Theoretical Framework

Harm Reduction

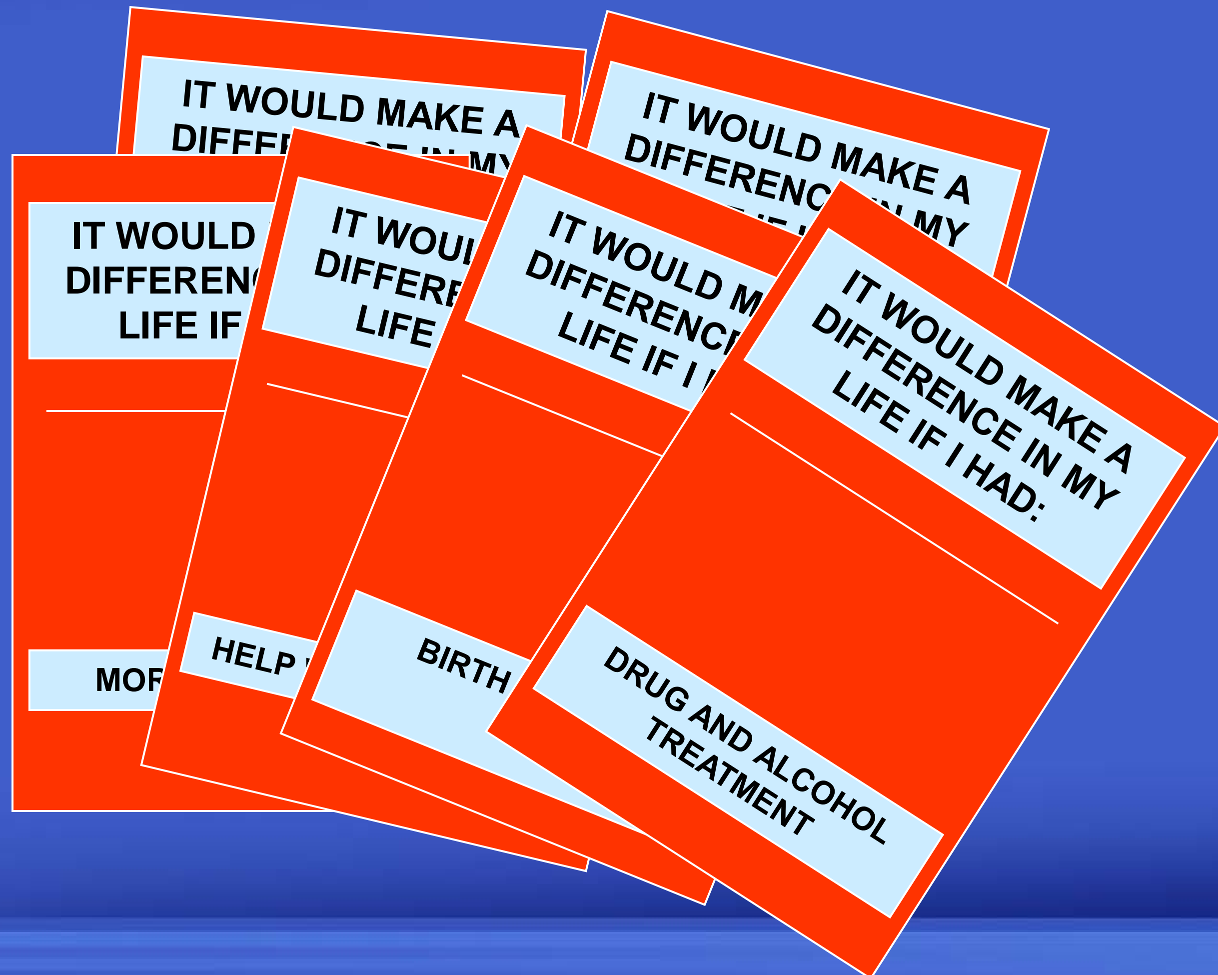
Addiction and associated risks are on a continuum. The goal is to reduce harmful consequences of the habit for mother and her child.

Intervention

Any steps toward decreased risk are steps in the right direction.

