Introduction

Preventing FASD requires complex, multilevel work. To achieve a real reduction in substance use among pregnant women, strategies are needed across various health and human service systems. These include services such as information dissemination, outreach and early intervention, and alcohol treatment.¹

Identifying Addiction Disorders in Women

Identifying addiction disorders in women of childbearing age and with risk factors for FASD is an important part of FASD prevention.

Prevention Approaches

SAMHSA has developed a Strategic Prevention Framework focused on shaping healthy environments, supportive communities, and neighborhoods, which are connected to families and friends and then to substance abuse prevention and crime-free programs. Within this broader context, communities can support many FASD prevention efforts. The Institute of Medicine (IOM)² has developed a three-pronged approach to prevention:
• **Universal** prevention promotes the health and well-being of all individuals in society or a particular community. Universal prevention targets the general public or an entire population group. Examples are public service announcements and informational brochures.

• **Selective** prevention targets individuals or a population group at higher risk of developing a particular condition. An example would be screening women of childbearing age for alcohol problems.

• **Indicated** prevention targets high-risk individuals who have detectable signs or symptoms of a condition or biologic markers indicating predisposition to the condition. An example would be substance abuse treatment for mothers of children with an FASD.²

Preventive interventions are designed to minimize risk factors and maximize protective factors. Risk factors increase the chances of engaging in harmful behaviors. Protective factors decrease the chances of engaging in harmful behaviors. Risk and protective factors exist in a variety of domains in a person’s life:

• Individual: biologic and psychological dispositions, attitudes, values, knowledge, skills, problem behaviors
• Peers: norms, activities, bonding
• Family: function, management, bonding
• School/work: bonding, climate, policy, performance
• Community: bonding, norms, resources, awareness/mobilization
• Society: norms, policy/sanctions, environment

The table provides examples of risk and protective factors for FASD in the various domains related to alcohol use during pregnancy.

**Risk and Protective Factors in Various Domains**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Low self-esteem, unemployment, tobacco use, binge drinking</td>
<td>Prenatal care, meaningful employment, education</td>
</tr>
<tr>
<td>Peers</td>
<td>Friends who drink while pregnant</td>
<td>Supportive peers who share messages about the harm of drinking while pregnant</td>
</tr>
<tr>
<td>Family</td>
<td>Heavy drinking by parents and siblings</td>
<td>Supportive partners and relatives who share messages about the harm of drinking while pregnant</td>
</tr>
<tr>
<td>School/work</td>
<td>Drinking behavior of coworkers</td>
<td>Alcohol-free social gatherings</td>
</tr>
<tr>
<td>Community</td>
<td>Tolerance toward heavy drinking</td>
<td>Education of health care and social service providers and law enforcement officers</td>
</tr>
<tr>
<td>Society</td>
<td>Alcohol culture</td>
<td>Norms against drinking while pregnant</td>
</tr>
</tbody>
</table>

**Sources:** Stratton, K.; Howe, C.; and Battaglia, F., eds. 1996. *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment.* Washington, DC: National Academy Press; Wilsnack, S.C.

Most women reduce or stop drinking during pregnancy. This reduction may be linked in part to prevention messages in reading material and radio and television advertisements. Various media campaigns have helped raise awareness of the dangers of alcohol use during pregnancy. Print materials are also effective. NOFAS has new patient education materials that encourage abstinence from alcohol during pregnancy and educate women about what constitutes risky drinking and how alcohol affects the developing fetus.

Universal approaches can help raise awareness about an issue but rarely bring about behavior change. Warning labels on alcoholic beverages appear to have a preventive effect on lighter drinkers. But they have little effect on the heaviest drinkers, who are most at risk of bearing a child with an FASD. Therefore, other approaches are needed with the heaviest and most long-term drinkers.

Alcohol Screening

Effective Screening

- Emphasize that the questions are routine and that you ask all patients to improve your practice
- Avoid stating questions to provoke a quick "no".
  - You don’t drink, do you?
- Ask open ended questions.
  - How much alcohol do you drink?
  - When was your last drink?

Researchers have identified age, socioeconomic status, spousal characteristics, and other risk factors for FASD. This information can help provide appropriate targets for selective and indicated prevention strategies. The first challenge in implementing such prevention strategies is
to identify women at increased risk of having children with an FASD. Screening for alcohol problems at primary and prenatal care clinics can help.

A common way to identify at-risk drinkers is to use short screening questionnaires. Many of the more popular questionnaires are less accurate for women than for men. In addition, questions about the quantity and frequency of alcohol use are extremely poor in identifying alcoholism. However, they can be used to open a discussion about drinking behavior.

