Executive Summary

Introduction

About FASD

Overview

Fetal Alcohol Spectrum Disorders (FASD) is a non-diagnostic umbrella term describing the range of effects that can occur in an individual whose mother consumed alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. As is discussed in greater detail later in this TIP, these disorders often co-occur with substance abuse and mental health issues, and generally require treatment modifications for successful outcomes. They are 100 percent preventable, however, if those at risk of consuming alcohol during pregnancy are identified and effective prevention strategies are used.

Possible diagnoses within the spectrum include Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (pFAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Static Encephalopathy/Alcohol-Exposed (SE/AE), and Neurobehavioral Disorder/Alcohol Exposed (ND/AE). (See box, FASD: Key Terms, for a fuller description of the disorders within the spectrum and related terminology.)

FASD: Key Terms

- Fetal Alcohol Spectrum Disorders (FASD): Umbrella term referring to a group of disorders caused by prenatal exposure to alcohol; a particular condition on the fetal alcohol spectrum is referred to as “an FASD.” Now generally considered to refer to Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), Alcohol-Related Neurodevelopmental Disorders (ARND), Static Encephalopathy/Alcohol-Exposed (SE/AE), and Neurobehavioral Disorder/Alcohol Exposed (ND/AE). See below for all. A variety of diagnostic approaches exist for the disorders within the spectrum; the five most commonly used approaches are included in the key terms below, and are summarized/compared in Appendix E.

Disorders currently or previously described as forms of FASD (in alphabetical order):

- Alcohol-Related Birth Defects (ARBD): Term used to describe individuals who present with congenital defects (including malformations and dysplasia), but not the growth or cognitive/behavioral impairments typically seen in FAS (see definition below). Now less used, although diagnostic guidelines still exist through the Institute of Medicine (IOM; see Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment, below in this box).
- Alcohol-Related Neurodevelopmental Disorder (ARND): Term created by the IOM to describe individuals with prenatal alcohol exposure and neurodevelopmental abnormalities, but no
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FAS facial phenotype. The neurodevelopmental abnormalities are characterized by a complex pattern of behavioral or cognitive conditions inconsistent with developmental level and not explained by genetic background or environment. Problems may include learning disabilities; school performance deficits; inadequate impulse control; social perceptual problems; language dysfunction; abstraction difficulties; mathematics deficiencies; and judgment, memory, and attention problems. The term ARND presents with the same limitations as the discontinued term Fetal Alcohol Effects (see definition below), as one cannot confirm that the neurodevelopmental disorder present in a child with prenatal alcohol exposure was caused by the alcohol exposure in the absence of the FAS facial phenotype. Some diagnostic systems replace the term ARND with Static Encephalopathy/Alcohol-Exposed and Neurobehavioral Disorder/Alcohol Exposed (SE/AE and ND/AE; see definitions below).

• **Fetal Alcohol Effects (FAE):** Term introduced in the late 1970’s to describe less complete partial expressions of FAS (see definition below) in individuals with prenatal alcohol exposure (Clarren & Smith, 1978). Aase, Jones, and Clarren (1995) expressed concern about the validity of the term FAE and proposed abandoning its clinical use, as it implied a causal association (between prenatal alcohol exposure and abnormalities observed in an individual patient) that could not actually be confirmed.

• **Fetal Alcohol Syndrome (FAS):** Term for what is generally considered to be the most recognizable form of FASD. These individuals exhibit the FAS facial phenotype, impaired growth, and cognitive and behavioral abnormalities.

• **Neurobehavioral Disorder/Alcohol Exposed (ND/AE):** Term used to describe individuals with prenatal alcohol exposure, moderate cognitive/behavioral impairment (equivalent to moderate ARND), and no FAS facial phenotype.

• **Partial FAS (pFAS):** Term applied to individuals who exhibit FAS without growth deficiency, or exhibit FAS with most but not all of the facial features.

• **Static Encephalopathy/Alcohol Exposed (SE/AE):** Term used to describe individuals with prenatal alcohol exposure and severe cognitive/behavioral impairment (equivalent to severe ARND), but no FAS facial phenotype.

Additional terms are presented in alphabetical order:

• **Alcohol-Exposed Pregnancy (AEP):** Any pregnancy during which the woman drinks any amount of alcohol at any time during the pregnancy. This exposure does not mean the offspring has been affected in any way, but it does place the offspring at some degree of risk for an array of developmental difficulties, including damage to the brain and central nervous system, retardation of growth and other physical effects, and cognitive and behavioral impairments.

• **Diagnosis:** In the context of this TIP, “diagnosis” refers to the formal identification of an FASD by a qualified team and/or dysmorphologist (someone who specializes in structural, or birth, defects). When the TIP discusses the primary diagnosis that brought the client into your substance abuse or mental health setting, or for which your setting is primarily assessing or treating the client, it will be referred to as the “primary treatment issue.”

• **Diffuse Brain Damage:** Damage to the brain that is not localized or necessarily the result of a specific traumatic incident to one part of the brain. Such damage can arise from other sources besides alcohol or occur from multiple sources including alcohol. As an AEP (see definition above) can impair the development of multiple parts of the brain of the fetus over the period of pregnancy, an FASD can be considered a manifestation of diffuse brain damage. However, not all diffuse brain damage is the result of alcohol and its expression does not always qualify as an FASD.

• **FASD 4-Digit Diagnostic Code (Astley, 2004b):** Comprehensive, reproducible method for diagnosing the full spectrum of outcomes of patients with prenatal alcohol exposure. First
developed in 1997 by the Washington State FAS Diagnostic and Prevention Network (FAS DPN), the Code was revised in 1999 and again in 2004. Summarized in Appendix E.

- **Fetal Alcohol Spectrum Disorder: Canadian Guidelines for Diagnosis** (Chudley et al., 2005): Canadian guidelines for the diagnosis of FAS, pFAS, and ARND. Summarized in Appendix E.

- **Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment** (Stratton, Howe, Battaglia, & the Committee to Study Fetal Alcohol Syndrome, 1996): Diagnosis and treatment guidelines developed by the IOM and published in 1996. These guidelines would be revised by Hoyme, May, and Kalberg (2005) in *A Practical and Clinical Approach to the Diagnosis of Fetal Alcohol Spectrum Disorders: Clarification of the Institute of Medicine Criteria*. Each is summarized in Appendix E.

- **Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis** (Bertrand et al., 2004): FAS diagnosis and referral guidelines developed by the Centers for Disease Control and Prevention (CDC). Summarized in Appendix E.

- **Intervention**: In the context of this TIP, ‘intervention’ describes 1) a brief methodology for informing women of childbearing age about the results of alcohol screening and the dangers of alcohol use during pregnancy, or 2) the selection of an appropriate treatment methodology to best meet the needs of a client who has or may have an FASD, and any accompanying modifications or accommodations in treatment planning.

