FASD)

- Umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy
- May include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications
- Not a diagnosis



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Why Prevention of Alcohol Exposed Pregnancies Matters

- FASD are birth defects that is 100% preventable
- Prenatal alcohol exposure leading to an FASD causes permanent brain damage with lifelong implications
- The brain damage results in behavioral issues that appear willful
- Typical interventions are not effective if the brain processing issues are not taken into account
- FASD are recognized as the leading known cause of mental retardation

Why Prevention of Alcohol Exposed Pregnancies Matters

- Caused by the effects of alcohol on the developing fetus
- Alcohol is a teratogen
 - A substance that might interfere with the normal development of a fetus
- According to the Institute of Medicine, of all drugs of abuse, alcohol causes the most serious neurobehavioral effects on the fetus
- Alcohol is used more frequently than any other drug of abuse and is often used in combination with other drugs of abuse

Why Prevention of Alcohol Exposed Pregnancies Matters

- Women do not set out to harm their children
- Not a new disorder
- Fetal alcohol spectrum disorders can occur in any community where women drink
- Most women do not know when they become pregnant
- The only proven safe amount of alcohol to drink during pregnancy is none

Why Prevention of Alcohol Exposed Pregnancies Matters

- Alcohol has been found in breast milk
- There are mixed reports about how long it stays in breast milk
- The idea that drinking (especially beer) during breast feeding increases the expression of breast milk is not accurate
- The brain continues to develop well after birth
 - Alcohol affects brain development
- It is very costly to raise a person with an FASD

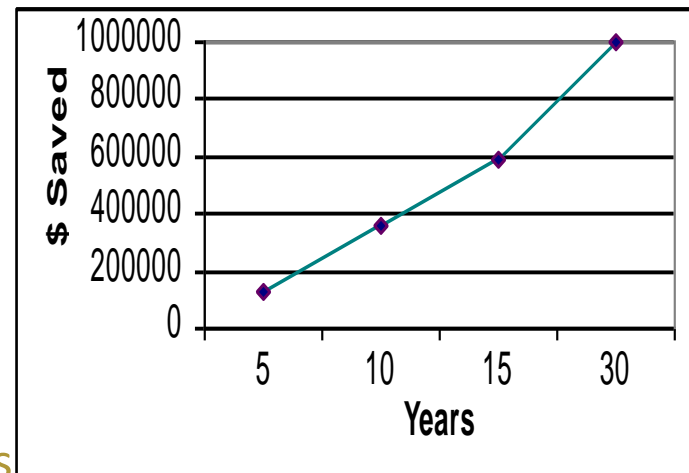
Economic Costs of FAS

- FAS alone cost the United States more than \$4 billion in 1998.
- The average lifetime cost for each child with FAS is \$2 million.
 - \$1.6 million for medical care services
 - \$0.4 million for loss of productivity



Economic Costs of FAS

- One prevented case of FAS saves:
 - \$130,000 in the first 5
 - \$360,000 in 10 years
 - \$587,000 in 15 years
 - More than \$1 million in 30 years



Increased savings
through prevention

Drinking Patterns in Youth

- 81% of youth have tried alcohol by grade 12 (National Center on Addiction and Substance Abuse: CASA)
- 29.9% of students had more than 5 drinks on more than 1 occasion in the past 30 days (Youth Risk Behavior Surveillance Survey: YRBSS)
- 46% of all high school students in the U.S. have had sexual intercourse (YRBSS)
- 23% of sexually active youth report having unprotected sex as a result of alcohol or drug use (CASA)

Drinking Patterns in Youth

- Teens tend to drink larger amounts of alcohol per sitting (CASA)
- Adolescents who drink are more likely to binge drink in early pregnancy compared to adults (Cornelius et al. 1997)
- Teenagers tend to recognize their pregnancies later than adults (Cornelius et al. 1997)
- In 2001, 455,158 women under age 20 gave birth (Child Trends September 2002)

Alcohol and Women

- All beverages with alcohol are harmful to the fetus. It does not matter what form the alcohol comes in
 - E.g., wine spritzers, alcohol pops, beer, wine, mixed drinks
- A drink \neq a drink \neq a drink
 - All beer and wine do not have the same alcohol content
 - a typical drink is often more than a standard drink
- Kaskutas and Graves (2001) studied alcohol consumption in 321 pregnant women
 - When self selecting drinks, their estimated drink size was up to 307% greater than standard measures

Who is at Risk of Giving Birth to a Child with an FASD?

- Women with co-occurring disorders
- Families with a history of multigenerational alcohol use
- Women who have experienced stressors that increase the risk of alcohol use or abuse
- Women who have an FASD
- Women who have given birth to a child with an FASD
 - Highest risk group
- **All women of childbearing age who consume any alcohol**

Prevention Is the Only Solution

- Ask all women of childbearing age about alcohol use:
 - Ask routinely at every medical appointment.
 - Ask at appointments in various systems.
 - Ask in a nonjudgmental manner.
 - Use effective screening tools.
 - Ask about possible prenatal exposure.



Photo courtesy of Microsoft.

Talk About Alcohol Use

- Talk about the effects of alcohol on an individual and on a fetus:
 - Begin at an early age, such as elementary school
 - Indicate that stopping drinking at any time during pregnancy will help the fetus



Convey the message: “Stop and think. If you are or might be pregnant, don’t drink.”

