Pregnant and Parenting Women Tool Kit: Preventative Services in Women’s Treatment

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WSN Business Day 2012

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If you have any trouble logging into your account or forget your password, please email Kelly Zentgraf at kzentgraf@nasadad.org for assistance.
Participants: Christine Reid (AR), Karen Mooney (CO), Barbara Brooks (IL), Brenda Lands (LA), Karen Pressman (MA), Ruth Jacobson-Hardy (MA), Kristen Jiorle (ME), Angie Smith-Butterwick (MI), Shannon Einspahr (MO), Nancy Heller (NE), Linda Parker (NH), Chris Scalise (NJ), Pamela Espinoza (NM), Betsy Fedor (NV), Kelly Reid (OK), April Johnson (OR), Laura Rostolsky (PA), Barbara Shoup-Anderson (SD), Linda McCorkle (TN), Becky King (UT), Martha Kurgans (VA), Sue Green (WA), Cynthia Black (WV), Shawna Kautzman Pena (WY)

NASADAD: Rick Harwood, Sarah Wurzburg, Marcia Trick, Cliff Bersamira, Kelly Zentgraf, Anne Diehl

Presenters:
- Karen Pressman and Ruth Jacobson-Hardy, Massachusetts Initiatives
- Dr. Norma Finkelstein, Family-Centered Care
- Angie Smith-Butterwick, Michigan Initiatives

Karen Mooney, Co-Chair of the Pregnant and Parenting Women Subcommittee, welcomed participants and conducted roll call.

Norma Finkelstein, Ph.D.: Family-Centered Care:
Dr. Norma Finkelstein discussed the incorporation of family and children’s services as a key element of the paradigm shift toward gender-responsive, trauma-informed family-centered treatment. In this model, there is a focus on the family rather than the individual as the client as well as less separation between prevention, early intervention, and treatment. She explained that though Federal prevention often focuses on adolescents, children should be the number one prevention priority group because the younger the child at the age of intervention, the lower the chance of negative outcomes. There are two primary approaches in this model: building on each family member’s strengths and understanding relational issues; and providing treatment to family members by involving safe intimate partners/significant others in treatment while offering referrals to family members as needed. Dr. Finkelstein spoke about the third edition of SAMHSA’s National Registry of Effective Programs and Practices (NREPP), which includes a session entitled “Being a Father”, which incorporates trauma-based evidence-based practices (EBPs) like Child-Parent Psychotherapy (CPP). She described adequately providing familial services within a time- and financially-constrained system as their largest struggle.

Dr. Finkelstein also spoke about the home-based integrated treatment model that includes four family recovery specialists as part of the Family Recovery Project. The fact this is a Federal grant allows for sufficient time to engage clients, meet their needs, and stay involved through transitions. EBPs used include Motivational Interviewing (MI), Cognitive-Behavioral Therapy (CBT), care coordination, trauma-informed treatment, Seeking Safety, and the Nurturing Parent Program. She then spoke about lessons learned from collaboration in the Family Recovery Council. Lessons include listening to one another and tolerating the discomfort that differing points of view can create; being role models so that cross-system partners plan, lead, and participate in meetings equally; and reinforcing common goals and understanding. She concluded by speaking about Project Bright, a three-year grant funded by the Center for Mental Health Services and the National Child Traumatic Stress Network, which is designed to address traumatic stress in parents in recovery from SUDs and CODs and their children (from birth to age five). The goals of this project were to address symptoms of complex trauma and build resilience in young children; enhance the quality of parent-child relationships through RF; and build capacity to address the needs of children with trauma. This program is based on CPP, with several modifications. They decreased length of
Karen Pressman and Ruth Jacobson-Hardy, Massachusetts Initiatives:
Karen Pressman introduced Ruth Jacobson-Hardy and indicated that Ruth would be presenting on the program she works with. Ruth spoke about the Family Recovery Project. The project includes a systems collaboration with the Family Recovery Council of Hampden County. They are one of 53 grantees funded by the US Administration for Children and Families’ Children’s Bureau that receives technical assistance (TA) from the National Center for Substance Abuse and Child Welfare (NCSACW). This project serves parents who have lost or are at risk of losing custody as well as their children, their partners, and other family members, with the goal of “moving individuals and families towards health and recovery while ensuring child safety”. The Family Recovery Collaborative (RFC) is a statewide coordination of activities related to substance abuse and child welfare issues co-facilitated by the Massachusetts Bureau of Substance Abuse Services and the Massachusetts Department of Children and Families (DCF).