- **Screening**: ‘Screening’ is a familiar term in mental health and substance abuse treatment settings. Validated screening instruments for identifying alcohol use among women are available, and no modification to the basic understanding of screening is necessary for their use. To accomplish the important goal of screening for an individual with an FASD in your setting, formalized tools are limited. However, this TIP does provide indicators to look for, and screening may need to be done more informally through guided observation and/or diagnostic interviewing. In most cases, screening for an FASD will need to occur over time, rather than being a process that can be completed through the use of a simple, brief instrument administered once (e.g., at intake).

- **Static Encephalopathy**: Permanent or unchanging brain damage. Effects on development depend on the part(s) of the brain involved and the severity of the damage.

- **Teratogen**: Any substance that can damage a developing fetus. Common teratogens include alcohol, tobacco, lead, radiation, and exposure to infectious disease.

**Prevalence**

The prevalence of FAS in the United States has been estimated at 1–3 per 1,000 live births among the general population (Stratton et al., 1996) and 10–15 per 1,000 in some higher-risk populations, such as children residing in foster care (Astley, Stachowiak, Clarren, & Clausen, 2002; Astley, 2004a). The prevalence of the full spectrum of FASD in the general population is estimated at 9.1 per 1,000 live births, though a review of in-school screening and diagnosis studies suggest that the national rate could potentially be closer to 50 per 1,000 (May et al., 2009). In addition, recent retrospective analyses of hospital admissions data indicate that under-reporting of alcohol misuse by women may further disguise true prevalence (Morleo et al., 2011).

Although prenatal alcohol exposure has been clearly established as a causal factor for FASD in animal models, the amount of alcohol required to cause damage to the fetus remains in question, and may differ based on the individual. Factors such as dose of alcohol, pattern and timing of exposure, genetics, whether the mother also smoked and/or used other drugs, general health and nutrition of the mother, her level of stress and/or trauma, and her age all may play a role in the impact that alcohol has on the developing fetus (Guerri, Bazinet, & Riley, 2009). Animal studies do suggest that binge drinking (four or more drinks on one
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occasion) is associated with more severe effects (Bonthius & West, 1988; Clarren, Astley, Gunderson, & Spellman, 1992), and it is generally asserted that there is no known ‘safe’ level of alcohol consumption during pregnancy (Office of the Surgeon General, 2005; Hicks & Tough, 2009; Feldman et al., 2012).

Not every woman who consumes alcohol during pregnancy will give birth to a child with an FASD. However, because science has not determined a safe level of alcohol that may be consumed during pregnancy, the possibility of an FASD is created any time a woman consumes alcohol while pregnant.

Due to the range of deficits—and variability in degree of severity of each deficit—within the diffusely damaged brain, FASD can present as functionally different in each individual that is affected. However, certain cognitive, behavioral, and adaptive functioning problems are common across the spectrum, including lower IQ, impaired learning ability, and difficulty processing information (such as not being able to remember or follow instructions, or poor verbal receptive skills) (Streissguth, Barr, & Bookstein, 1996; Bertrand et al., 2004; Streissguth et al., 2004; Astley et al., 2009a; Astley, 2010). Physical abnormalities and facial dysmorphology (i.e., congenital malformation) are only common with FAS. Other functional issues regularly observed include attention deficit (Nanson & Hiscock, 1990; Lee, Mattson, & Riley, 2004), decreased proficiency in cognitive planning (Kodituwakku, Handmaker, Cutler, Weathersby, & Handmaker, 1995; Kodituwakku, Kalberg, & May, 2001; Rasmussen, 2005), reduced working memory (Burden, Jacobson, Sokol, & Jacobson, 2005; Astley et al., 2009b; Green et al., 2009), reduced response inhibition (Noland et al., 2003; Mattson, Crocker, & Nguyen, 2011), socially inappropriate behaviors (Bishop, Gahagan, & Lord, 2007; Jirikowic, Kartin, & Olson, 2008; Mattson, Crocker, & Nguyen, 2011), and deficits in fine motor (Kalberg et al., 2006; Jirikowic et al., 2008) and visual-spatial functions (Chiodo, Janisse, Delaney-Black, Sokol, & Hannigan, 2009; Mattson et al., 2010).

Cost Factors

Estimates of the cost to raise a child with an FASD vary depending on the source and the factors included in the analysis, and detailed cost estimates are generally only available in relation to the specific condition of FAS. Nonetheless, these costs are significant. In an analysis of medical expenditures for pediatric Medicaid enrollees, Amendah, Grosse, and Bertrand (2010) found that, for a child with identified FAS, incurred health costs were nine times higher than for children without an FASD. Astley, Bailey, Talbot, and Clarren (2000a) further isolated cost factors in a demonstration of primary FAS prevention in an FASD diagnostic clinic that targeted high-risk women; using this approach, the cost of raising a child with FAS was found to be roughly 30 times higher than the cost of preventing FAS in the child.

The most widely acknowledged estimate of the lifetime cost of care for an individual with an FAS is that of Lupton, Burd, and Harwood (2004), who adjusted figures originating with Harwood and Napolitano (1985) for 2002 dollars to suggest that the figure was roughly $2 million (including medical treatment, special education, residential care for persons with mental retardation, and productivity losses; in 2012 dollars, this would be over $2.5 million). The overall annual cost of FAS to the U.S. healthcare system (based on an assumption of 2 cases per 1,000 live births) is estimated at $5 billion (Lupton et al., 2004).
Part 3 of this TIP, the online Literature Review, contains additional information on FASD surveillance and cost factors, as well as the impact of alcohol on the brain and behavior.

**Historical Background**

FASD is often described as a ‘new’ or ‘recent’ discovery. In fact, references to the harmful effects of maternal drinking on infant outcome date back to biblical times: “Behold, thou shalt conceive, and bear a son; and now drink no wine or strong drink” (Judges 13:7, as noted in Clarren & Smith, 1978). In addition, several comprehensive descriptions were compiled by physician groups in the 18th and 19th centuries (Royal College, 1726; Sullivan, 1899; Goodacre & Mercer, 1965). The more recent history commonly referred to begins in 1968, when Lemoine, Harousseau, Borteyni, and Menuet from France published an article describing children with distinctive facial features and other symptoms related to prenatal alcohol exposure. In 1970, unaware of the Lemoine publication, Ulleland and colleagues published similar observations describing a small group of alcohol-exposed infants admitted to several high-risk maternal-child health clinics at the University of Washington (Ulleland, Wennberg, Igo, & Smith, 1970; Ulleland, 1972). This work would eventually lead to a seminal, collaborative article describing the pattern of outcomes associated with prenatal alcohol exposure (Jones, Smith, Ulleland, & Streissguth, 1973), as well as the publication that coined the term FAS (Jones & Smith, 1973).