Who Needs To Know

- Women of childbearing age?
- Women who have a history of alcohol or other drug use?
- Women who are at risk?
- Teenagers?
- Men?
- **EVERYONE!**



Alcohol Screening

Fleming (1997)

- The rate of alcohol screening in health care settings is less than 50%
- In a study of a general medical clinic, only 20% of patients reported that they had been asked about their alcohol use in the previous 6 months
- Of 110 patients who met DSM criteria for alcohol abuse or dependence in a study rural primary care, only 9 said that their physician talked to them about their drinking in the last 6 months

Barriers to Alcohol Screening

Fleming (1997)

- Insufficient training in medical school and residency
- Shortage of role models
- Lack of performance feedback
- Inadequate standards of care
- Inflexible clinic systems

Barriers to Alcohol Screening

Dubovsky (2003)

- Discomfort talking about alcohol use
 - Inadequate training of practitioners
 - Don't know what to do with a positive response
 - Fear of losing patients
- Inadequate referral resources Concerns about labeling the person
- Concerns about disclosure influencing medical coverage

Barriers to Alcohol Screening

Dubovsky (2003)

- Too much else to cover in a visit
- Not enough time
- Not seeing alcohol use in their patient population as a problem
- Personal and/or family experiences with alcohol

Strategies to Increase Screening Rates

Adapted from Fleming (1997)

- Group education sessions
 - Onsite programs
 - Step-by-step, evidence based clinical protocols
 - Peer group discussion
 - Skills based role playing
 - Brief interventions
 - Screening tools
 - Credible experts delivering the training sessions
 - Change attitudes
 - Values clarification
 - Follow-up sessions

Strategies to Increase Screening Rates

Adapted from Fleming (1997)

- Education by respected colleagues
- Performance feedback
- Educational outreach to individual physicians
- Financial incentives or penalties
- Establish screening as a standard of care

Evidence Based Practices in the Prevention of Alcohol Exposed Pregnancies

- Screening and Brief Intervention, Project CHOICES, and the Parent-Child Assistance Program are practices that have shown effectiveness in reducing the incidence of alcohol exposed pregnancies
- These practices can be integrated into existing systems of care
- Brief screening of women can be done in physician visits

Screening and Brief Intervention

- For pregnant women
- Addresses consequences of drinking during pregnancy and benefits of stopping
- Reviews risky drinking situations and coping strategies
- Asks for a commitment to not drink in the next month
- For those not willing to stop drinking, discusses cutting down
- Can be implemented into existing programs

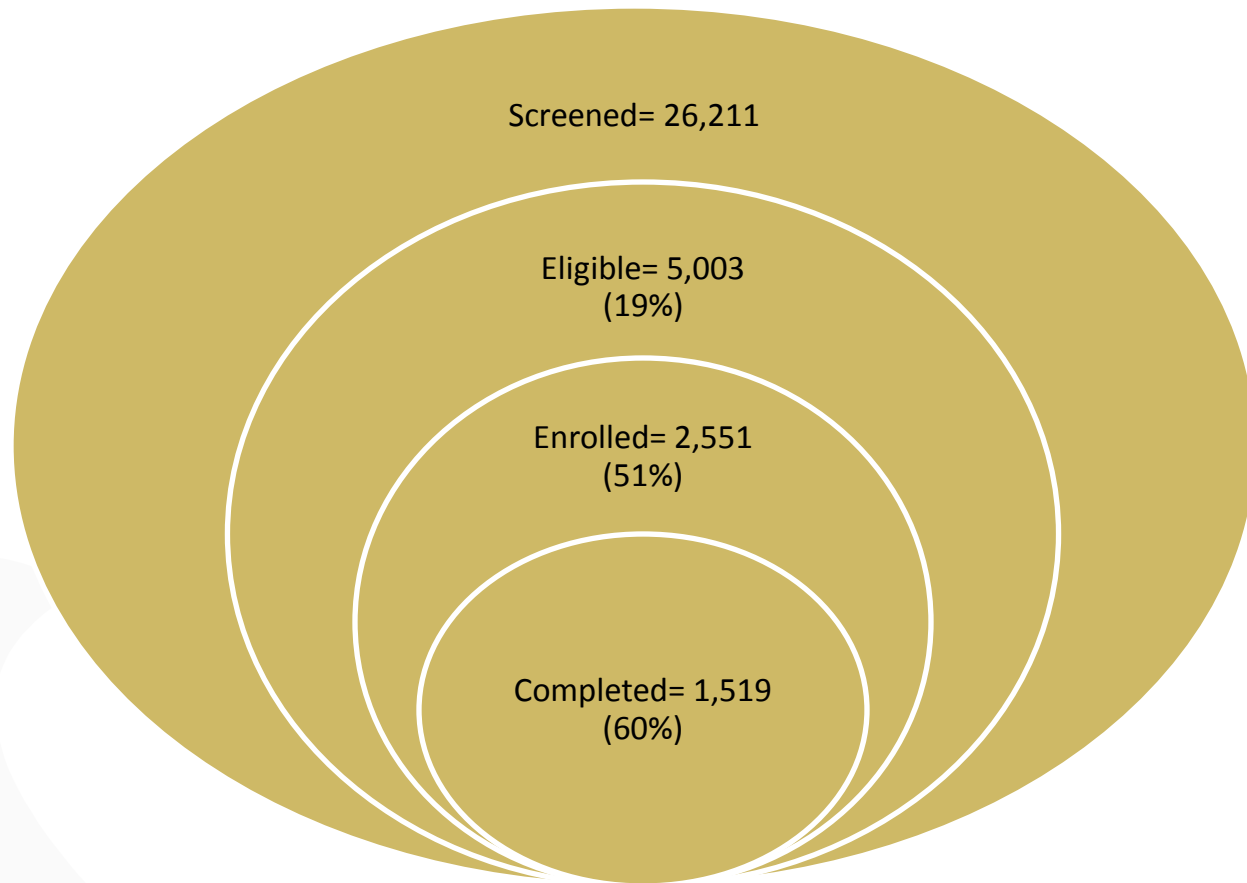
Screening and Brief Intervention Program Developed at UCLA

- Mary O'Connor and Shannon Whaley
- Randomized clinical trial of current drinkers (N=345) in WIC clinics in Southern California
- At 36 weeks of pregnancy, the control group was 5 times more likely to be drinking than intervention group
 - Assessment only control: 8.7% drinking
 - Brief intervention: 1.7% drinking
- 6.5% were referred to alcohol treatment program