The Family Recovery Council includes the DCF, the BSAS, substance abuse and mental health treatment providers, the school system, the legal system, faith-based providers, parents/caregivers in recovery, and more. It aims to remove barriers to treatment services for families struggling with co-occurring disorders (COD) and improve communication and collaboration across systems. Coordination of care is emphasized in order to better engage and retain families in services. The Family Recovery Council holds quarterly council meetings for all members, local and statewide; monthly committee meetings for local members; and biweekly leadership meetings for local and State representatives. Karen spoke about the Communication, Cross-Training, and Public Relations Committees and explained that the project-funded Coordinator does an excellent job of keeping each group on track. Lessons learned in these meetings include the importance of cross-systems collaboration and ongoing training.

Angie Smith-Butterwick, Michigan Initiatives:
Angie Smith-Butterwick spoke about Michigan’s development of a fetal alcohol spectrum disorder (FASD) policy in 2008. Providers in Michigan saw a need for intervention for alcohol use in pregnant women using other drugs, since alcohol is often a secondary drug of choice for that population and because a higher number of those women have FASD themselves. In 2010, a student from Wayne State University offered to study FASD policy in Michigan and found that half of all providers are aware of FASD programs and that 40% had implemented a FASD policy. In this study, treatment providers indicated a need for more client educational materials pertaining to FASD. As a result, another Wayne State University student is currently undertaking the effort to develop the materials.

Secondly, in 2008, Michigan received the Parent-Child Assistance Program (PCAP) grant for a three-year intensive case management program aimed at reducing FASD births. So far, they have served 82 mothers. They have also been able to sustain the program after the grant ended by creating a technical assistance advisory for Enhanced Women’s Services, which incorporates PCAP principles such as trauma-informed and gender-responsive training as well as transportation to appointments by advocates. However, in this program, both alcohol and drug use is targeted. Additionally, because this is a Block Grant-funded service, women whose parental rights are terminated cannot receive services. Currently, three counties using PCAP are in the process of transitioning to Enhanced Women’s Services. When asked about the length of treatment, Angie noted that PCAP lasted from two to three years and that the Enhanced Women’s Services covers from 18 months to three years, which is billed as case management and financed through a combination of Medicaid and Block Grant dollars. She explained that the existence of peer-based services in mental health helped pave the way for these efforts.
NASADAD Women’s Services Network
Pregnant & Parenting Women Webinar

Norma Finkelstein, Ph.D.
Institute for Health and Recovery
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February 8, 2012
Incorporating Family & Children’s Services: Key Elements of a Paradigm Shift

Gender-Responsive, Family-centered

Prevention & Early Intervention

Trauma-Informed
Paradigm shift: Towards gender-responsive, trauma-informed, trauma-specific family-centered treatment which includes resilience and strengths based prevention and treatment services for children
Family-Centered Care: Relational-Cultural Model

Multiple vulnerabilities (mental illness, substance use, poverty, discrimination, trauma, homelessness, physical health problems) for women, families, children, significant others

Parenting and family relationships critical to recovery

Comprehensive, family-centered treatment
Relational-Cultural Theory

Stone Center, Wellesley College

• Women’s sense of self organized around making and maintaining affiliations
• Stresses development through connections
• Shifts emphasis from separation or images of connection as negative to “relational self” as core self structure/basis for growth and development
• Connections fundamental to psychological growth and healing
From Individual to Family-Centered Approaches

- Treatment to promote well-being of entire family; family is client rather than single individual
- Parent and child well-being are intertwined whether parent and children live together or apart
- Children are primary, not solely collateral clients
• Relationships with children strengthen rather than “overwhelm” the treatment experience

• Connection/relationships are central to treatment; treatment aims to repair “disconnections”

• Recovery occurs in context of relationships—not in isolation
For Children

- Children have rarely been focus of our interventions
- Studies have mainly measured treatment retention/reduction in maternal substance abuse as primary outcome; assumed parenting, work with children, secondary to this primary goal
- Used to think that just keeping kids with their moms would be enough
- We have found that the children have needs of their own
Children and Trauma

• Trauma derails normal child development
  – When children exposed to chronic trauma, energy normally invested in development of competencies, internal sense of efficacy, achievement, and confidence in approaching new tasks is instead invested in survival.