In the roughly 40 years that have followed, extensive study has been conducted on alcohol’s teratogenic effects, as well as on interventions for women of childbearing age who consume alcohol, leading to several significant federal milestones in addressing FASD. In 1996, the Institute of Medicine (IOM) published *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment* (Stratton et al., 1996), leading the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to establish the Interagency Coordinating Committee on FASD (originally Interagency Coordinating Committee on FAS) to address that publication’s recommendations. Then, in 2000, Congress set forth mandates related to children’s health, including FASD, leading the Centers for Disease Control and Prevention (CDC) to establish the National Task Force on FAS and FAE (completed in 2007), and SAMHSA to establish the FASD Center for Excellence in 2001.

In the decade since the Congressional mandates, the research and knowledge base around FASD has expanded greatly. According to Goodlett (2010), a PubMed search of FAS-, FASD-, or fetal alcohol-specific terminology at the end of 2010 returned nearly 3,900 articles published since 1973, of which more than 38 percent had been published since 2000. This growth is translating to practice: Since 2001, the FASD Center for Excellence alone has funded more than 70 subcontractors across the United States to carry out pilot efforts to implement FASD-related services into existing programs, including substance abuse and mental health treatment settings.

This body of work has revealed an unfortunate paradox: Individuals with an FASD require more intensive and personalized services, and early diagnosis and intervention have been identified as critical to improved outcomes and minimized secondary disabilities (Streissguth et al., 2004; Astley, 2010). Yet, individuals with an FASD often go undiagnosed or are misdiagnosed (Greenbaum, Stevens, Nash, Koren, & Rovet, 2009), are difficult to identify early and may not receive appropriate early intervention (Olson, Jirikowic, Kartin, & Astley, 2007), and often receive services that do not account for their disabilities and thus may result in poor outcomes.
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**Audience: Who Should Read This TIP?**

This TIP is designed for use by behavioral health providers, particularly substance abuse and mental health treatment professionals, not only because these are the primary constituencies of SAMHSA but also because individuals with FASD experience higher rates than the general population of both substance abuse and mental health issues (Streissguth et al., 1996; O’Connor et al., 2002; Streissguth et al., 2004; Clark, Lutke, Minnes, & Quellette-Kuntz, 2004; Astley, 2010). In addition, individuals with an FASD exhibit higher rates of life problems commonly encountered in substance abuse and mental health treatment populations, including higher risk of suicide (Huggins, Grant, O’Malley, & Streissguth, 2008), exposure to multiple traumas throughout the lifespan (Henry, Sloane, & Black-Pond, 2007; Greenbaum et al., 2009), homelessness (Fryer, McGee, Matt, Riley, & Mattson, 2007), and increased interaction with the criminal justice system (Streissguth et al., 1996; Streissguth et al., 2004).

This TIP is also important because there are great opportunities for FASD prevention in mental health and substance abuse treatment settings. According to the 2009 *National Survey on Drug Use and Health* (NSDUH), 17.1 percent of women age 18 or over in the U.S. received mental health treatment or counseling in 2009, compared to only 9.2 of men in the same age group (Center for Behavioral Health Statistics and Quality [CBHSQ], 2010), while the *Treatment Episode Data Set* (TEDS) indicates that 33.0 percent of admissions to substance abuse treatment facilities in 2011 were female, more than half of whom (50.5 percent) indicated alcohol as a primary, secondary, or tertiary substance of abuse (CBHSQ, 2013). Thus, these settings provide ideal opportunities to implement brief, effective approaches to preventing an AEP.

Part 1 of this TIP is for frontline personnel and consists of three chapters:

- **Chapter 1** discusses approaches to FASD prevention; that is, assisting women who are in treatment settings and are pregnant or may become pregnant to remain abstinent from alcohol. In providing these guidelines, this TIP adopts the IOM model for prevention, which sees prevention as a step along a continuum that also incorporates treatment and maintenance.

- **Chapter 2** discusses methods for identifying individuals in treatment who have or may have an FASD, referring them for diagnosis where possible, and providing appropriate interventions to meet their needs. These clients are assumed to be adolescent or older, as they would need to be capable of presenting in treatment on their own (although the TIP strongly recommends including the family in treatment, when possible).

- **Chapter 3** provides clinical vignettes designed to realistically portray the provider–client interactions that might take place when providing FASD prevention or interventions.

Part 2 provides administrators with strategies and tools for undertaking the activities that will support treatment professionals and clients and for making the changes required to incorporate FASD prevention and/or intervention in daily practice. Part 2 also includes methods, materials, resources, and examples to assist administrators with quality improvement and ongoing evaluation of the necessary programmatic changes.

At the same time, the clinical and administrative guidance set forth in this TIP has strong applicability across healthcare and social service settings. While the client interactions
described generally involve substance abuse and mental health treatment, any provider assisting women at risk of an AEP or assisting individuals who may have an FASD can implement the majority of these recommendations if they adapt them for that professional’s setting. This is particularly the case if the setting in question overlaps with the life issues that more frequently occur among individuals with an FASD, as discussed above (i.e., criminal justice, housing, primary care).

Barriers to Treatment: The Need for the TIP

For a variety of reasons, including the somewhat hidden nature of many of the symptoms, individuals with an FASD are frequently misdiagnosed or their condition is not recognized (Olson et al., 2007; Greenbaum et al., 2009). This, in turn, leads to care that is not matched to the patient’s needs and strengths, increasing the risk for secondary disabilities (Streissguth et al., 2004).

Added to this, recent statistics on drinking among pregnant women show that AEP prevention is as serious an issue as appropriate services for individuals who have an FASD (see box, Drinking Rates Among Pregnant Women, in the next chapter). AEP prevention may not be a familiar goal in mental health and substance abuse treatment settings. Yet these are ideal settings in which to prevent prenatal alcohol exposure, as behavioral health professionals routinely work with women of childbearing age (age 10–49 years). Treatment can then have a positive effect not only on the client, but on his or her family and generations to come.

Ideally, this TIP will help to alleviate many barriers to providing successful treatment for these two populations, including:

- The application of treatment approaches that, while effective with general populations, may not be ideally suited to the needs of individuals with an FASD;
- A lack of awareness among treatment professionals of the rapid developments in the field of FASD services over the last decade; and
- Helping clients deal with feelings of shame, loss, or fear of discrimination.

Lack of Success With Typical Treatment Approaches

Prenatal exposure to alcohol has many teratogenic effects, among them that it can alter brain structure and function, meaning that people with an FASD do not process information in the same ways that those without an FASD do. These effects are permanent; an FASD cannot be ‘cured.’ Processing differences that may affect treatment can take many forms, including:

- Poor receptive language skills (difficulty with complex language and multiple instructions);
- Difficulty with social cognition and accurately understanding social cues;
- Difficulty taking in new information, and in generalizing learning to new settings; and
- Not always connecting cause and effect (particularly if the effect is delayed).

Expert consensus suggests that treatment approaches that rely on an assumption of normal functioning of these cognitive processes are likely to be less effective with individuals with an FASD. This appears to be true for both mental health and substance abuse treatment settings.