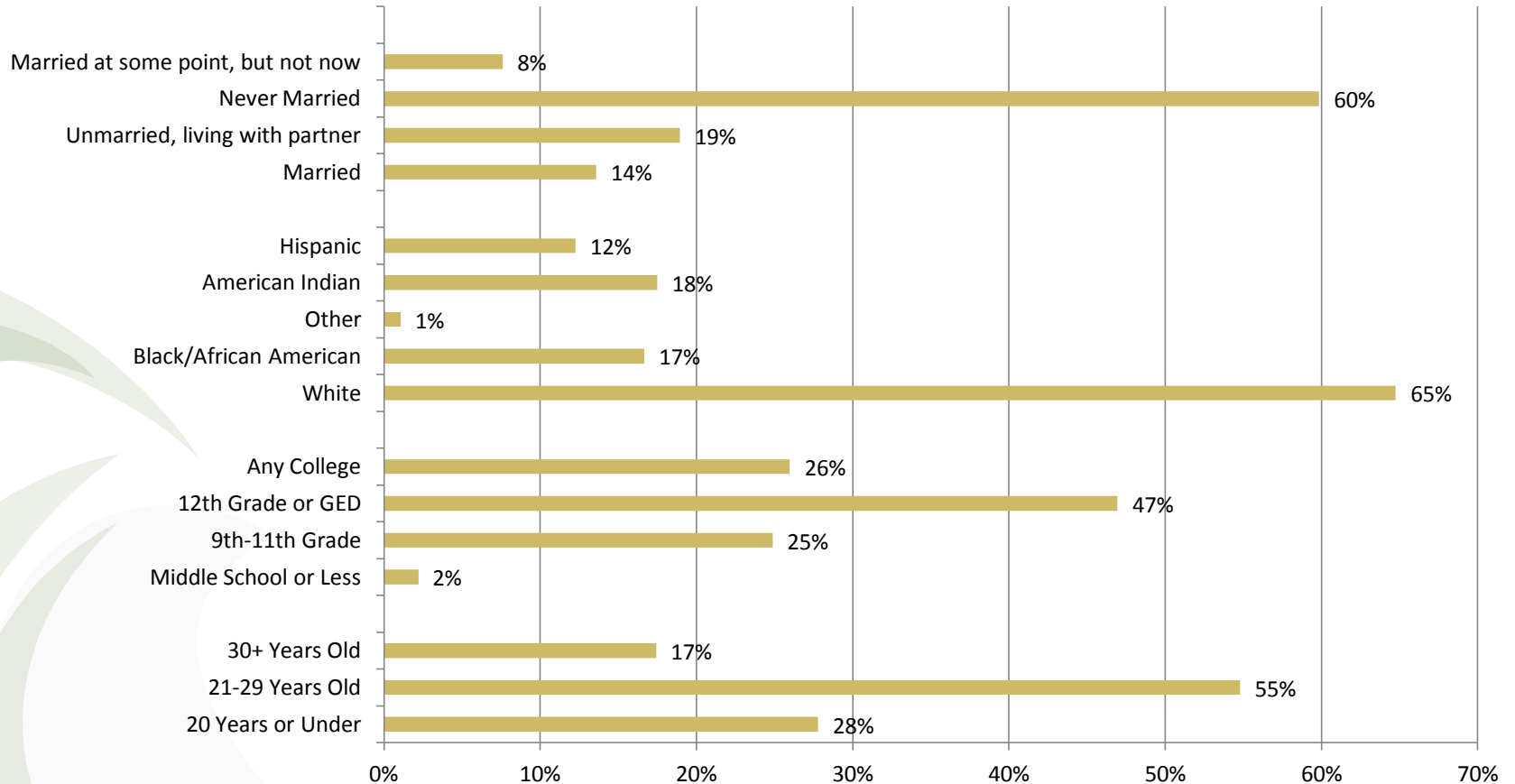


Findings from Implementation in WIC Clinics and Healthy Start Programs

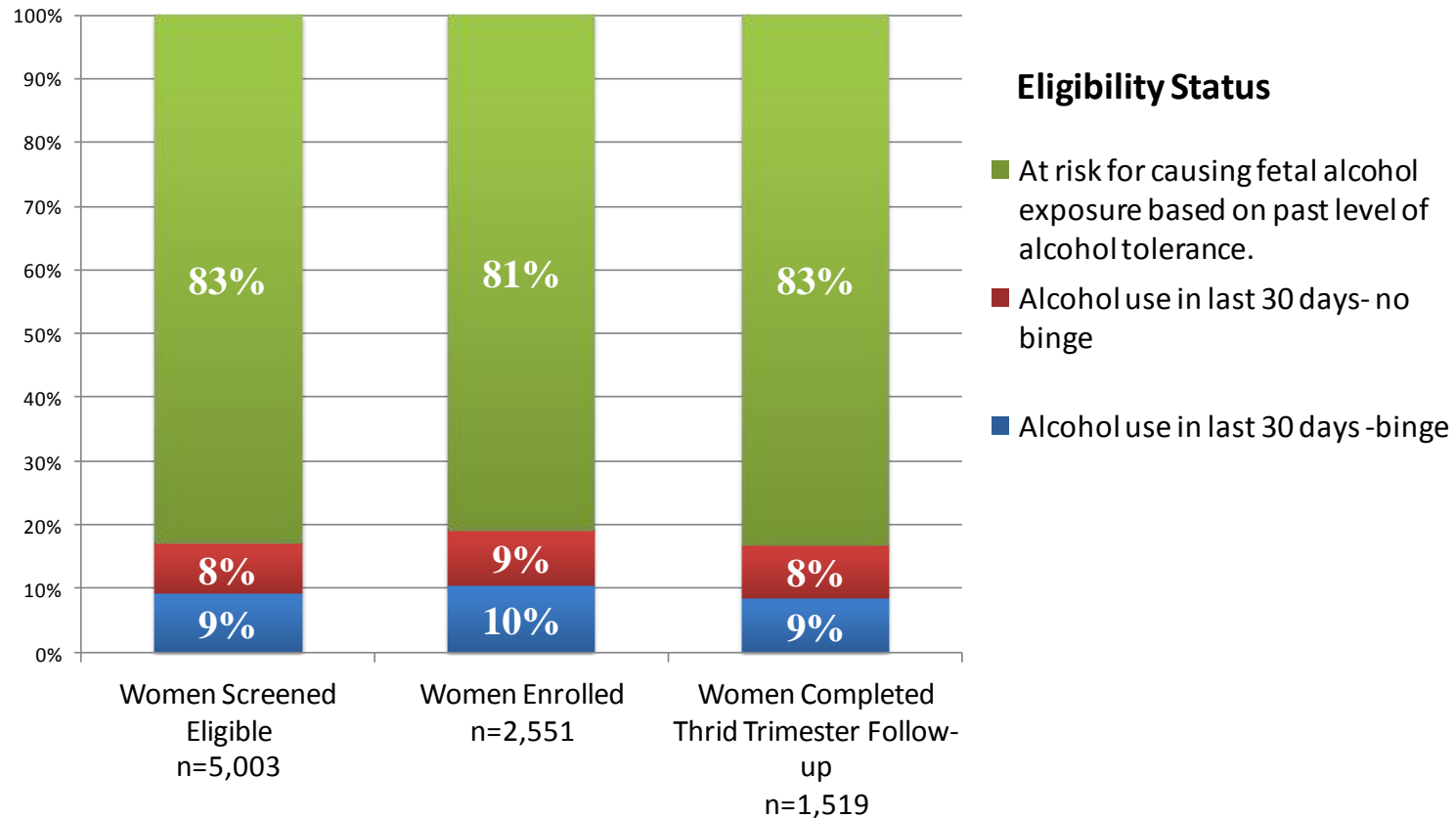
SBI: Number of Women Screened, Eligible, Enrolled, and Completed