Lessons Learned:
Help Client Identify Goals

The Difference Game



Client Goals

The Difference Game

- Identify the “baby” steps it will take to reach each goal.
- Make sure at least some of these baby steps are attainable in the 4-month period.
- *The client must observe herself succeeding in order for her to build self efficacy and move toward change.*

Lessons Learned:
Quality Control Through Outcome and Process Evaluation

Measure & Monitor

- Identify program outcomes
- Evaluate progress
- Identify areas for improvement
- Develop protocols (e.g., boundaries)

Individualized feedback helps staff see their outcomes relative to others, encourages them to learn improvement strategies from others

Weekly, monthly, biannual feedback

Lessons Learned:
Supervision, Group Staffing, Team Support

Supervisor meets individually with advocates every other week:

- Review each case
- Make recommendations
- Discuss how the focus can be re-directed to the Big Picture and client goals, and away from small crises the client can handle
- Listen for common issues/problems that should be addressed with the group in weekly staffing

Group staffing once a week:

- Brain-storming, problem–solving sessions that leave participants in a positive frame of mind for the challenges they face

Close-knit state team interaction:

- Meetings every 3 months
- Annual retreat

Strategies for Preventing Alcohol/Drug Exposed Births

- Alcohol/Drug Treatment
- Family Planning

Alcohol & Drug Treatment

BEFORE

- Mandated treatment may be necessary.
- Seek women-only treatment setting.
- Seek treatment where children can stay.
- Gain cooperation of client support system.
- Prepare the client for what to expect.

Alcohol & Drug Treatment

DURING

- Get Releases of Information signed.
- Maintain boundaries with treatment agency.
- Arrange for child visitation.
- Stay in close touch.
- Arrange for post-treatment, transitional housing.

Alcohol & Drug Treatment

AFTER

- Relapse is part of the disease; be explicit and honest about consequences.
- Help client identify triggers and make a plan, e.g. call advocate immediately.
- Introduce client to relevant support groups.
- Consider relocation to new neighborhood.

Family Planning:
Rates of Unintended Pregnancy

U.S. Unintended Pregnancy……………… 50%

Of these:

Unintended live births	23%
Abortions	27%

Using contraception before pregnancy 48%

WA State Unintended Pregnancy…….. >50%

Using contraception at time of pregnancy 43.4%

Henshaw, 1998; WA State DSHS RDA, April 2004

Family Planning

- Does NOT mean never having another baby
- DOES mean having more control over whether, and when, to have another child

Family Planning Strategies

Education

- Basic anatomy, how pregnancy occurs
- How various family planning methods work
- Possible contraindications
- Consider lifestyle and health status
- Consider cognitive and functional status

Family Planning Strategies

Encourage clients to discuss, acknowledge previous experiences.

Motivational Interviewing: help client identify pros and cons of having another child; revisit this topic.

Reestablish client goals every 4 months. How will having another child affect achieving goals?

Preventing Future Alcohol-Exposed Births

At PCAP replication sites, 78 women were binge drinkers (≥5 drinks/occasion) during the index pregnancy.

At PCAP exit, 51 (66%) were no longer at present risk of having another alcohol exposed pregnancy:

- 24 (31%) using reliable contraception;
- 18 (23%) abstinent from alcohol/drugs >= 6 months;
- 9 (12%) both reliable contraceptive and abstinent.

Preventing Future Alcohol-Exposed Births

- Without PCAP about 30% (or 23) of 78 drinking mothers would have had another highly exposed birth.
- We reduced that by 66%, preventing about 15 alcohol-exposed births.
- The incidence of FAS is estimated at 4.7% to 21% among heavy drinkers.

Therefore, we estimate PCAP prevented at least one and up to three new cases of FAS.

Preventing Future Alcohol-Exposed Births: Cost Savings

The average lifetime cost for an individual with FAS is $1.5 million.

PCAP costs about $15,000 / client for 3 years (intervention, administration, evaluation).

If we prevented just <u>one</u> new case of FAS, the estimated lifetime cost savings = cost of PCAP for 102 women.