Cognitive–Behavioral Therapy (CBT) models, for instance, are verbally based insight therapies designed to reduce target symptoms, and are based on the idea that inaccurate thoughts are linked to maladaptive feelings and behaviors. However, CBT approaches do not fit well
given that individuals with an FASD have biologically based cognitive deficits (O’Connor et al., 2002). Behaviors of individuals with an FASD may result from errors in thinking that are difficult to change because of underlying diffuse brain damage. Modification to CBT, and adding other approaches, will be needed to maximize treatment efficiency and success.

The disease model of substance abuse treatment, which advocates lifelong abstinence from alcohol, also relies on the assumption that a client has normative function. Behavioral health professionals assume that the client can comprehend that he or she has a ‘disease’ and also that he or she can plan ahead to recognize why it is important to achieve abstinence. For an individual with an FASD, this link may be difficult to make, and so his or her substance abuse or mental health target symptoms may be harder to change (and change harder to maintain) because of the underlying diffuse brain damage.

**Rapid Developments in the Field**
The tremendous growth in FASD-related research and the establishment of the SAMHSA FASD Center for Excellence have practical implications for behavioral health professionals, in that the field of FASD-related practices is growing dynamically. Much of the practical guidance in this TIP has emerged only over the last 5 to 10 years. Even professionals who have had some form of FASD training in the past are likely to discover new and useful strategies in this TIP that can be effectively applied in their programs.

**Treatment Barriers**
Despite their unique treatment needs, clients with an FASD or pregnant women at risk of an AEP still share with any other client a significant, common barrier to treatment success: The impact of negative self-perception. An individual with an FASD or a woman who has consumed alcohol during pregnancy may perceive themselves negatively, either because of internal feelings of shame, a sense of not belonging, or due to experiencing external shaming or judgment. These internal feelings and external experiences can each become a barrier to treatment (Astley, Bailey, Talbot, & Clarren, 2000b; Salmon, 2008).

When implementing the practices recommended in this TIP, behavioral health professionals are urged to keep sight of the importance of addressing the client’s feelings and experiences, as well as the need for sensitivity to issues such as gender, ethnicity, cultural background, and sexuality, as these factors impact treatment success among individuals with an FASD and women of childbearing age as significantly as any other treatment population.

“We must move from viewing the individual as failing if s/he does not do well in a program to viewing the program as not providing what the individual needs in order to succeed.”

Dubovsky, 2000
Prevention of Alcohol-Exposed Pregnancies Among Women of Childbearing Age

Introduction

This TIP adopts the IOM continuum of care model, which sees prevention as a step along a continuum that also incorporates treatment and maintenance (see Figure 1.1, below). The IOM model defines three types of prevention: universal, selective, and indicated.

- **Universal prevention** “[a]ddresses [the] general public or [a] segment of [the] entire population with average probability, risk or condition of developing [a] disorder” (Springer & Phillips, 2007). Universal prevention can take a variety of forms, including media campaigns, large-scale health initiatives (e.g., immunization), point-of-purchase signage, and warning labels on products.

- **Selective prevention** is designed for a “[s]pecific sub-population with risk significantly above average, either imminently or over [his or her] lifetime” (Springer & Phillips, 2007), and can include “screening women for alcohol use, training healthcare professionals, working with family members of pregnant women who abuse alcohol, developing biomarkers, brief interventions, and referrals” (Grant, 2011).

- **Indicated prevention** “[a]ddresses identified individuals with minimal but detectable signs or symptoms suggesting a disorder” (Springer & Phillips, 2007), such as pregnant women who drink heavily, or women who have already given birth to a
child with FASD and continue to drink. Indicated prevention can include some of the same methods applied in selective prevention, but applied more intensively based on the severity of the alcohol-related problem.

For the purposes of the AEP prevention discussion in this chapter, women of childbearing age (i.e., females age 10–49) in your treatment setting should receive AEP prevention based on the following:

- **Universal prevention**: A woman who is not pregnant, and either reports no alcohol use or does not screen positive for at-risk alcohol use;

- **Selective prevention**: A woman of childbearing age who reports alcohol use but has only one of the two indicators for an indicated intervention; she is either pregnant but does not screen positive for at-risk alcohol use, or she screens positive for at-risk alcohol use but is not pregnant; or

- **Indicated prevention**: A woman of childbearing age who screens positive for at-risk alcohol use and is pregnant.

This chapter will first discuss screening, then appropriate brief interventions for AEP prevention in each of the three categories, before discussing treatment issues and referral. In each category, screening is a vital starting point before moving on to appropriate prevention, treatment, or referral.

**Professional Responsibility to Screen**

As the box “Risk Factors for an AEP” (next page) makes clear, a variety of factors can impact a woman’s consumption of alcohol during pregnancy. These and other factors make it critical to inquire about alcohol use among all women of childbearing age in behavioral health settings for alcohol consumption:

- There is no known safe level of alcohol consumption during pregnancy, and even low levels of prenatal alcohol exposure have been shown to negatively impact a fetus (Chang, 2001).
Screening facilitates the implementation of appropriate interventions, at the earliest possible point (Leonardson, Loudenburg, & Struck, 2007).

Prevented AEP can result in significant cost savings through prevented cases of FASD and reduced use of the health and social services systems (Abel & Sokol, 1991; Astley et al., 2000a; Lupton et al., 2004; Astley, 2004a).

Screening is an ethical obligation, one that should be conducted equally of men and women regardless of race and economic status, and which should be performed with women using instruments that are designed for women (Committee on Ethics of the American College of Obstetricians and Gynecologists [ACOG], 2008). Additionally, in an FASD prevention study assessing the feasibility of identifying high-risk women through the FASD diagnostic evaluation of their children, Astley and colleagues (2000a) concluded that these women are not only at high risk for producing more children damaged by alcohol exposure, but they themselves often face serious adverse social, mental, and physical health issues, as well. Thus, one could argue that it would be unethical to ignore their existence and ignore opportunities to provide them with advocacy support and primary prevention intervention.

Awareness does create change: Statistics from SAMHSAs NSDUH (May 21, 2009) suggest that drinking rates among women drop considerably during pregnancy, particularly in the second and third trimesters when there is a much higher awareness of pregnancy status.

In addition, screening:

- Gives the client permission to talk about drinking;
- Helps to identify and or clarify co-occurring issues;
- Minimizes surprises in the treatment process; and
- Can mean more effective treatment.