  Blaustein, 2007

• “Toxic stress” — affects architecture of brain; routinely operate in survival mode

  Shonkoff, 20
Childhood trauma has high co-morbidity with a number of disorders including:

- Depressive disorders
- Attention deficit disorders
- Anxiety disorders
- Conduct disorders
- Substance abuse disorders
- Explosive disorders
- Affective disorders
Importance of Family Treatment

• Just as traumatic experiences/familial substance abuse can undermine brain development, good experiences can enhance it
  – “Plasticity,” malleability of child’s developing brain, importance of working with young children

• Why EI is so important—gives child best chance to follow developmental trajectory unencumbered by effects of trauma/substance abuse/mental health problems

• Need interventions to support children’s resilience and family relationships

• This should be our #1 prevention priority group

MA Advocates for Children, 2005
Impact of Recovery on the Family

- Changes roles and relationships among all family members
- Stimulates guilt and remorse for past behavior
- Stimulates fear and loss
- Can stimulate traumatic memories

Families need support to tolerate feelings and stay with it.
Family-Centered/ Trauma-Informed Services

- Benefit both parents and children
- Broaden focus from nuclear family to network of supports—relatives, friends, etc.
- Are strengths-based, empowering and focus on resiliency building and healthy coping skills
- Are aimed at relationship strengthening
- Address impact of substance use & trauma on entire family
- Value families having meaningful voice and choice
- Are inclusive, flexible, responsive, and culturally relevant
Two Primary Approaches

1. “Keeping the family in mind”
   - Pay attention in treatment to relational issues and “disconnections” and address relational barriers to recovery
   - Validate women’s strengths in relationship
   - Build on these strengths, not view all relationships as negative
   - Model healthy, mutual relationships
2. Provide treatment to family members
   • Involve **safe** intimate partners and significant others in treatment
   • Attend to repair of connections to partners/extended family/children
   • Provide treatment or referrals to treatment for partners/significant others, other family members
Other Family Members/Partners

• Substance use creates stressors, often chronic and multiple, for close family members—a large but neglected high-risk group
  – Heightened risk for symptoms of mental and physical illness, DV, financial difficulties, marital/family disruption

• How do you adequately provide familial services in a time- and financially-constrained system?

Samford, et al., 2001
Parenting

• Compromised parenting has as great, if not greater, negative effects on child development than prenatal substance exposure
  
  Lester, Andreozzi, & Appiah, 2004; Messinger et al., 2004; AIA, 2008

• Parenting services are critical for child outcomes. Since a range of factors can contribute to poor parenting and poor child outcomes, it is the quality of the parent-child relationship that mediates the effects of most other risk factors on child development
  
  Dawe, Harnett, et al., 2000
In Addition to Parenting Skills, Parenting Supports Should…

• Work on issues of attachment, safe and stable relationships with children
• Address grief and loss
• Help resolve issues of past behavior with children
• Help parents decide what to tell their children
• Promote involvement in advocating for help/support for their children
Nurturing Program for Families in Substance Abuse Treatment and Recovery

(On SAMHSA National Registry of Effective Programs & Practices)
Parenting is not solely a set of skills:

It is a relationship within a family.

Nurture the parent.
• **Third edition**: 3 new sessions (“Being a Father”) for working with fathers

• Incorporates trauma-based EBPs: CPP & RF

• New Individual Guide to be used in individual counseling, home visiting
MA Statewide Dissemination

- Funded by BSAS: statewide trainings for treatment programs
- Parent-Child Specialists build capacity by co-facilitating NP groups and providing supervision & technical assistance to publicly funded treatment programs statewide
Family Recovery Project (FRP)

- 5-year project (2007-2012) funded by Children’s Bureau
- Collaboration between BSAS, DCF, & IHR
- Serves families involved with DCF where substance use/co-occurring disorders is preventing completion of DCF service plan goals – have lost custody or at imminent risk of losing custody
Home-Based Integrated Treatment Model

- Substance use & co-occurring mental health disorders/trauma treatment
- Intensive care management/resources & referrals
- Individual, couples & family treatment
- Children’s services
- Parenting
- Liaison to DCF & other state agencies
Staff

- 4 Family Recovery Specialists provide **home-based** behavioral health disorders treatment
- Evaluation – Brandeis University
- “Core Team” – statewide & regional representatives from DCF, DPH/BSAS, IHR
- Family Recovery Collaborative – systems work
What makes FRP services unique?