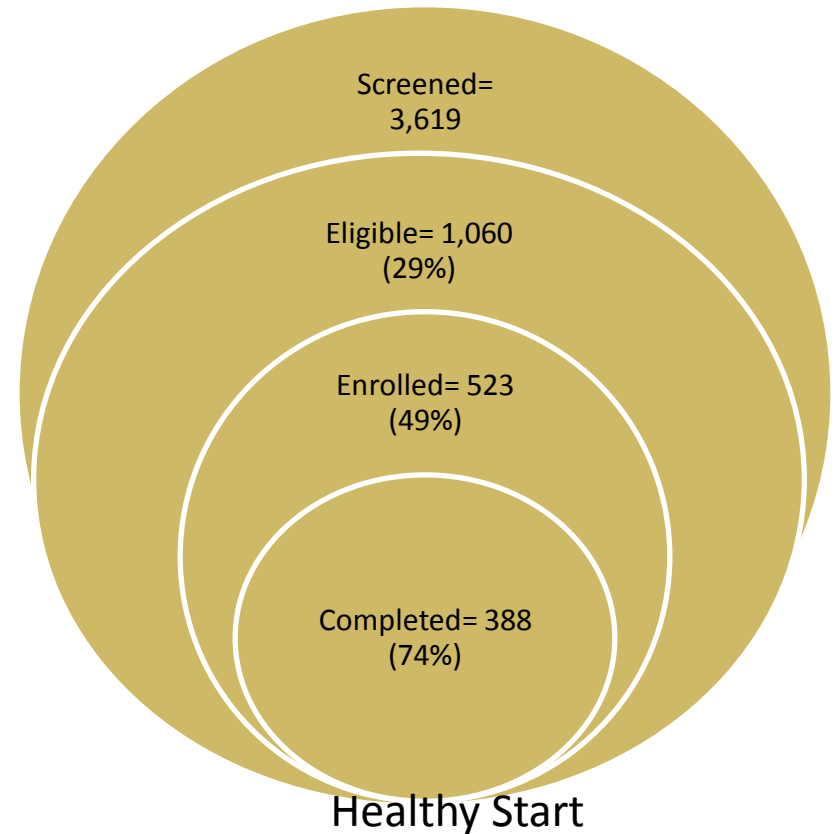
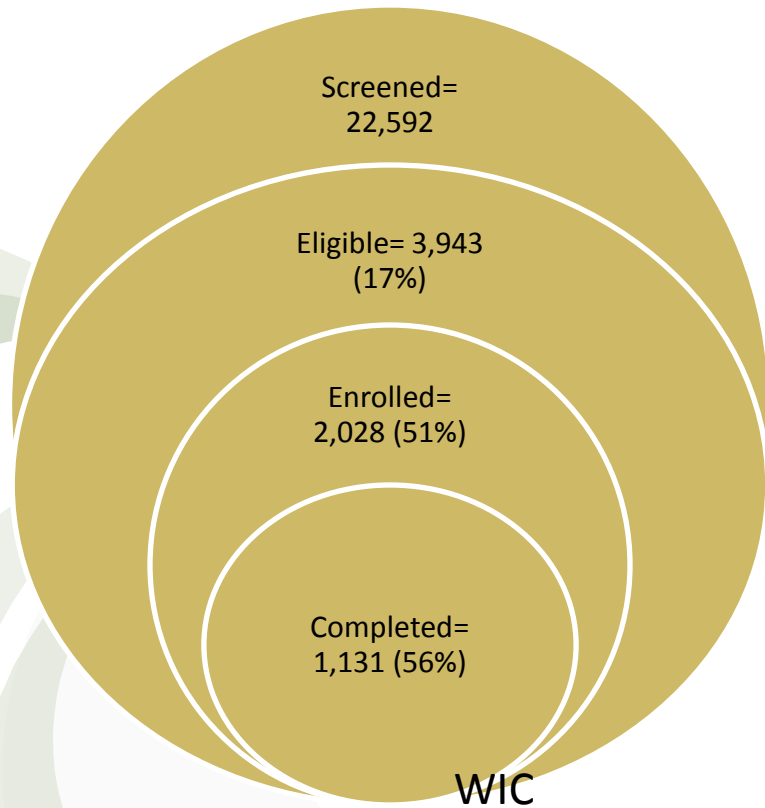
SBI: Demographic Data for Eligible Women Receiving Initial Intervention