For various reasons, such as stigma, women tend to underreport their drinking. In addition, women who are not primary wage earners may not experience adverse effects of drinking, such as job loss and legal problems. Standard screening instruments may not identify women whose drinking problems are expressed in other ways.

Studies have shown that some screening tools may be effective. In one study, the T-ACE questionnaire was more effective than assessments by health care staff in identifying pregnant women at risk for problem drinking. The T-ACE is one of several commonly used screening tools (see appendix). Three other screening tests, the CAGE, the TWEAK, and AUDIT (Alcohol Use Disorders Identification Test) have been identified as effective for women, but they appear to be more sensitive for alcohol abuse and dependence in African American women than in white women.
More work is needed to develop instruments for use among general populations of women of childbearing age. Once women at risk for having children with an FASD are identified, several key questions arise. These include the woman’s readiness for change, factors that affect readiness, and turning points toward abstinence. These issues need to be addressed and evaluated to improve screening and identification of women at risk.

Women at risk include women of childbearing age who are sexually active and do not use adequate birth control. Women who drink or use drugs are also at risk. However, screening all women of childbearing age for alcohol use can help prevent FASD. Diagnosis of alcohol abuse requires gathering information about the adverse consequences of a client’s drinking behavior. Steps in the screening process include:

- Ask about alcohol and drug use. Identify the most appropriate screening tool or tools.
- Assess for alcohol- and drug-related problems. Physical findings related to alcohol abuse may occur late in the course of the disorder. Some symptoms may be early indicators. These include high blood pressure, nonspecific complaints, insomnia, depression, anxiety, and stomach problems. Clues can also be found in the client’s medical, family, and social histories.
- Advise appropriate action. Even after gathering data, counselors and health care professionals may still be unsure about the diagnosis. It is important to share concerns and elicit responses to questions.
- Monitor patient progress. Specific recommendations are most effective for both client adherence and future evaluation.

When Screening

- A positive response is likely to be accurate, however a negative response may not be accurate
- Continue to ask about alcohol use on subsequent visits and watch for signs and symptoms of alcohol use
- Screening will assist in identifying higher risk drinking and can help you link patients to needed resources and services
- The goal is to reduce all forms of maternal alcohol use
The Institute of Medicine recommends that any health care provider who encounters a woman who is abusing alcohol consider:

- Brief intervention therapy
- Counseling regarding the risks of prenatal alcohol exposure
- Referral to more formal alcohol abuse treatment

It is also important to ask women who are abusing alcohol about their prior pregnancies. This can help identify children who may be affected with FASD.

**Discuss Birth Experiences with Women:**

**Red Flags:**
- Two or more miscarriages?
- Stillbirths?
- Infant/child deaths (SIDS)?
- Children with LD, ADHD, MH or behavioral disorders?
- Children diagnosed with FASD?

Positive response to any of the above questions should warrant a screening of all children for possible FASD (where substance use is known or suspected) - Mitchell 2004

For women who drink during pregnancy, comprehensive clinical women-specific treatment programs may be needed. The literature on gender differences among substance abusers clearly demonstrate that women’s experiences with substance abuse are different from those of men.

Consistent gender differences are found in:

- Predisposing factors contributing to the development of substance abuse
- Patterns of substance abuse
- Context in which substance abuse begins and continues
- Problems and consequences resulting from substance abuse
- Co-occurring problems and issues interacting with substance abuse
- Access to substance abuse treatment
- Experiences while in substance abuse treatment
Biological Differences

Women experience major organ complications more rapidly than men:

- Liver damage
  - Cirrhosis
- Brain damage
- Heart disease
  - High blood pressure
  - Stroke
- Breast cancer
- Gastrointestinal hemorrhage
- Anemia
- Malnutrition
- Colon cancer

» NIAAA, Alcohol Alert 1999

Critical treatment components for women include:

- Gender sensitive program climate
- Educational seminars targeting gender-specific issues
- Medical and health services addressing women’s concerns
- Child-related services, including colocation of children
- Family-focused services
- Educational and vocational services
- Training programs to enhance women’s effectiveness in interpersonal and survival skills
- Legal assistance
- Programs addressing issues of sexuality and intimacy
- Relationship counseling that challenges socialized gender role assumptions
- Programs to address trauma and victimization in childhood and adulthood

Women-specific alcohol and drug abuse services may include the following modalities and services:

- Individual or group counseling, such as brief interventions, cognitive-behavioral therapy, mentoring, and therapeutic communities
- Family therapy
- Crisis intervention
- Referral to self-help groups, such as Alcoholics Anonymous
- Relapse prevention
NOFAS Curriculum for Allied Health Professionals

- Parenting skills training
- Case management
- Information and education about the effects and risks of alcohol consumption

The Substance Abuse and Mental Health Services Administration has an online treatment facility locator that can be used to identify appropriate programs and facilities.