- **Home-based and flexible**
  - Meet with entire family
  - One clinician provides concrete (care management) and clinical treatment services
  - Frequency and length of visits
- **Time** to engage, meet concrete needs, stay through transitions
- EBPs used: MI, CBT, Care Coordination, trauma-informed treatment, Seeking Safety, Nurturing Program
Local Collaboration: Family Recovery Council of Hampden County

Working together to support families in recovery from substance use and co-occurring disorders
Family Recovery Council

Agencies and individuals committed to family recovery, including:

- Department of Children & Families (DCF)
- DPH: Bureau of Substance Abuse Services (BSAS)
- Substance Abuse Treatment Providers
- Early Intervention Providers
- Corrections System
- Providers of violence/trauma services (DV, rape crisis)
- School Systems
- Legal System
- Community-Based Programs
- Mental Health Treatment Providers
- Faith-Based Programs
- Parents/Caregivers in Recovery
Family Recovery Council: Lessons Learned

• Listen to each other. Tolerating the discomfort of differing points of view builds trust and respect.
• Listen again. Then focus on problem solving.
• Be role models: cross-systems partners should plan, lead, and participate in meetings equally.
• Reinforce common goals and understanding: “Relapse is a recovery AND a safety issue.”
Project BRIGHT

- 3-year grant funded by CMHS/NCTSN
- Designed to address traumatic stress in parents in recovery from SUDs/CODs & their children (birth to 5)
- Parents & children in residence at 8 Family Residential Treatment (FRT) programs across MA
- Collaborators: IHR; Jewish Family & Children’s Services; Boston University School of Social Work; Boston Medical Center, Child Witness to Violence Project
Project BRIGHT Goals

- Address symptoms of complex trauma and build resilience in young children
- Enhance the quality of parent-child relationships through Reflective Function (RF)
- Build capacity of FRTs to address children’s trauma needs; to “keep the child in mind”
- Pilot adaptation of Child Parent Psychotherapy (CPP) as model for this population
Child-Parent Psychotherapy (CPP)

- Developed by Alicia Lieberman, Patricia Van Horn & colleagues at UCSF
- Relationship-based dyadic intervention
- Focuses on the trauma-affected attachment of parents & young children
- Focuses on improving the parent-child relationship
- The relationship is the client
BRIGHT Modifications/Adaptations to CPP

- Length of treatment shortened to 6-8 months
- Bring philosophy and principles of CPP to FRT
- Include women who are pregnant – anticipate their children’s needs related to danger and safety
- Added focus on Reflective Functioning: For women in recovery from SUD/COD, treatment that targets maternal reflective capacity has been shown to be effective

(Suchman, Nancy, et al., 2008)
What is my child trying to tell me?

The attachment process boils down to detective work.

• “Keeping the child in mind”
• “I’m so much more aware of this baby because I was high when my older kids were little.”
• “I would never think you could ask those questions about your child.”
Thank You!
FAMILY RECOVERY PROJECT:
FAMILY ENGAGEMENT AND COMMUNITY COLLABORATION IN SUBSTANCE ABUSE TREATMENT AND CHILD WELFARE

NASADAD Women’s Services Network

Pregnant and Parenting Women Webinar

RUTH JACOBSON-HARDY, MA LADC I

Western Mass Regional Manager
Department of Public Health/Bureau of Substance Abuse Services

February 8, 2012
Family Recovery Project

• Clinical project

• Systems collaboration
  – Family Recovery Council of Hampden County
Family Recovery Project Overview

- 5-year project funded by the US Administration for Children and Families/Children’s Bureau – Regional Partnership Grant Program
- Technical Assistance provided by the National Center for Substance Abuse and Child Welfare (http://www.ncsacw.samhsa.gov)
- 53 grantees nationally
Who We Serve

**FRP:** *(clinical work)*
Families involved with DCF who have lost custody of their children or are at imminent risk of losing custody, the children of clients, their partners, and other family members.