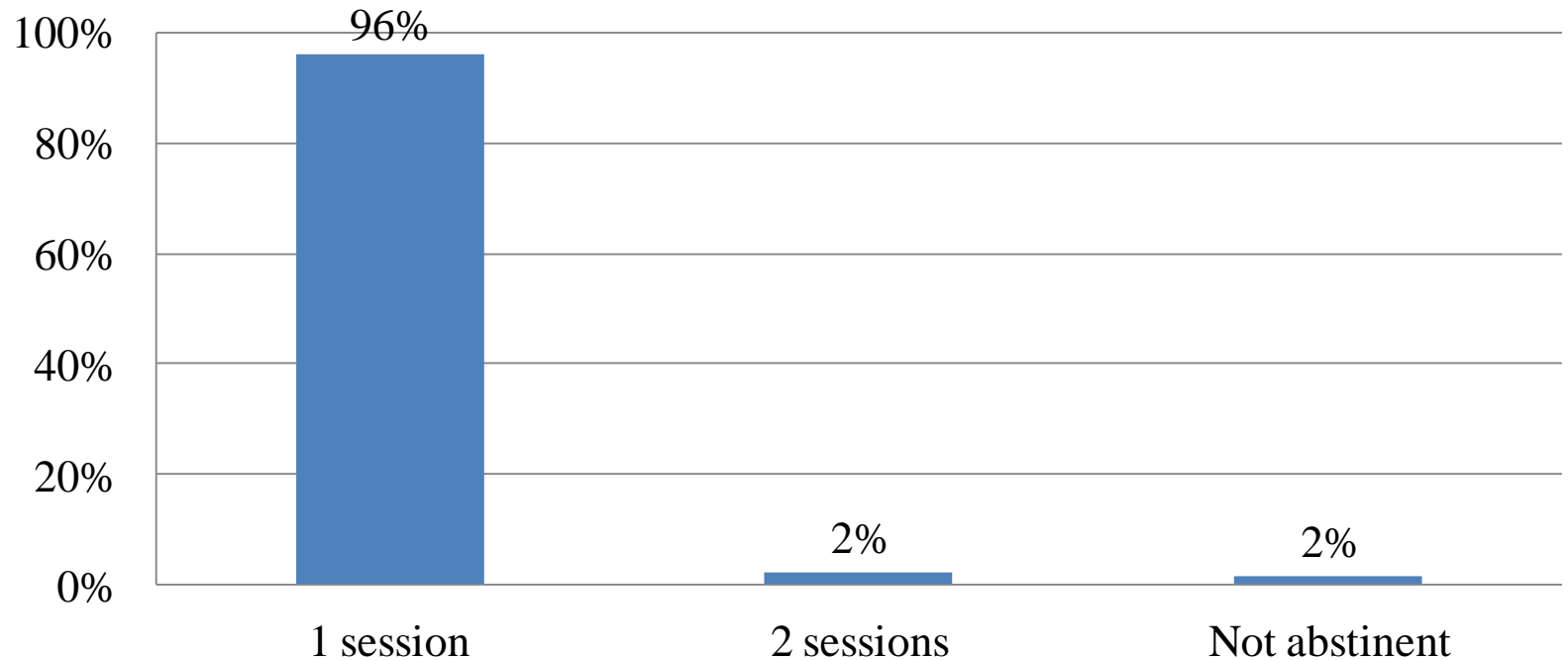
SBI: Eligibility Status of Women who Screened Eligible, Enrolled, and Completed Third Trimester Follow-up



SBI: Number of Women Screened, Enrolled, Eligible and Completed Third Trimester Follow-up for WIC and Healthy Start



SBI: Achievement of Abstinence* Through Third Trimester: $n = 256$



*Among women who reported alcohol use at screening

SBI: Summary of Outcomes

- Most women receiving the initial intervention screened eligible based on past level of alcohol tolerance (81%)
- Almost all women reported abstinence at third trimester follow-up (99.68% of women who were eligible based on past level alcohol tolerance and 98.44% of women who were eligible based on past 30-day alcohol use)
- For women who achieved abstinence, results were generally seen after one follow-up session
- Of women drinking alcohol at screening, 83% of those screened in the first trimester achieved abstinence during the first or second trimester

Project CHOICES

- CDC intervention study for non-pregnant women
- Dual intervention focusing on reducing alcohol use and increasing consistent effective contraception for women of childbearing age at high risk for an alcohol exposed pregnancy
- Four motivational interviewing sessions and one visit to a family planning provider
- 67% of women either reduced their alcohol use, increased their use of effective contraception, or both
- Women with lowest baseline drinking were most successful primarily by using effective contraception and secondarily by reducing alcohol use
- Can be implemented into existing systems of care
- Needs to be modified for women with an FASD