**Ongoing Assessment to Obtain Accurate Diagnosis**

Some women with alcohol problems may also have an FASD. These women may need to be referred for diagnosis of an FASD. Identifying FASD is crucial because it can affect the woman’s recovery and the treatment methods used (see Competency III). At least one study has shown that prenatal alcohol exposure is a risk factor for substance abuse problems in adolescents, making diagnosis of an FASD critical in these clients. In addition, identifying co-occurring disorders is crucial to ensure appropriate treatment of all disorders.

**Brief Intervention and Motivational Interviewing**

Research indicates that brief interventions can be effective in reducing alcohol use during pregnancy, especially if a partner is included. Brief interventions can also be effective in reducing alcohol use among women of childbearing age. The intervention typically involves one or two 15-minute counseling visits with a physician. The sessions include advice, education, and use of a scripted workbook to develop a contract to reduce alcohol use.

Brief interventions often use motivational interviewing, which is based on stages of change theory. Motivational interviewing helps people make decisions along the stages of change. The diagram shows the stages of change, which are described below.

![Stages of readiness for change (read from bottom to top)](image)


- **Precontemplation:** The person is not considering change. He or she does not see the need and may be surprised to find that others think a problem exists.
• **Contemplation:** The person is ambivalent. Part of the person wants to change and part does not. The characteristic response of the contemplator is “Yes, but...”

• **Preparation:** The person feels ready to change. He or she may express feelings such as “Something’s got to change. I can’t go on like this.” If determination does not lead to action, the individual may temporarily return to the precontemplation stage.

• **Action:** The person has begun doing something about his or her behavior. This is usually when treatment starts.

• **Maintenance:** This is the hardest part of change. The challenge is to maintain the gains and avoid relapse.

• **Relapse:** More than 90 percent of problem drinkers or drug users will drink or abuse drugs again after treatment. They need to recover from the lapse as quickly as possible and reenter the change process. Relapse is not formally considered a stage. It is included because many individuals relapse and repeat stages.

Motivational interviewing helps people recognize their problems and increase their motivation to change. It is especially useful in resolving ambivalence. It is a supportive, respectful approach that is persuasive but not coercive. One useful model for understanding motivation is FRAMES.

FRAMES stands for six key elements that are effective in assisting persons with at-risk or problem drinking to change their drinking behavior:

• **Feedback:** Provide useful feedback based on screening.

• **Responsibility:** Emphasize personal responsibility and freedom to choose.

• **Advice:** Give specific advice about how to change drinking patterns.

• **Menu:** Provide the person with options.

• **Empathy:** Show an understanding of the person’s situation and be supportive.

• **Self-efficacy:** Convey the message that the person is capable of change.

Motivational interviewing strategies can help people stay focused and avoid getting sidetracked. It is important to reinforce statements that indicate a willingness to consider change. Resistance may indicate a different stage of change than previously thought. The goal is to understand where the person is and guide the process accordingly.

**Appropriate Preconception Planning Methods**

Prepregnancy counseling is critical for all women of childbearing age and is important in preventing FASD. Many women drink in the early stages of pregnancy, before they know that they are pregnant. In addition, about half of all pregnancies are unplanned. Women need to be encouraged to plan their pregnancies and to abstain from alcohol use before and during pregnancy.
Primary Prevention of FASD
Reproductive Health Planning
Discuss birth control options with clients while in treatment

- Depo-Provera – once every three months hormonal injection
- Ortho Evra – aka “The Patch,” applied once a week, minimal side effects
- Nuva Ring - a once-a-month vaginal insert, minimal side effects
- IUD

Addiction professionals can help by talking to their clients about the dangers of alcohol use during pregnancy. Discussing plans for pregnancy is also important to promote a healthy, alcohol-free pregnancy. Women with alcohol problems may need assistance with family planning to avoid pregnancy while they are drinking. Motivational interviewing plus a contraception counseling session can decrease the risk of alcohol-exposed pregnancy in women in high-risk settings.  