### Risk Factors for an AEP

#### Substance Abuse/Mental Health Factors

- History of alcohol consumption (NIAAA, 2000; Bobo, Klepinger, & Dong, 2007)
- Family background of alcohol use (Stratton et al., 1996; Leonardson et al., 2007)
- History of inpatient treatment for drugs or alcohol and/or history of inpatient mental health treatment (Project CHOICES Research Group, 2002)

#### Personal/Sexual/Family Factors

- Previous birth to a child with an FASD (Kvigne et al., 2003; Leonardson et al., 2007)
- Lack of contraception use/unplanned pregnancy (Astley et al., 2000b)
- Physical/emotional/sexual abuse (Astley et al., 2000b)
- Partner substance use/abuse (Stratton et al., 1996; Leonardson et al., 2007)
- Multiple sex partners (Project CHOICES Research Group, 2002)
- Smoking (CDC, 2002; Leonardson et al., 2007)
- Never having been tested for HIV (Anderson, Ebrahim, Floyd, & Atrash, 2006)
- Lack of education, income, and/or access to care (Astley et al., 2000a)
Drinking Rates Among Pregnant Women

According to SAMHSA’s 2010 NSDUH, “Among pregnant women aged 15 to 44, an estimated 10.8 percent reported current alcohol use, 3.7 percent reported binge drinking, and 1.0 percent reported heavy drinking. These rates were significantly lower than the rates for non-pregnant women in the same age group (54.7, 24.6, and 5.4 percent, respectively). Binge drinking during the first trimester of pregnancy was reported by 10.1 percent of pregnant women aged 15 to 44” (Office of Applied Studies [OAS], 2011). All of these estimates are based on data averaged over 2009 and 2010. (Binge drinking for women has been defined by NIAAA as four or more drinks on one occasion [2004]).

In telephone interviews with 4,088 randomly selected control mothers from the CDC’s National Birth Defects Prevention Study who delivered live born infants without birth defects during 1997–2002, Ethen and colleagues (2009) found even higher numbers: 30.3 percent of respondents reported alcohol use during pregnancy, with 8.3 percent reporting binge drinking during pregnancy (approximately 97 percent of those indicating binge drinking stating that it was during the first trimester).

In addition, one study of stool and hair samples of neonates who had been prenatally exposed to heavy ethanol use suggested that these children were also 3.3 times more likely to have been exposed to amphetamines and twice as likely to have been exposed to opiates, both of which can also impair long-term child development (Shor, Nulman, Kulaga, & Koren, 2010). Another recent study found that, among 1,400 patients with prenatal alcohol exposure attending an FASD diagnostic clinic in Washington state, 62 percent were prenatally exposed to tobacco, 37 percent were prenatally exposed to marijuana, and 38 percent were prenatally exposed to crack cocaine (Astley, 2010).

Statistics from SAMHSA’s TEDS and from SAMHSA’s NSDUH indicate a potentially greater need to address the FASD issue specifically in substance abuse treatment settings: More than 22 percent of pregnant women admitted into treatment from 1992 to 2006 indicated alcohol as their primary substance of abuse (OAS, 2006).

Lastly, 49 percent of all pregnancies in the United States are unintended (Finer & Henshaw, 2006). As a result, many women will consume alcohol without knowing that they are pregnant.

Procedures for Screening

Behavioral health settings are busy, and screening procedures must be efficient. Figure 1.2, *Screening Decision Tree for AEP Prevention*, provides a procedure for an opening question about alcohol use, moving on to screening (if necessary), suggested instruments for screening, and next steps. The goal of screening is to determine, as quickly and as accurately as possible, whether a client is at risk and therefore brief intervention and treatment or referral is warranted.

The screening instruments recommended in Figure 1.2 are not the only options available for determining client alcohol use, but are validated as indicated in the decision tree (Sokol & Clarren, 1989; Russell, 1994; Chang, 2001). Nonetheless, if your agency does not use these instruments or does not have a ‘perfect’ alternative, it is better to screen with what is available to your program than to not screen women of childbearing age at all.

*Part 3 of this TIP, the online Literature Review, includes further discussion of these and other alcohol screening instruments for use with women.*

Screening should be done with sensitivity to the client’s level of health literacy, or, “the degree to which people have the capacity to
**Figure 1.2: A Screening Decision Tree for AEP Prevention**

AEP prevention can be simple and brief. The TIP consensus panel developed the following Screening Decision Tree for AEP Prevention to help behavioral health providers quickly touch upon the topic of alcohol use with all women of childbearing age, and then provide brief but effective prevention or intervention.

1. Have you had any alcohol in the past year?
   - Yes
   - No
   1. Are you pregnant?
      - Yes
      - No
      1. T-ACE or TWEAK or CRAFFT Interview*
         - Positive: Indicated intervention and treatment or referral (see below)
         - Negative: Selective intervention and treatment or referral (see below)
      2. AUDIT-C*
         - Positive: Selective intervention and treatment or referral (see below)
         - Negative: Universal prevention message (see below)

* The T-ACE and TWEAK are validated for use with pregnant women. The CRAFFT Interview may be more helpful when assisting adolescent clients. The AUDIT-C is validated for use with non-pregnant women. All of these instruments are reprinted in Appendix B of this TIP.
obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Parker, Ratzan, & Lurie, 2003; Liechty, 2011). More than a third of adults in the United States do not have adequate health literacy (Kutner, 2006; Liechty, 2011), so the prevention message may need to be simplified and reinforced by asking the client on several occasions and in a variety of ways. This means that your agency will likely need to screen at several different points in time.

In addition, talking about alcohol use or seeking help for an alcohol-related problem can be potentially embarrassing or difficult for the client (NIAAA, 2005). Counselors should be conscious of this risk, and be respectful when raising the issue of alcohol use. Additional sources of information that can help to identify alcohol use include collateral reports from family and friends of the client, and client medical/court records.

Vignette #2 in Part 1, Chapter 3 incorporates discussion of drink size and the use of a visual aid with a client.

Selecting an Appropriate Prevention Approach

Based on the results of your client screening, the next step is to decide on an appropriate brief approach: Universal prevention message or selective or indicated brief intervention. Brief interventions are associated with sustained reduction in alcohol consumption by women of childbearing age, and those discussed have shown promise for being adaptable to various settings and needs (Fleming, Barry, Manwell, Johnson, & London, 1997; Manwell, Fleming, Mundt, Stauffacher, & Barry, 2000; Burke, Arkowitz, & Menchola,

What Is a Standard Drink?

All clients being screened for alcohol consumption should be given a clear indication of what constitutes a ‘standard drink.’ A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

<table>
<thead>
<tr>
<th>12 oz. of beer or cooler</th>
<th>8-9 oz. of malt liquor</th>
<th>5 oz. of table wine</th>
<th>3-4 oz. of fortified wine (such as sherry or port)</th>
<th>2-3 oz. of cordial, liqueur, or aperitif</th>
<th>1.5 oz. of brandy (a single jigger)</th>
<th>1.5 oz. of spirits (a single jigger of 80-proof gin, vodka, whiskey, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>~5% alcohol</td>
<td>~7% alcohol</td>
<td>~12% alcohol</td>
<td>~17% alcohol</td>
<td>~24% alcohol</td>
<td>~40% alcohol</td>
<td>~40% alcohol</td>
</tr>
<tr>
<td>12 oz.</td>
<td>8.5 oz.</td>
<td>5 oz.</td>
<td>3.5 oz.</td>
<td>2.5 oz.</td>
<td>1.5 oz.</td>
<td>1.5 oz.</td>
</tr>
</tbody>
</table>

When using these prevention approaches, counselors should remember that no intervention constitutes full treatment of a woman’s alcohol use. Each is designed simply to encourage a dialogue about alcohol and begin a process of change. Each should be the basis for ongoing evaluation and an informed approach to treatment or referral. For programs that do not have existing approaches to substance abuse treatment, procedures for appropriate referral are discussed after the brief interventions.