**Family Recovery Council:** *(cross-systems work)*
Providers from various systems and all those who can support families in recovery.
Shared Values Between Systems

DCF social workers and Substance Use Disorder (SUD) Treatment Program clinicians share the goal of moving individuals and families towards health and recovery while ensuring child safety.
State-Level Collaboration: Family Recovery Collaborative

The Family Recovery Collaborative (FRC) is the statewide group responsible for the coordination of statewide activities related to substance abuse, family systems and child welfare issues, co-facilitated by DPH/BSAS and DCF.

- NCSACW Technical Assistance 2005 & 2009
- Memorandum of Understanding
- Values and Principles
Local Collaboration: Family Recovery Council of Hampden County

Working together to support families in recovery from substance abuse and addiction.
Family Recovery Council: Our Vision

Every family will have access to the services and supports needed to promote full recovery.
Family Recovery Council: Our Mission

• To remove barriers to treatment services for families struggling with substance abuse and co-occurring mental health disorders

• To improve communication and collaboration across systems, in order to provide high-quality care and coordination of support for families in recovery
Family Recovery Council: Our Philosophy

• When agencies work together, families are better able to access the services they need quickly and smoothly.

• Coordination of care will help engage and retain families in services, leading to better outcomes.
Family Recovery Council: Our Structure

- **Biweekly Leadership Team meetings:** local and state representatives
- **Monthly Committee meetings:** local members
- **Quarterly Council meetings:** all members, local and statewide
Family Recovery Council: Who We Are

Agencies and individuals committed to family recovery, including:

- Department of Children and Families (DCF)
- DPH: Bureau of Substance Abuse Services (BSAS)
- Substance Abuse Treatment Providers
- Early Intervention Providers
- Corrections System
- School Systems
- Legal System
- Community-Based Programs
- Mental Health Treatment Providers
- Faith-Based Programs
- Parents/Caregivers in Recovery
Family Recovery Council: Quarterly Council Meetings

Goals:

• To share information and resources: A key presentation at each meeting

• To build working relationships

• To establish best practices for collaboration

• To inform and update on the work of the committees of the council
Family Recovery Council: Communication Committee

• Goal: To establish best practices for smooth collaboration between the child welfare system, treatment providers, and other agencies.

• Best practice recommendations focus on:
  – Referral Process (including signed releases)
  – Substance Abuse Assessment
  – Communication around Ongoing Treatment
  – Collaborative Teamwork (e.g. Safety Planning, Case Conferences, clarifying expectations, discharge planning)
Best Practices in Communication: “Test Drive”

Who’s Involved?

• 3 DCF Units (one unit from each DCF area office in Hampden County)

• Substance Abuse Treatment Providers in Hampden County (self-selected)
Best Practices in Communication: “Test Drive”

Tools Created to Support our Model:

• Brochure for Parents/Caregivers
• Referral Form
• Assessment Form
• Treatment Status Update Form
• Manual
• Summary of Best Practices
Best Practices in Communication: “Test Run”

Implementation Plan:

• Kick-off celebration/training on Nov. 9th
• Ongoing T/A and support
• Leadership Team
• Evaluation (surveys)
• Revise and expand... Hampden County and beyond
Family Recovery Council: Cross-Training Committee

• Goal: To ensure that those who support family recovery better understand the issues involved, thereby improving their own practice and ability to work collaboratively.

• Cross-Training Activities focus on:
  – Training child welfare staff around substance abuse treatment;
  – Training substance abuse treatment providers around child welfare issues, parenting, and family recovery focus;
  – Training others in the “Collaborative Team” around family recovery issues (e.g. legal system, school system, corrections system, faith-based leaders, etc.)
Cross-Training Activities

• Spring conference: June 6, 2012
• DCF Family Recovery Fairs in exchange for Provider Training on DCF
• Trainings on specific issues, such as:
  ▪ Balancing Addiction, Recovery, and Parenting
  ▪ Safety Planning
  ▪ Substance-Exposed Newborns
  ▪ Trauma Informed Treatment
  ▪ Medication Assisted Treatment and Parenting
Family Recovery Council:
Public Relations Committee

• Goal: To promote positive, community-wide messages about family recovery and how to access existing resources.