Issues to discuss during preconception counseling include:

- The various methods of contraception and the attitudes of the woman, her significant others, and her community regarding their use. The addiction counselor might need to refer the client to family planning resources. Family planning is usually not part of the addiction professional’s job.
- The impact of alcohol and other drug use during pregnancy on the woman and the fetus.
- The teratogenic impact of prescribed medications, such as Antabuse and various anticonvulsants. Again, a referral might be needed, since most addiction professionals are not trained in pharmacology.
- Alternative medications with reduced or no teratogenic potential for such common problems as seizure disorder. An obstetrician or geneticist can recommend such medications.

Clients who temporarily require medications such as Antabuse, or those who choose to postpone childbearing, may want an effective, reversible form of contraception. Substance-using women
who have a history of irregular menses and involuntary infertility need to know that sobriety or the successful initiation of a recovery program may result in a resumption of ovulation and an increased risk of unplanned pregnancy. Such clients need referrals to appropriate specialists. Addiction professionals need to be familiar with available specialists in their area.

**FASD Prevention Resources**

Materials are available that can be used in FASD prevention efforts. Many of these are for general populations, but some can be used with women in treatment or aftercare. Others have been developed for specific populations, such as Native women.

- Pauktuutit Inuit Women’s Association, Before I was Born resources, [http://209.217.87.67/FAS/index.html](http://209.217.87.67/FAS/index.html)
- Association of Iroquois and Allied Indians, Guarding the Unborn Spirit resources, [www.kemmurchproductions.com/store.htm](http://www.kemmurchproductions.com/store.htm)
- Rural Cap Alaska, Early Decisions resources, [www.earlydecisions.org/](http://www.earlydecisions.org/)
- An Inner Voice Tells You Not to Drink or Use Other Drugs poster, [www.health.org/govpubs AVR161/](http://www.health.org/govpubs AVR161/)

Organizations that have information and resources include:

- Colorado FAS/ATOD Prevention Program, [www.uchsc.edu/ahec/fas/](http://www.uchsc.edu/ahec/fas/)
- National Organization on Fetal Alcohol Syndrome, [www.nofas.org](http://www.nofas.org)
- Minnesota Organization on Fetal Alcohol Syndrome, [www.mofas.org](http://www.mofas.org)
- University of Washington Fetal Alcohol and Drug Unit, [http://depts.washington.edu/fadu/](http://depts.washington.edu/fadu/)
- American Society of Addiction Medicine, [www.asam.org](http://www.asam.org)
Techniques to Engage Substance-Abusing Women Into Treatment and Recovery

Women face many barriers in accessing treatment. The box below presents some of these barriers.

### Barriers for Women in Seeking Treatment

#### Personal barriers (the woman’s feelings and life situation)
- Shame and guilt
- Denial of problem
- Fear of losing primary relationships, support, and security
- Overwhelmed by other personal issues (housing, violence) so that treatment is not a priority
- Sole custody of children and possibility of losing custody due to substance use

#### Interpersonal barriers (family, partner, peer relationships)
- Fear of losing children to partner or child welfare
- Lack of family or social support (denial, resistance to treatment)
- Tendency to be involved with partners who use substances themselves or hide the woman’s substance abuse

#### Societal barriers (broader community and societal attitudes)
- Stigma attached to women who misuse substances
- Stigma attached to women who seek treatment
- Internalized stigma
- Greater pressure not to enter treatment

#### Program/structural barriers (treatment services and structure)
- Male-oriented identification and treatment models
- Lack of flexible services (time, duration, criteria for entry)
- Lack of a program, information, or strategies to effectively reach women who need treatment
- Cost of treatment and costs associated with treatment (especially child care and transportation)
- Lack of women-centered services
- Lack of low-cost reliable child care


Addressing such barriers is important in engaging women into treatment. Techniques for enhancing access to care include:

- Use of treatment approaches that respond to women’s needs
- Approaches that reflect women’s realities
- Treatment services that are available to all women but are based on an individual woman’s specific needs and circumstances
- Approaches that reflect ethnic, racial, cultural, and geographical differences in needs among women substance abusers
Additional methods for engaging women into treatment include:

- Raising community awareness of substance use problems among women at risk and providing information on available services
- Enhancing the knowledge and skills of those in a position to identify, refer, and support women with substance use problems to access treatment. These may include community leaders, community peers, religious leaders or spiritual advisers, primary care providers, and other service providers, such as mental health and child welfare
- Improving treatment access through outreach

**Community Awareness and Education**

The literature on women with substance use problems emphasizes the need to raise community awareness about women with substance use problems and treatment options. Raising awareness about women’s substance use problems can help reduce stigma. Awareness, coupled with information about available treatment services, can increase women’s access to treatment. Suggested strategies include:

- Develop awareness material that is informative, non-stigmatizing, accessible, and solution oriented (location of treatment facilities, cost, criteria for admission, etc.).
- Provide information through the media, such as printed material posters and pamphlets, articles in magazines and newspapers, the telephone directory, radio and television, and the World Wide Web. (Materials available from NOFAS and the FASD Center for Excellence)
- Post information in a variety of locations where women gather, such as health services, shops and stores, community centers, places of worship, workplaces, and other culturally relevant settings.
- Hold community forums, workshops, or other meetings to provide information and education on the topic.
- Train community volunteers, building on and linking to existing services for women.