CHOICES

Of 2,445 Women Screened, Number Eligible, Enrolled and Completing Program

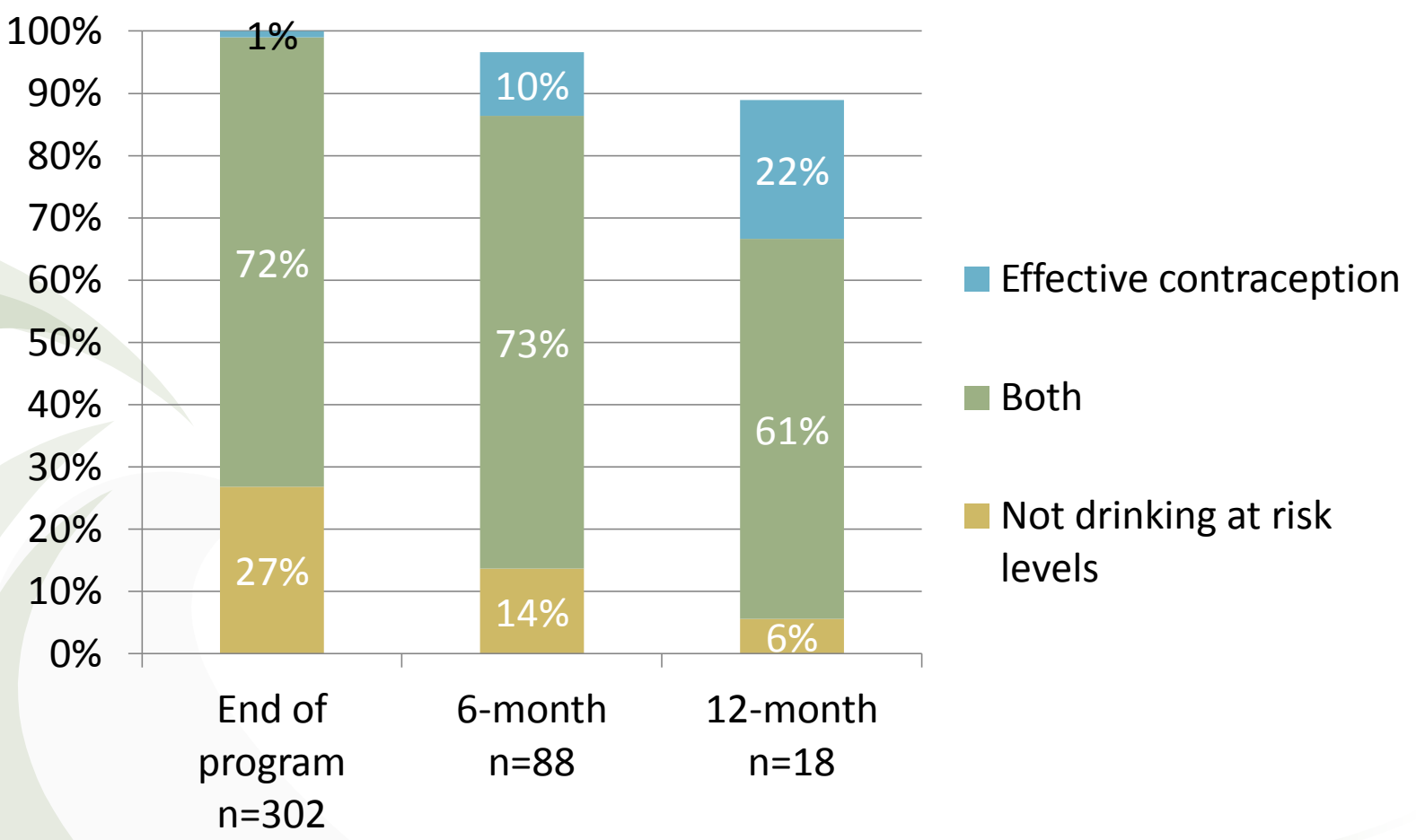


*Completed program are eligible clients who participated in 4 MI sessions and 1 contraceptive visit and an end of program assessment

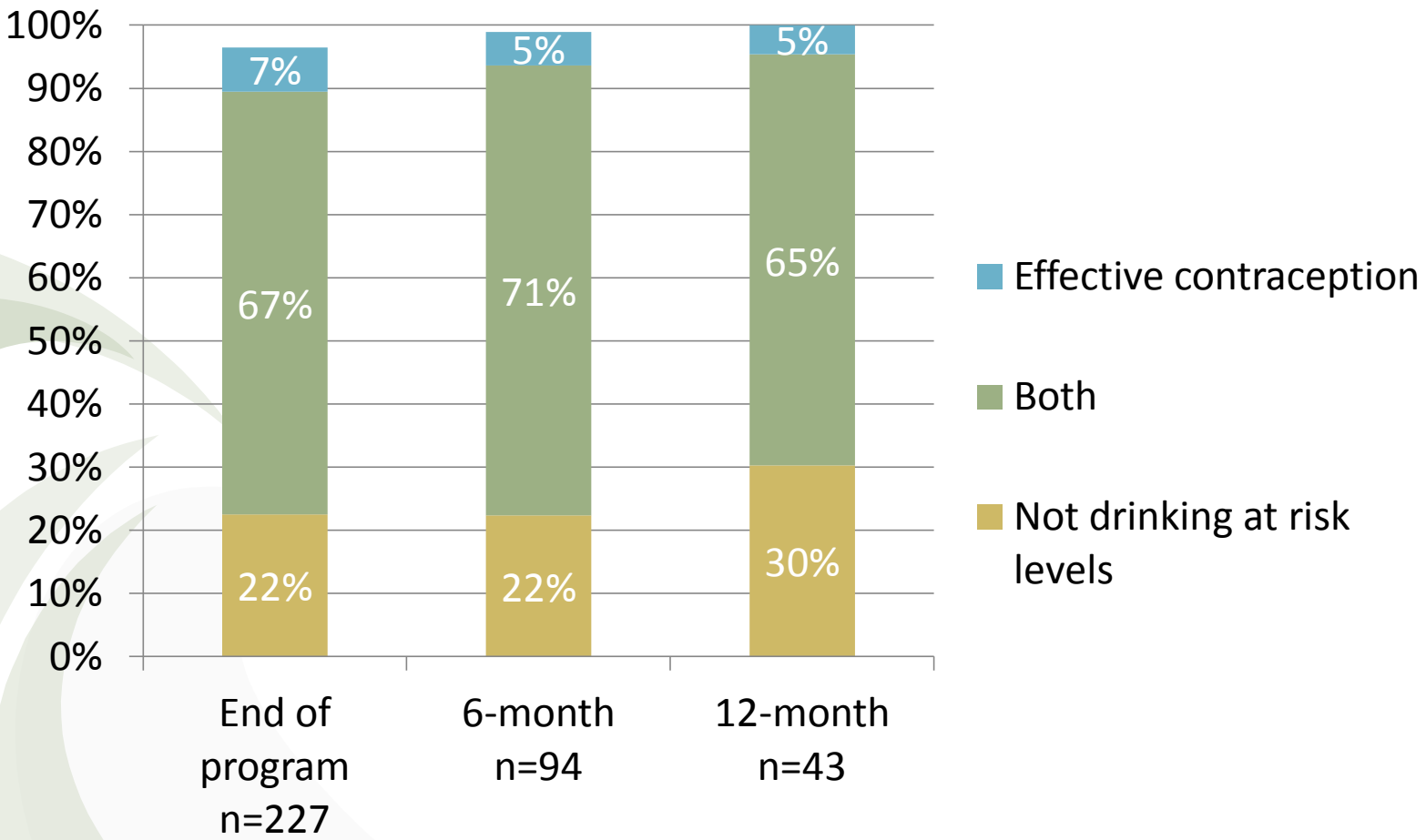
Project CHOICES Program Impact

- At six months after end of program, of those who received the follow up:
 - 96.6 percent of women in residential programs were not at risk of an alcohol exposed pregnancy (N=88)
 - 99 percent of women in community-based programs were not at risk of an alcohol exposed pregnancy (N=94)

CHOICES: Reduced Risk of Alcohol Exposed Pregnancy for Women in Residential Treatment



CHOICES: Reduced Risk of Alcohol Exposed Pregnancy for Women in Community Settings



Parent-Child Assistance Program (PCAP)

- 36 month paraprofessional home visitation advocate model targeted to women at very high risk of an alcohol exposed pregnancy
- Goals:
 - Assist mothers in obtaining treatment, maintaining recovery, and resolving problems associated with substance abuse
 - Guarantee that children are in a safe environment and receive appropriate health care
 - Link families with community resources
 - Demonstrate successful strategies for preventing future births of children affected by prenatal exposure