**Universal Prevention**

As indicated in Figure 1.2, *Screening Decision Tree for AEP Prevention*, a woman who is not pregnant, and either reports no alcohol use or does not screen positive for at-risk alcohol use, can receive a simple universal prevention message. Consider the following scripted messages.

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### Universal AEP Prevention Statement and Possible Follow-Up Questions

“**It’s great that you’re choosing not to drink alcohol. I know you aren’t currently pregnant or planning to become pregnant, but you are in the primary childbearing years right now. If you change your mind about pregnancy or discover in the future that you are pregnant, or you do begin to drink, please keep in mind that research has shown a link between drinking during pregnancy and the baby having an FASD. A child with an FASD can have physical and behavior problems, as well as cognitive problems (or, problems with the brain). These effects are caused by the alcohol, and they don’t go away, although they can be treated. There is no known safe amount of alcohol to consume during pregnancy, and any type of alcohol can cause FASD.**

*Can I give you a brochure [or Web address, such as [www.fasdcenter.samhsa.gov](http://www.fasdcenter.samhsa.gov)] to take with you? This will explain more about FASD and how to have a healthy baby. Even if you aren’t planning to become pregnant, you could share it with a friend or family member who is.*”

*****

**If asked:** Why is there no known safe amount of alcohol that a woman can have during pregnancy?

**Answer:** The amount of alcohol required to damage an unborn baby differs based on the individual. Things like how much alcohol a woman drinks, how often she drinks during pregnancy, and which trimesters she drinks in all play a part. It also depends on genetics, whether the woman smokes or uses other drugs, her general health and nutrition, her age, and her levels of stress or trauma. That’s why the Surgeon General recommends that pregnant women not drink any alcohol at all.

**If asked:** What kinds of alcohol should I avoid?

**Answer:** All alcohol can harm a baby while you’re pregnant, not just beer, wine, and hard liquor. Wine coolers and ‘alco-pops’ also count. Anything with alcohol. Even some over-the-counter medications have a lot of alcohol in them; if you’re pregnant or thinking of becoming pregnant, you should be careful about those, too.

**If asked:** Where can I find more information about FASD?

**Answer:** In addition to the SAMHSA FASD Center for Excellence ([www.fasdcenter.samhsa.gov](http://www.fasdcenter.samhsa.gov)), the CDC ([http://www.cdc.gov/ncbddd/fasd/index.html](http://www.cdc.gov/ncbddd/fasd/index.html)) provides extensive information about FASD.

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Whether asked for more information or not, the universal AEP prevention message should be accompanied by appropriate awareness materials, either in print or via a Web address. The SAMHSA FASD Center for Excellence provides a series of consumer fact sheets called *What You Need to Know* that provides helpful information about how to have a healthy baby. Appendix C, *Public and Professional Resources on FASD*, has links to additional information resources.

At the same time, counselors should keep in mind with universal AEP prevention that, in some situations, women may deny using alcohol, but a combination of signs and symptoms suggest otherwise. In such cases, it may be prudent to re-screen frequently (Taylor, Bailey, Peters, & Stein, 2009).

**Selective Prevention**

The following section discusses two brief interventions for AEP prevention that are appropriate with women of childbearing age who report alcohol use but have only one of the two indicators for an indicated intervention; they are either pregnant but do not screen positive for at-risk alcohol use, or they screen positive for at-risk alcohol use but are not pregnant. These are organized in terms of the time required to perform the intervention effectively. As with universal prevention, each of these approaches should be accompanied by appropriate FASD information material, such as the *What You Need to Know* fact sheets, either in hard copy or through a Web link.

The first selective intervention, called ‘FLO’ for short, is a simple, three-step approach (see box below). An example of using the FLO approach with a client is illustrated in Vignette #1 in Part 1, Chapter 3 of this TIP.

The second selective intervention, FRAMES, is a more established and slightly more detailed method for motivating a client toward change, and has demonstrated positive results in brief intervention situations (Miller & Sanchez, 1994; Miller & Rollnick, 2002). See the box on the following page.

Each of these brief interventions discusses ‘action plans’ or strategies for changing alcohol-related behaviors. For counselors who are not already well-versed in substance use-related change strategies, NIAAA has provided a brief guide to simple change strategies in the publication *Helping Patients Who Drink Too Much* (2007). Basic strategies to discuss with the client can include:

- What specific steps the client will take (e.g., not go to a bar after work, measure all drinks at home, alternate alcoholic and non-alcoholic beverages);
- How drinking will be tracked (diary, kitchen calendar);
- How the patient will manage high-risk situations; and

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**FLO (Feedback, Listen, Options)***

1. **Provide Feedback** about screening results. If possible, confirm the results with additional screening and provide information about recommended drinking limits. (For women who are—or are planning to become—pregnant, the ideal goal is abstinence.)

2. **Ask clients** for their views about their own drinking and **Listen** carefully to encourage their thinking and decision-making process.

3. **Provide medical advice**, and negotiate a decision about **Options** clients can pursue, including establishing a goal and developing an action plan.

• Who might be willing to help the client avoid alcohol use, such as a significant other or a non-drinking friend.

**Indicated Prevention: Alcohol Screening and Brief Intervention (SBI)**

Alcohol Screening and Brief Intervention (SBI) is a workbook-based brief intervention that is appropriate with women of childbearing age who screen positive for at-risk alcohol use and are pregnant. SBI generally takes 10 to 15 minutes to complete, and has been shown to positively impact abstinence rates and key subsequent health factors in the newborn, including higher birth weight/length and lower mortality (O’Connor & Whaley, 2007).

*The WIC Project Care: Health and Behavior Workbook* was originally developed for Women, Infants and Children (WIC) programs, which provide support to current and expecting mothers, but the workbook can be used across settings. It is crafted in very simple language and uses traditional brief intervention techniques, including education and feedback, cognitive–behavioral procedures, goal-setting, and contracting. The care provider should go through the workbook *with* the client. As with both universal and selective prevention, the SBI approach should be accompanied by appropriate FASD print materials or a relevant and reliable Web link for further information.