**Training Primary Care and Other Helping Professionals**

Women use health services to a greater extent than men. Women with substance use problems often make initial contact with services other than specialized substance abuse treatment services. They may:

- Visit their doctor or other primary health care worker for routine health care
- Seek counseling for family or mental health problems
- Seek specialized medical services such as prenatal care
- Come to the attention of child welfare authorities or the criminal justice system

Training staff in these settings to routinely screen for substance use problems and refer or briefly intervene when problems are identified can improve outcomes, particularly with early intervention.
Training should address knowledge, skills, and attitudes about women with substance use problems and the effectiveness of treatment. A survey of women in treatment found that most (74 percent) believed it was appropriate for doctors and other health workers to routinely ask their clients about their use of alcohol and other drugs and to offer advice and support.\textsuperscript{17}

People with substance use problems often have an array of needs that cannot be addressed by a single service. For women, coordination and collaboration between substance abuse treatment services and other services are crucial. Services may include prenatal and obstetric/gynecological services, child welfare services, crisis services such as women’s shelters, and mental health services. In addition, different services will be required at different phases of the client’s substance abuse treatment. For example, during aftercare, employment and housing services are important.

Providing training is one approach to networking and linking. Training can be reinforced by other activities such as:

- Collaboration between sectors to develop best practice models for addressing dual problems (e.g., women with substance problems who have experienced violence)
- Shared or cross-training between sectors (e.g., HIV/AIDS treatment services and substance abuse treatment services)
- Substance abuse treatment staff assigned to work from a health or social service agency or vice versa
- Visits to primary care or other service providers to explain the needs and services required by women receiving substance abuse treatment services
- Partnership agreements between services that have mutual clients\textsuperscript{18,19}

\textit{Outreach Services}

Outreach services extend beyond usual agency activities to engage individuals who have or are at risk of developing a substance use or related health problem. Outreach often focuses on reaching those who are “hard to reach or hidden” and not in contact with other services. Outreach activities may also be designed to reach people already in contact with services but who need accessible substance abuse treatment services.

The development of outreach services should be based on a careful assessment of the characteristics, life circumstances, and needs of the specific group who will receive the services. In some cultures, men and women live more segregated lives and this must be taken into account in planning outreach services. In some cases, such as homeless women, safety may be the primary concern.

Outreach activities may occur in community centers, cafes, drop-in or storefront agencies, police stations, shelters, places of worship, hospitals, prisons, social and health care settings, or any natural setting where women gather. Outreach may be done by telephone or delivered by mobile vans or cars. Some programs establish satellite offices in accessible locations. To establish trust,
continuity is important for recipients of outreach services, particularly for clients who are at high risk, such as women living in violent situations.

Peer outreach can be an effective way to reach women who are not in contact with professional services or who live in places with strong cultural taboos against substance use by women. Literature on the subject suggests that among some groups, peers may be viewed as more credible, and women who use substances may find it easier to establish trust and discuss personal issues with peers. Peer outreach workers can provide users with information on how to reduce risk behaviors, teach by example, and link substance users with treatment and other health and social services. Women who have successfully completed treatment can be role models and provide support to women during the treatment process. **Alcoholics Anonymous** is a well-established form of peer outreach. In addition, the **National Organization on Fetal Alcohol Syndrome** runs a support network for mothers who have given birth to children with an FASD. These women are particularly high risk of having future children with an FASD.

It is also important to identify and address life needs, such as food, shelter, and housing, a safe place to spend time away from the street, child care, and mental and physical health care. Responding to these immediate needs can begin the process of engagement.

Below are some key themes in providing appropriate services to pregnant and parenting women, based on results of studies from the Pregnant and Postpartum Women with Their Infants program of the Center for Substance Abuse Treatment.

### Key Themes for Substance Abuse Treatment Services That Are Responsive to Gender

- **Respectful service philosophy**, which addresses women’s shame and guilt, loss of control over their lives and their mistrust of the systems scrutinizing them, by providing an environment that is non-judgmental and promotes mutual respect and empowerment and builds on women’s strengths.