Parent-Child Assistance Program (PCAP)

- Average caseload is 10-15
- Does not provide direct treatment
- Visit clients, transport clients and their children to appointments, and act as a broker and advocate with appropriate service providers
- Work within the context of the extended family, trace missing clients, and stay in touch with family
- Provide advocacy services for the child, regardless of custody
- No eject policy with relapse or setbacks

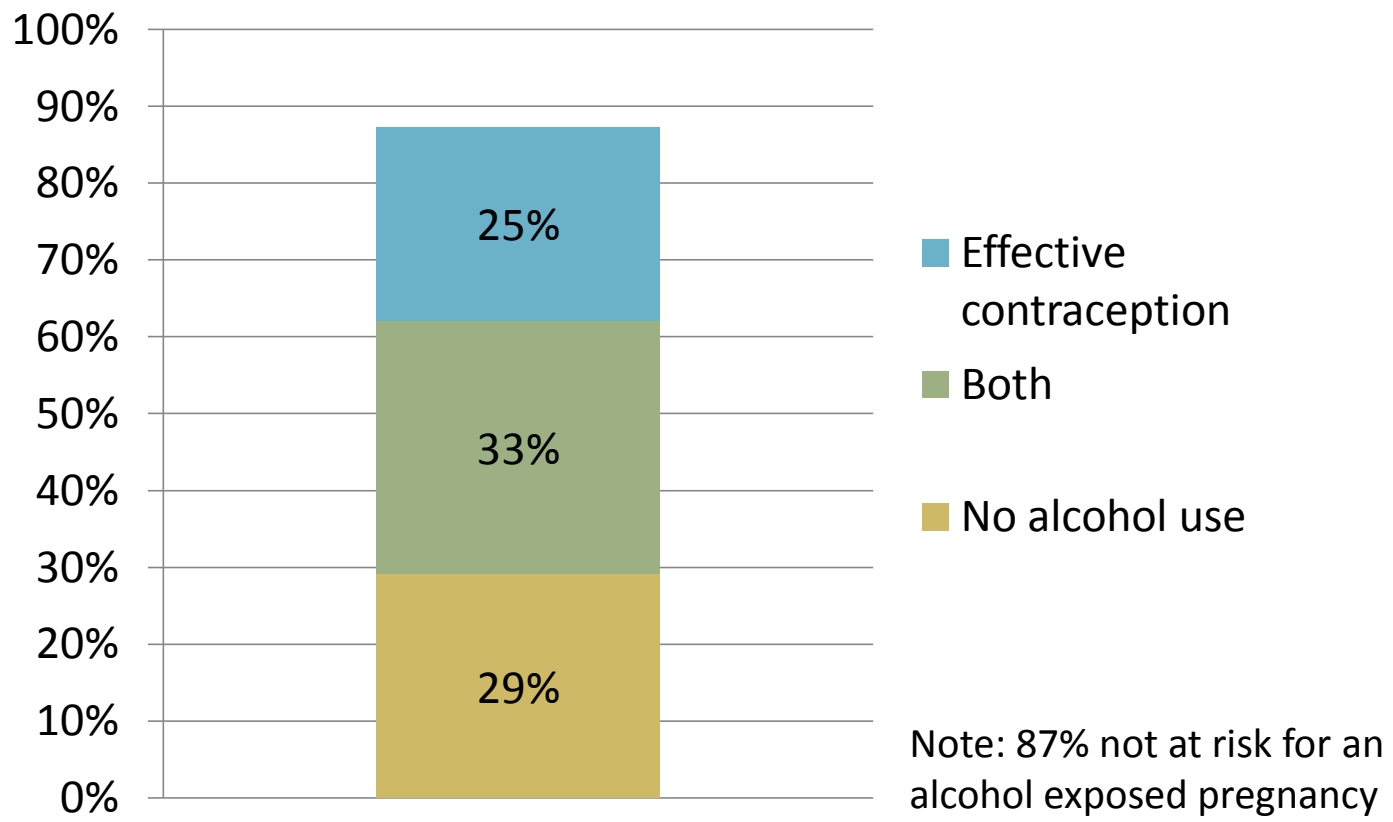
Parent-Child Assistance Program (PCAP)

- Cost of PCAP averages \$5000-\$6000 per woman per year
- The cost of raising one individual with FAS has been determined by economists to be at least \$2 million over a lifetime
- Any program or intervention that reduces the incidence of an alcohol exposed pregnancy by even one and costs less than \$2 million should be recognized as a cost effective intervention
- Investment in those interventions that can reduce alcohol exposed pregnancies are all cost effective