Benefits and Costs of Prevention and Early Intervention Programs

	Benefits	Costs	Benefits per Dollar of Cost	Benefits Minus Costs
* Home Visiting Programs for At-Risk Mothers and Children	$11,089	$4,892	$2.27	$6,197

Washington State Institute for Public Policy, July 2004 found an average net lifetime benefit of $6197 per client among selected well-researched home visiting programs, including PCAP.*

www.wsipp.wa.gov

Working With Women Who Have Fetal Alcohol Spectrum Disorders

Pilot project funded by the March of Dimes Birth Defects Foundation (2001-2002)

- A pilot community intervention for young women with fetal alcohol spectrum disorders. *Community Mental Health Journal* 2004, 40(6): 499–511.
- Quality of life and psychosocial profile among young women with fetal alcohol spectrum disorders. *Mental Health Aspects of Developmental Disabilities* 2005, 8(2): 33–39.

Profile: PCAP FASD Clients (N=19)

- Average age = 22 Years
- Mostly white (60%), unmarried(85%), and poorly educated (45%)
- Troubled life history profiles
    - Family history drug/alcohol abuse (100%)
    - Sexual abuse (79%)
    - Physical abuse (84%)
    - Unstable and disrupted care giving (100%)
- High levels of psychiatric distress and behavioral problems
- Poor quality of life relative to other at-risk populations

Community Service Providers: What We Found

- Providers knew very little about FASD.
- Providers had limited direct experience with this population.
- Few services were suited for individuals with FASD.
- Obtaining a diagnosis in adulthood was difficult.
- Even for experienced PCAP advocates, working with an FASD client was more difficult than working with a typical PCAP client.

Educating Providers

- We identified key providers interested in the problem, and willing to work with a PCAP client who has FASD.
- We provided: FASD education, a PCAP case manager, and follow-up consultation.

Education + hands-on experience = FASD demystified

Providers learned to deliver services appropriately tailored to specific needs of FASD patients.

Advocates' Experience: "She just doesn't get it!"

- The impact of neuropsychological deficits was obvious.
- Advocates had to modify their usual approaches.
- Clients were often unable to learn new skills or learned them very slowly.

Strategies to Use with Clients Who Have FASD

- Use short sentences, concrete examples, and avoid analogies
- Present information using multiple modes
- Simple step-by-step instructions (written and/or with pictures)
- Role-playing
- Ask patient to demonstrate skills (don't rely solely on verbal responses)
- Revisit important points during each session

Strategies to Use with Clients Who Have FASD

- Teach generalization: Don't assume a lesson learned in one context will transfer to another
- Help client identify physical releases when escalating emotions become overwhelming
- Be alert for changes/transitions—monitor more carefully, do advance problem-solving

An experienced and clinically supported case manager, working in collaboration with her client and a network of educated providers, might reasonably expect to accomplish a number of intervention steps over a 12-month period.

FASD clients may need life long advocacy, but intervention steps can be taken in the short term:

1. Secure stable housing, and safe placements for the children.
2. Secure some financial stability for the future (SSI, DDD).
3. Assist clients in choosing a reliable contraceptive method.
4. Establish an educated network of service providers and committed mentors who will continue to work with clients.

“Think Younger”

Adjust expectations to be more congruent with the individual’s *developmental level of functioning.*

Diane Malbin: FASCETS (Fetal Alcohol Syndrome Consultation Education and Training Services, Inc.) www.fascets.org; dmalbin@fascets.org

Ongoing Challenge:

Maternal Alcohol Use During Pregnancy

It's not *"just alcohol"*

February 21, 2005
U.S. Surgeon General Releases Advisory on Alcohol Use in Pregnancy

Women who are pregnant or who may become pregnant should abstain from alcohol consumption in order to eliminate the chance of giving birth to a baby with any of the harmful effects of the Fetal Alcohol Spectrum Disorders (FASD).

This updates a 1981 Surgeon General's Advisory.

If I'm pregnant, can I …

…fly a plane?
"Yes – if you could before, says Dr. Donald Gibb of London's Portland Hospital. In commercial jets, he says, short rides are fine up to 36 weeks."

…have a beer?

"The Centers for Disease Control says "no level of alcohol…has been determined safe," but some doctors feel limited drinking – no more than a pint a day, suggests Dr. Gibb – after the first trimester is okay."

…bleach or dye my hair?
"Many doctors give a thumbs up after the first 12 weeks, so long as chemicals are kept away from the scalp."

- People Magazine, April 17, 2006, pp 102-107