- **Comprehensive and practical care** by combining substance use treatment with an array of services such as prenatal care, medical care, parenting education, family planning, attention to nutrition and housing needs and counseling on violence and relationship issues, as well as practical supports such as babysitting costs and transportation to appointments. A philosophy that supports women’s choice in the life areas they want to work on and provides “one-stop shopping” or a well-integrated network of services contributes to program effectiveness.

- **Inter-agency collaboration and coordination** to engage and retain women in treatment and provide the range of services required. Inter-agency collaboration and coordination can address issues such as differing service philosophies and approaches, promoting joint training, sharing of resources and joint planning and, in particular, promoting collaboration between the addiction treatment system, the child welfare system and the foster care system.

- **Broad and flexible continuum of care**, which can support women in entering, re-entering and completing treatment.

- **Outreach to reduce internal barriers**, such as shame and fear, and to make pregnant women aware of available services either directly through interventions, such as street outreach, or through education of other service providers. Home outreach and transportation are important factors in treatment compliance and outcome.
- Case management and flexible scheduling, which may include home visits, telephone contact, professional or peer advocacy, help with transportation and processes that allow women to enter and re-enter treatment and accommodates their need to attend to other issues such as medical appointments or responding to child welfare authorities.
- Attention to family issues, by integrating children and partners into women’s care and supporting women in their decisions regarding reunification or disconnection, is a critical component of effective care for pregnant and parenting women.
- Continued support or aftercare is critical for women because of the many changes that they experience following the intensive phase of treatment. This includes developing new social networks, relationship issues, family-role changes, working on relapse prevention strategies, etc.

**Guiding Principles for Service Delivery**

Some of the principles that are essential to working well with women are the same as those in dealing with any client group. Other principles are uniquely important to women. The table shows key principles that are important in guiding gender-specific services for women. These are derived from the substantial best practice literature that describes the barriers to treatment that women face, the key principles for women’s treatment, and the elements of women-centered care.

<table>
<thead>
<tr>
<th>Guiding Principles for Service Delivery</th>
<th>Key Issues</th>
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<tbody>
<tr>
<td>Work from respectful, nonjudgmental service philosophies that ensure safe and compassionate care. Use strength-based, empowerment approaches.</td>
<td>Women face barriers in accessing and completing treatment, such as shame and guilt, denial, fear, feelings of powerlessness, and low self-esteem.</td>
</tr>
<tr>
<td>Provide responsive and practical help that directly addresses key service barriers. Provide cross-disciplinary care for women.</td>
<td>Interpersonal and systemic barriers to service access include fear of losing custody of children, family and child care responsibilities, social and economic circumstances, lack of support from partners, stigma, lack of flexible services, and lack of information about treatment services.</td>
</tr>
<tr>
<td>Collaborate with other services to provide a holistic service for women.</td>
<td>Many women experience co-occurring health and other problems, including issues related to mental health, violence and sexual abuse, body image, self-esteem, mothering, reproductive health, and sexuality.</td>
</tr>
<tr>
<td>Focus on women’s relational needs and supportive connections between women in treatment programming.</td>
<td>Building healthy peer and family relationships are important areas for women in recovery.</td>
</tr>
<tr>
<td>Provide comprehensive wraparound services for pregnant women, including priority access, service coordination, collaboration, outreach, case management, and advocacy.</td>
<td>Pregnant women with substance use problems often face greater barriers in accessing help.</td>
</tr>
<tr>
<td>Provide information and education in ways that are accessible and relevant to women.</td>
<td>Women have various needs for information and styles of learning.</td>
</tr>
<tr>
<td>Deliver prevention initiatives that address the specific health, social, and cultural issues affecting women of all ages and at key life transitions.</td>
<td>Prevention strategies must be well targeted to be effective. Social expectations and influences that have an impact on women’s substance use must be considered.</td>
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Comprehensive FASD Prevention Programs

A review of more than 160 articles described treatment programs designed to reduce fetal alcohol exposure in alcohol- and drug-dependent women. The review suggested that programs that provide comprehensive and coordinated treatment attract more pregnant women into care and are more effective. A number of sources suggested that the most effective treatment approach combines social, cognitive-behavioral, medical, and referral services. The article also notes that many consider an active case manager essential to coordinate services.

An example of a successful case management program is the Parent-Child Assistance Program (P-CAP) in Seattle. It began in 1991 and has been replicated in other communities. P-CAP is an intensive home visitation model for mothers at highest risk.