P-CAP Program Impact

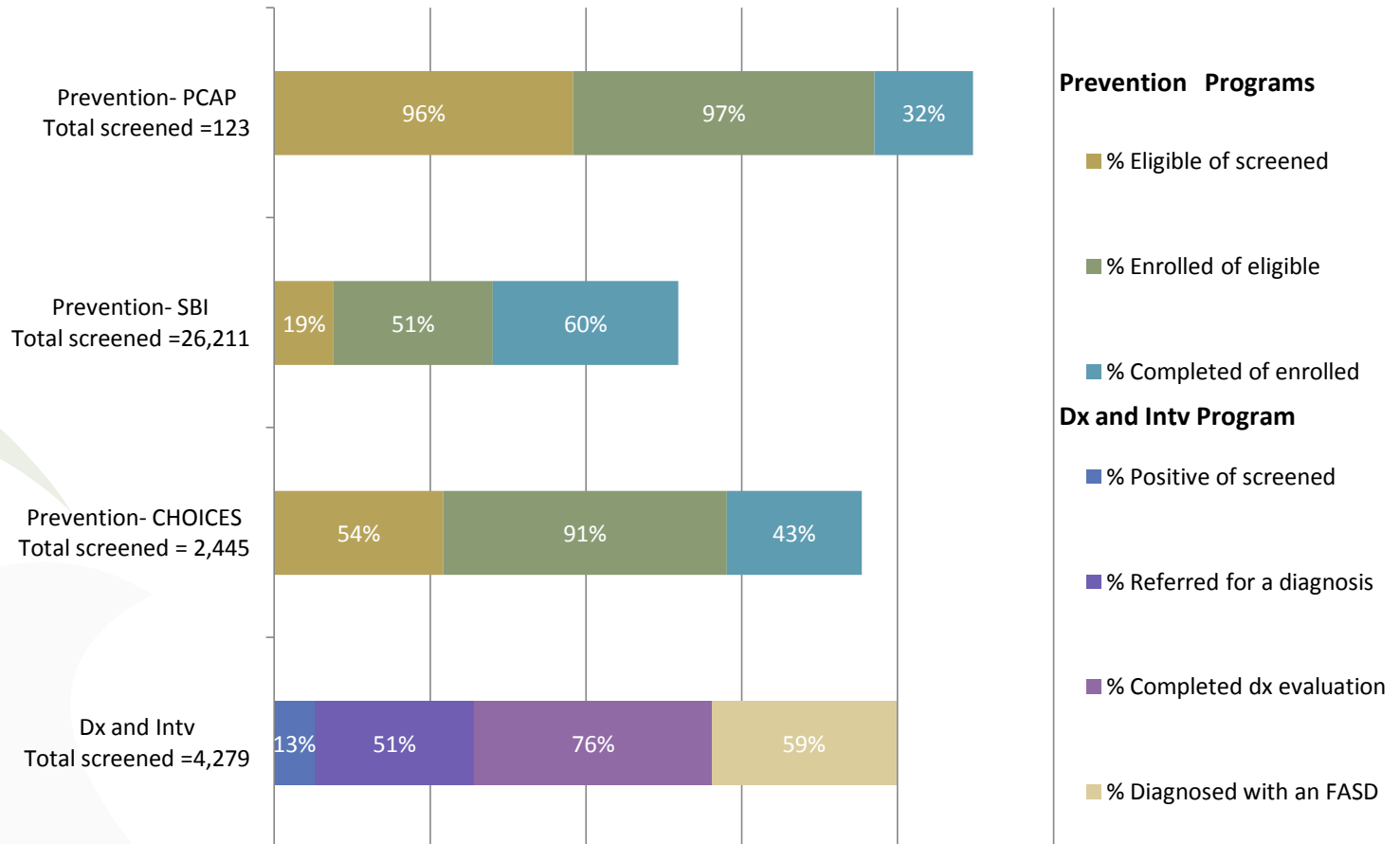
- All women had alcohol exposed pregnancies prior to baseline (N=99)
- 90 women were not at risk of an alcohol exposed pregnancy at their most recent bi-annual report
- 3 subsequent pregnancies were alcohol free
- 71% involved in treatment during P-CAP
- 50% were living in permanent housing at most recent biannual
- 65% of target children were living with biological family at most recent biannual
- 87% not at risk for an alcohol exposed pregnancy

P-CAP: Risk of Alcohol Exposed Pregnancy At Most Recent Biannual $n = 103$



Note: Data for September 1, 2008 – March 31, 2012

Total Numbers Across Programs



Sustainability Outcomes After Funding

- Project CHOICES (6)
 - 1 full; 5 partial
- SBI (7)
 - 4 full; 3 partial
- P-CAP (2)
 - 1 full/1 partial

OVERALL – 100% sustaining at least partial components of the program

What We Can Do

- Ask about alcohol use
 - Especially all women of child bearing age
 - Ask in a way that promotes honesty
 - Utilize screening tools shown to be effective with individuals seen
 - E.g., women who are pregnant
 - Ask about possible prenatal exposure
- Talk about alcohol use and its effects
 - Begin at an early age
 - A SAMHSA study found that the average age of first alcohol use for youth in systems of care is 11.6

What We Can Do

- Talk about the effects of alcohol on an individual
- Talk about the effects of alcohol on a fetus
- Provide the individual with information
- Inform people that at any time during pregnancy, stopping drinking will be helpful for the fetus
- Convey the message:
 - If you are pregnant, thinking of getting pregnant, or have been in a situation where you might have gotten pregnant, don't drink

What We Can Do

- Keep communication open
 - A study found that teenage women with specific knowledge about FAS drank less before pregnancy, during the first trimester, and were less likely to drink to intoxication
 - Most teenage girls who stopped or reduced drinking said it was due to concern for the baby

What We Can Do

(Dubovsky 2004)

- Raise awareness in school
 - Ask their school to put up posters about drinking and pregnancy
 - Ask for information about FASD to be included in health class (there are programs that have been developed for Native communities)
 - Have an assembly to talk about the effects of alcohol on a person and on a baby
 - Start early
 - Set up a mentoring program
 - Help them get to class on time
 - Tutor them

What We Can Do

(Dubovsky 2004)

- Raise awareness in the community
 - Ask for posters and materials about drinking during pregnancy to be posted at doctors' offices, treatment centers, community centers, grocery stores, liquor stores
 - Volunteer to help with an FAS Awareness Day program (September 9). Many states and communities have such programs. You can find out information about FAS Awareness Day at www.fasday.com
 - Help get the message across that focusing on this issue will help their community grow and flourish
 - Help others understand that it is not just that they are lazy

What We Can Do

(Dubovsky 2004)

- Address issues for one's family and friends
 - Recognize that there is more of a risk of having unprotected sex if someone is drinking
 - Talk with others about the fact that many people don't know when they are first pregnant and those first weeks are very important to the development of the baby
 - Talk with your friends who are drinking and pregnant about what that could do to their baby and tell them you know they wouldn't harm their baby
 - Give them information about drinking and pregnancy, in a supportive way

What We Can Do

(Dubovsky 2004)

- Address issues for one's family and friends
 - Have alcohol free parties
 - Offer to support family and friends to get the help that they need so they can
 - Recognize when someone might be having problems because of prenatal alcohol exposure
 - Provide them with ways to succeed
 - One thing to do at a time
 - A lot of repetition
 - A lot of support
 - Have someone take responsibility for seeing that the person with a FASD gets to his/her appointments on time (for doctors, social events, etc.)

Resources

- SAMHSA FASD Center for Excellence: fasdcenter.samhsa.gov
- Centers for Disease Control and Prevention FAS Prevention Team: www.cdc.gov/ncbddd/fas
- National Institute on Alcohol Abuse and Alcoholism (NIAAA): www.niaaa.nih.gov/
- National Organization on Fetal Alcohol Syndrome (NOFAS): www.nofas.org
- National Clearinghouse for Alcohol and Drug Information: ncadi.samhsa.gov