The workbook can be downloaded for free in multiple languages from the WIC Web site: [http://www.phfewic.org/Projects/Care.aspx](http://www.phfewic.org/Projects/Care.aspx)
Providing Intervention/Treatment: Additional Factors to Consider

The following are factors to keep in mind when delivering a brief intervention for AEP prevention, as well as when delivering full substance abuse treatment (for agencies that are able to offer such care).

- Selective and indicated prevention services should be delivered by someone with motivational interviewing (MI) skills if at all possible. While a detailed discussion of MI techniques is outside the scope of this TIP, SAMHSA provides a Web site (http://www.motivationalinterview.org/) that contains extensive materials and training resources for providers looking to develop their MI skills. See also TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment (SAMHSA, 1999).

- Consider the woman’s age and circumstances, and how these impact intervention/treatment. For example, life factors and obstacles to abstinence (family responsibilities, work, other children, etc.) will probably be very different for a teen vs. an older woman.

- Consider cultural context, as well; the cultural factors that impact treatment may be very different for an African-American, Hispanic/Latina, Asian-American, or Native-American woman (or a woman of any other minority) than for a Caucasian woman.

- Be willing to make modifications (e.g., frequency, duration) to maximize opportunities for prevention and recovery.

- Include and engage families in treatment, including significant others, grandparents, guardians, and custodians.

- Include relapse prevention.

- Include family support skills.

- Consider additional counseling factors:
  - Parenting skills (that work for both the parent and the child)
  - Trauma and abuse
  - Co-occurring mental health issues

- Using a calendar with a client who is already pregnant may help her differentiate when she found out she was pregnant from when she actually became pregnant. She may have consumed alcohol for some time before knowing of the pregnancy, and showing that the drinking occurred even before she knew she was pregnant can help her feel less pressured and alleviate feelings of guilt. Clients may feel guilty and not tell the whole truth (or even withhold the truth). This means that getting an accurate picture of alcohol use may require multiple screenings. It is critical to build trust over several sessions. [Vignette #4 in Part 1, Chapter 3 demonstrates the use of a calendar with a client.]

- Watch for clients who ‘shut down’ on the topic of alcohol, and be understanding if the client experiences a sense of panic.

Ensuring Effective Contraception

A woman who drinks alcohol at risky levels may not always follow prescribed procedures for effective contraception (Astley et al., 2000b). Review contraception use with her to ensure that she has full contraceptive coverage every time she has sexual intercourse. This might include providing secondary, back-up, or emergency contraception methods. For example, along with oral contraceptives, advise her to use condoms, which have the added benefit of reducing sexually transmitted diseases.

about what she may have unintentionally done to her baby.

- If the client is not pregnant but is drinking, and is not resistant to talking about contraception, qualified professionals can consider adding a discussion of effective contraception (see box, “Ensuring Effective Contraception”) to discussions about drinking reduction.

**Approaches to Resistance**

With any approach to AEP prevention, counselors should keep in mind that, while a female client may feel safe enough to share about her alcohol use, she may not be ready to take the next step of comprehensive assessment and treatment (Astley et al., 2000b). A woman may present as resistant, reluctant, resigned, or rationalizing. The publication *Substance Abuse During Pregnancy: Guidelines for Screening* (Taylor et al., 2009) provides guidance on meeting these various forms of resistance. In addition, see the box below.

**Procedures for Referral**

If you believe, based on screening and interaction during intervention, that your client requires assistance that is best delivered in another care setting (or treatment in another setting becomes necessary due to factors such as criminal justice or social service involvement), you should discuss the benefits of treatment with the client and offer to provide her with a referral to a local substance abuse treatment center or other appropriate provider. A general list of treatment facilities can be searched through The SAMHSA Treatment Locator (http://findtreatment.samhsa.gov). Additional referral possibilities include the following:

- County substance abuse services;

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**Resistant, Reluctant, Resigned, or Rationalizing**

<table>
<thead>
<tr>
<th><strong>Resistant: “Don’t tell me what to do.”</strong></th>
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<tbody>
<tr>
<td><strong>Provider Response:</strong> Work with the resistance. Avoid confrontation and try to solicit the woman’s view of her situation. Ask her what concerns her about her use and ask permission to share what you know, and then ask her opinion of the information. Accept that the process of change is a gradual one and it may require several conversations before she feels safe about discussing her real fears. This often leads to a reduced level of resistance and allows for a more open dialogue. Try to accept her autonomy but make it clear that you would like to help her quit or reduce her use if she is willing.</td>
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<tr>
<th><strong>Reluctant: “I don’t want to change; there are reasons.”</strong></th>
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<tr>
<td><strong>Provider Response:</strong> Empathize with the real or possible results of changing (for example, her partner may leave). It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide her problem-solving.</td>
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<tr>
<th><strong>Resigned: “I can’t change; I’ve tried.”</strong></th>
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<tbody>
<tr>
<td><strong>Provider Response:</strong> Instill hope, explore barriers to change.</td>
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<table>
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<tr>
<th><strong>Rationalizing: “I don’t use that much.”</strong></th>
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<tbody>
<tr>
<td><strong>Provider Response:</strong> Decrease discussion. Listen, rather than responding to the rationalization. Respond to her by empathizing and reframing her comments to address the conflict between wanting a healthy baby and not knowing whether “using” is really causing harm.</td>
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### Targeted Referral Options

#### Non-Pregnant Women: Project CHOICES

Project CHOICES is an evidence-based intervention (Project CHOICES Intervention Research Group, 2003; Floyd et al., 2007) that targets women at risk of having an AEP before they become pregnant. The goal is to reduce drinking and/or prevent pregnancy through contraception.

The target population for Project CHOICES is women ages 18 to 44 who are sexually active and drinking alcohol at risk levels. The model uses a four-session intervention approach based in MI methods, and discussions in each session are tailored to the client’s self-rated readiness to change and interest in discussing alcohol use or contraception.

Project CHOICES programs exist in multiple settings, including residential and outpatient substance abuse treatment, community mental health treatment, jails, and community-based teen programs for girls. Eligibility criteria include 1) self-report of being sexually active, 2) being non-pregnant (but able to conceive), 3) high-risk drinking (8 or more drinks per week or 4 or more drinks in one occasion) in the past 30 days, 4) ineffective use of or no contraception, and 5) not currently trying to become pregnant or planning to try in the next 6 months.

The CDC provides additional information about Project CHOICES at [http://www.cdc.gov/ncbddd/fasd/research-preventing.html](http://www.cdc.gov/ncbddd/fasd/research-preventing.html).

#### Pregnant Women: Parent-Child Assistance Program (PCAP)

The Parent-Child Assistance Program (PCAP) is a scientifically validated (Grant et al., 2005) paraprofessional case management model that provides support and linkages to needed services to women for 3 years following enrollment. The goal is to reduce future AEP by increasing abstinence from alcohol and drug use and/or improving regular use of reliable contraception among enrollees.