As part of P-CAP, paraprofessional advocates are paired with clients for 3 years after the birth of a baby prenatally exposed to alcohol or drugs. They help link clients with community services. The advocates are extensively trained and closely supervised and have a maximum caseload of 15. Program results include fewer children born affected by alcohol and drugs, fewer foster care placements, and less family dependence on welfare. Other positive outcomes are an increase in family planning and child well-being.

Some communities have mandated court-ordered or involuntary participation in alcohol treatment for heavily drinking pregnant women. These programs have stimulated legal and ethical debates concerning the comparative rights of the pregnant woman, the fetus, and society. Although some positive findings exist, the effectiveness of this approach has not been determined.

Role of Men and Significant Others in FASD Prevention

To date, no FASD cases have been documented without maternal drinking or resulting from paternal drinking alone. Thus, in preventing FASD, the emphasis is on encouraging male partners to help pregnant women avoid alcohol. Friends and family members can help as well. Several Canadian researchers have explored this issue and offer suggestions for involving men.

Men become fathers in the context of a relationship and can have a serious influence on maternal drinking. A number of social risk factors associated with maternal alcohol use in pregnancy are attributed to their male partners:

- Men can play a critical role in preventing FASD by helping to prevent pregnancy in women who drink alcohol. According to one preconception study, 45 percent of women surveyed reported consuming alcohol 3 months prior to finding out they were pregnant. In another study, approximately 25 percent of American women studied reported that they used alcohol during their first months of pregnancy.
Although most women stop or reduce alcohol use when they learn they are pregnant, more than half of all pregnancies in the United States are unintended. Involving male partners in family planning can reduce the risk of an unplanned pregnancy and use of alcohol before the woman finds out she is pregnant.

- Men can also support an alcohol-free environment. Paternal drinking is a risk factor for maternal drinking. Male partners who oppose the mother’s plan to stop drinking make it harder for women to avoid alcohol.
- Another factor in maternal drinking is the nature of the couple’s relationship. “Paternal substance abuse may heighten the social stressors impinging on both mother and child.” This factor plays a major part when women use alcohol and other drugs to cope with emotional pain. In contrast, a stable and nurturing home protects against maternal drinking.
- The level of commitment in a relationship is another factor associated with maternal drinking. Marital status is a significant predictor of drinking during pregnancy. Single women are more likely to drink than married women.
- Physical and sexual abuse are risk factors for women drinking when pregnant. Use of alcohol by women to cope with violence and abuse is common. One study showed that almost all of the birth mothers of children with FAS investigated had been physically or sexually abused.

Fathers also need to encourage alcohol-free pregnancies in their daughters. Most young women who quit or reduce their drinking during pregnancy have been encouraged by others, specifically parents or mentors, to avoid alcohol use during their pregnancies. Similarly, women with a large and satisfactory support network, including their families, are more likely to abstain from alcohol use during pregnancy.

**Issues Related to Professional Values and Ethics**

FASD prevention can raise many issues for the addiction professional. Some people harbor negative feelings toward women who drink while pregnant, thinking they are ignorant or uncaring. Others think everyone knows that alcohol use during pregnancy is unsafe, so there is no need to discuss it. In some cases, stereotypes may lead to the belief that members of certain populations (e.g., middle or upper class) do not have problems with FASD. The reality is that any woman can have a child with an FASD. It is important to keep an open mind and to avoid harsh opinions or false assumptions.

**Nonjudgmental Behavior**

Perhaps the most important thing an addiction professional can do is maintain a nonjudgmental attitude. Women who have given birth to a child with an FASD are at high risk of having another child with an FASD. These women need a nonpunitive and nurturing environment to work through their issues. Pregnant women do not drink because they want to harm their fetuses or because they don’t care about their children. They have an addiction that needs to be treated like any other medical condition.
Some pregnant women with alcohol problems may fear losing custody of their children. However, child protective service agencies are mandated to help keep families together. An addiction professional can help coordinate with child protective services to develop a plan for family reunification. Many alcohol and other drug treatment programs find it difficult to deal with child custody and placement issues and may exclude women who could be involved with child protective services. This practice can do great harm by keeping women who need treatment most from getting it.

Women should not be barred from treatment or discriminated against because they are pregnant. Addiction professionals need to understand that the family situation for women may be fluid, rather than static. Children may be periodically absent and subsequently return to the home. Furthermore, alcohol and other drug use is a chronic relapsing disease. Relapse prevention must be an important part of any treatment approach.

**Stigma, Guilt, and Shame Experienced by the Client and Her Family**

It is easy to fall prey to the social stigma surrounding alcohol use during pregnancy. The addiction professional needs to avoid this attitude. Many women already feel guilt and shame about their drinking. Those who have a child with an FASD need help working through the issues related to hurting their child. Coping with her their feelings and learning to find support can help these women have alcohol-free pregnancies in the future.

The family may also have issues. Family members may feel guilty for not stopping the woman from drinking. They may feel responsible for the woman’s alcohol problems, especially if a parent or sibling has problems as well. They may be embarrassed by the woman’s alcohol problems and wish she would just “get her act together.” The addiction professional needs to be aware of these issues and address them in a sensitive manner. It helps to focus on the disease model of addiction and the idea that the person with alcohol problems does not lack character.

**Family, Cultural, and Spiritual Needs**

Sensitivity to family, cultural, and spiritual values is essential. Some families may be uncomfortable talking about alcohol use during pregnancy. In some cultures and religions, women’s drinking is forbidden or considered sinful. Acknowledging these views and helping individuals and families work through their issues can help in preventing FASD. Addiction professionals may want to seek creative ways to incorporate cultural and spiritual values into their work. For example, Native cultures consider pregnancy to be a sacred time. This belief can be used to encourage an alcohol-free pregnancy.

An assessment should be made of the woman’s literacy and reading level. This assessment should include the woman who is functionally illiterate or has low literacy in her native tongue as well as in English. Literacy- and reading-level information will affect patient education efforts and the ability to obtain informed consent. It can also be used to determine the need to use an interpreter or to provide materials in another language.
Information for Clients on Potential Hazards of Alcohol Use During Pregnancy

Addiction professionals play a critical role in educating women about the risks of drinking while pregnant, offering them support, and linking them to appropriate services and resources. Any woman who drinks during pregnancy risk having a child with an FASD. The safest advice providers can give women is to completely avoid alcohol while pregnant. There is no known safe type, amount, or time to use alcohol during pregnancy.

Emphasize the importance of family planning during treatment, aftercare, and ongoing recovery. The combination of alcohol treatment and family planning services can be quite effective in preventing FASD. A client may worry about alcohol she drank before she knew she was pregnant or before knowing the possible dangers. Let her know that getting treatment and stopping the alcohol use can reduce the risk of harm to her baby.

If you work with women who may be planning to become pregnant or who are having sex without contraception, explain the risks of drinking while pregnant. Incorporate the message into their treatment plan. Also consider advising them to consistently use a reliable birth control method. If you feel uncomfortable addressing this issue, you might want to refer the client to a medical professional.

Compassion, Honesty, and Integrity in Relationships

Communicating openly, sensitively, and honestly is essential to developing a trusting relationship. Women with addiction disorders are particularly vulnerable. They may judge themselves harshly or face judgment from family, friends, and community members. The following are some tips for effective and respectful communication:

- Use language that is clear and free of judgments.
- Be specific—Avoid generalization.
- Use language that is definable and not subject to multiple interpretations.
- Do not use psychiatric diagnoses as metaphors for other descriptions (e.g., using “schizophrenic” or “manic” to describe behavior).
- Use language that is specific to the issue.
- Use language that does not categorize people into generalized groups.
- Use objective language.
- Use language that is not open to interpretation, such as slang.
- Use language that individuals who are not in the mental health field can understand.
- Keep humor focused away from individuals. Joking is okay, but not at the expense of an individual.
- Use inclusive language, such as “we” (not “us” and “them”).
- Use language that does not separate groups by diagnoses or character traits.
- Use body movement and expression that connote inclusion and equality (e.g., avoid crossed arms).
• Check your voice for any unintended communication barriers, such as condescending tones, pitch, and volume.
• Check your own belief in what you are saying. If one uses “politically correct” words, but doesn’t believe in the message, the body will convey the real belief.

Remember to remain truthful and respectful. Focus on positive messages, such as those that convey hope, responsibility, gratitude, and solutions. Be persistent in your efforts, recognizing that attitude and behavior changes occur gradually over time.

**Take Away Message:**
- Identify women and/or their children with FASD
- Pursue an assessment and diagnosis when signs of FASD are evident
- Incorporate mind, body, and spiritual healing strategies when treating women or mothers of children with FASD
- Ensure that staff are:
  - trained to educate their clients on the effects of alcohol use during pregnancy on the developing fetus
  - competent in their ability to identify and appropriately pursue an assessment
  - trained to develop treatment plans for clients with possible FASD
  - discussing reproductive health options with women in treatment

**References**