The target population for PCAP is pregnant or post-partum women (up to 6 months) who have had an AEP and will self-report drug and/or alcohol use during the target pregnancy. The model is based in Relational Theory, the Stages of Change, and harm reduction.

PCAP programs exist in a variety of settings, including substance abuse treatment and family support centers. Eligibility criteria include self-report of heavy alcohol or illicit drug use during pregnancy and ineffective or non-engagement with community social services.

To learn more about PCAP, including contact information, background materials, an implementation guide, and relevant forms and materials, visit [http://depts.washington.edu/pcapuw/](http://depts.washington.edu/pcapuw/).
Chapter 1: Prevention of Alcohol-Exposed Pregnancies Among Women of Childbearing Age

- 12-Step programs;
- Hospital treatment programs;
- Mental health programs; and
- Special pregnancy-related programs, which can be identified through your state health department by calling 800-311-BABY (2229), or 800-504-7081 for Spanish.

Programs throughout the United States have worked and are working directly with the SAMHSA FASD Center for Excellence to implement SBI (summarized above), Project CHOICES, or the Parent-Child Assistance Program (PCAP) (both summarized in the box “Targeted Referral Options,” previous page). A program near you can be considered a source for possible referral or for guidance on locating a similar program. Please contact the FASD Center for Excellence for current program contact information (www.fasdcenter.samhsa.gov). Your local FASD State Coordinator may also be able to provide guidance on appropriate referrals. The National Association of FASD State Coordinators can be contacted via the SAMHSA FASD Center for Excellence Web site: http://fasdcenter.samhsa.gov/statesys temsofcare/nafsc.aspx.

The feasibility of fully implementing SBI, Project CHOICES, or PCAP in your agency will depend on your staff skill set, your collaborative network, your funding, and a variety of other factors that are examined in greater detail in the Administrative section (Part 2) of this TIP.

Providing a Referral: Additional Factors to Consider

- Discuss possible strategies for the client to stop consuming alcohol; for example, individual counseling, 12-Step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment (Taylor et al., 2009).
- Use an advocate or special outreach services, if available, such as PCAP or Maternity Support Services (Taylor et al., 2009). Refer to Appendix C, Public and Professional Resources on FASD, for additional sources of information on community supports.
- Obtain information about costs, which health plans cover alcohol services (e.g., Medicaid, Medicare, state assistance, and public programs), who to contact to refer a patient, the phone numbers, and the necessary procedures for enrollment. This will allow you to tailor the referral to the client’s needs and health insurance coverage (Higgins-Biddle, Hungerford, & Cates-Wessel, 2009).
- Identify the types of services available in your area (e.g., cognitive–behavioral, 12-Step, Motivational Enhancement Therapy) and the types of modalities (e.g., in-patient, outpatient), and prepare short descriptions of the available options so patients can understand the differences among alternative approaches (Higgins-Biddle et al., 2009).
- If possible, help the client make an appointment while she is in your office. If the woman is unwilling to make that commitment, ask if she would like some information to take with her if she should change her mind. Schedule the next visit, continue to maintain interest in her progress, and support her efforts to change. Monitor and follow up on any
Helping Your Clients Receive Culturally Competent Services

This TIP, like all others in the TIP series, recognizes the importance of delivering culturally competent care. Cultural competency, as defined by HHS, is...

“A set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time” (U.S. Department of Health and Human Services, 2003, p. 12).

This section discusses national information resources that are available on the topic of cultural competence or for providing care to specific cultural groups (listed alphabetically). However, the absence of a specific cultural group from this section is not meant to suggest that cultural competency is not an issue for that population. Individuals from all cultural backgrounds deserve respect and attention in a treatment environment, and the significance of culture needs to be recognized in relation to many different areas of a person’s life; race, ethnicity, gender, sexual orientation, age, socioeconomic status, language, etc.

Chapter 3 of this TIP, Clinical Vignettes, contains additional information on the essential elements of culturally competent counseling.

Hispanic/Latin Populations
If your agency is not fully capable in serving Hispanic/Latin clients or a Hispanic/Latin client requests culturally specific services, the National Council of La Raza provides a search tool (http://www.nclr.org/index.php/nclr_affiliates/affiliate_network/) that can direct clients to over 300 community-based organizations that provide a variety of health and general services for Hispanic/Latin populations.

In addition, SAMHSA’s National Hispanic & Latino Addiction Technology Transfer Center (ATTC) offers a variety of products and resources focused on the health needs of Hispanics and Latinos. Visit their Web site at http://www.attcnetwork.org/regcenters/index_nfa_hispaniclatino.asp.

Native Populations
If your agency is not fully capable in serving native clients or a native client requests culturally specific services, the Indian Health Service (IHS) provides an interactive search map (http://www.ihs.gov/findhealthcare/) that can be used to find an IHS, Tribal, or Urban Indian Health Program (UIHP) facility. This search engine scans a variety of settings, including hospitals, behavioral health settings, village clinics, and school health facilities.

If you are unable to locate services through the map, the Health Resources and Services Administration (HRSA) provides the HRSA Health Center locator (http://findahealthcenter.hrsa.gov/Search_HCC.aspx) to determine if there are other culturally specific services available in your area.

Cultural Competency Training/Learning
The SAMHSA FASD Center for Excellence can provide training or technical assistance (TA) on cultural competency topics, or can put your agency in touch with a nearby specialist. Training and TA request forms can be accessed online (http://www.fasdcenter.samhsa.gov). Chapter 3 of this part of the TIP, Clinical Vignettes, also contains a checklist of core competencies for the culturally sensitive counselor.

In addition, the HRSA’s Culture, Language and Health Literacy page (http://www.hrsa.gov/culturalcompetence/index.html) provides links to a range of resources on cultural competence when serving clients of differing cultures, genders, and sexual identities.
co-existing psychiatric conditions (Taylor et al., 2009).

- Maintain communication with the substance abuse treatment or other provider to monitor progress (Taylor et al., 2009).
- If immediate substance abuse treatment or other support is not available, the counselor or designated staff might meet with the woman weekly or bi-weekly to express concern and to acknowledge the seriousness of the situation (Taylor et al., 2009).

**Working with Women Who May Have an FASD**

When working with women of childbearing age, counselors may encounter clients who exhibit symptoms or characteristics suggesting that they themselves have an FASD. Research has identified intergenerational FASD as a pattern (Kvigne et al., 2003; May et al., 2005). Verifying the presence of an FASD is a process of observation, interviewing, and additional screening that takes time. The guidelines provided in the next chapter, *Addressing FASD in Treatment*, can prove helpful for counselors who want to pursue verification of a possible FASD in the client, and/or wish to modify their approach to delivering prevention or treatment/referral accordingly.

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**For more information on AEP prevention...**

Vignettes 1–4 in Part 1, Chapter 3 illustrate scenarios where a counselor practices AEP prevention approaches. In addition, Part 3, the online literature review, also contains further discussion of screening and prevention interventions.