• Current projects include:
  – Developing brochures for parents (offering support and resources); in multiple languages
  – Developing an informative, engaging website
  – Promoting the importance of family recovery at conferences and other community events
Family Recovery Council: Lessons Learned

• Listen to each other. Tolerating the discomfort of differing points of view builds trust and respect.

• Balance process and product by identifying the problems and then focusing on possible solutions (take action!).

• Being role models of cross-systems partnering by planning, leading, and participating in meetings equally.

• Reinforce common goals and understanding: “Relapse is a recovery AND a safety issue.”

• Each family case provides an opportunity to move cross-systems collaboration forward.
Family Recovery Council: Lessons Learned

- When difficulties happen, work to resolution using supervisors as needed: communicate back and forth
- Communicate praise as success happens: to family, to each other
- Use the lessons learned to inform others within your system: spread the good word
- Buy-in from administration is useful: find the leaders who will support collaboration
- State Agency Regional “Ambassador” Roles: DCF Regional SA Service Coordinator and BSAS Regional Manager help to promote the “Best Practices” model
Family Recovery Council: Lessons Learned

Cross Training needed: separately and together

• Each system needs to learn about the other
• Each system needs to learn from each other
• Each system needs to learn how our systems interact: cyclical process of learning
• Ongoing training needed

Project funded Coordinator is Key to keeping us all on tract!
INTRODUCTION:
A Substance Abuse Safety Plan is defined as: A document that addresses a variety of strategies for mitigating risk to children. It can be incorporated into a current service plan or developed during an emergency response. A Relapse Prevention Plan can be part of the Substance Abuse Safety Plan.

Safety Planning:
• Recognizes families as a valuable resource.
• Empowers them to be involved.
• Encourages families to take responsibility for the safety and well-being of their children.
• Identifies risks to plan around – Past and Present.

Safety Planning is a priority!
• It should be considered a “working document” that reflects the changing reality and support system of the family.
• All family members and identified supports should be aware of the plan and should be willing to follow through with its implementation if the primary caretaker threatens to relapse or a relapse occurs.
• It is very important that the Social Worker regularly review the Safety Plan with the family and update it accordingly.
When to Safety Plan:
• Exposure to other using adults
• Substance abuse related violence in the home
• Chemicals in the home for manufacturing
• Child left alone and/or taken to unsafe areas
• Parent driving under the influence with child in the vehicle
• No food/money/basic needs/unsafe conditions in the home

• Inconsistent discipline
• Child blamed for parental misfortune
• Emotional, verbal, physical & sexual abuse
• Substance abuse & weapons in the home
• Parentification of child

TRIGGERS to plan for:
✓ Sudden increase or decrease of money
✓ Re-uniting with old people, places, things
✓ Hanging around “using” friends
✓ Break-up of a relationship or loss of a loved one
✓ Stopped going to support groups, AA/NA meetings
✓ Anger with Social Worker at service plan
✓ Transportation
√ Availability of drugs
√ Move of residence
√ Living situation
√ Triggers occurring
√ Minimizing
√ Change of lifestyle

NOW WHAT?
1. Does the family believe that the Safety Plan can work? Listen for any hesitation or concerns.
2. Review the Safety Plan regularly.
3. Be sure to give all family members and their supports a copy of the Safety Plan.
4. Assure supports they can contact you with any questions or if they decide to back out of the plan.
5. If/When the plan has been implemented, how did it go? Be sure to debrief and make any modifications to the Safety Plan necessary.

LINKS AND RESOURCES

- Substance Abuse Intranet Site Directions
  1. Select DCF Intranet Home page PPP-Tab
  2. Left hand side select 2nd box “Practice and Policy”
  3. Left hand side select “Integrated Clinical Practice”
  4. Right hand side select “Substance Abuse Unit”
- Signs and Symptoms of Substance Abuse
- Safety Planning Forms
- Safety Planning Guide
Risks of parental substance abuse are well documented and related to some form of child abuse and or neglect. According to the National Center on Addictions and Substance Abuse at Columbia University (CASA 1999), children whose parents abuse substances are 4 times more likely to be neglected, and 3 times more likely to be abused.

Listed Below are Risk Factors and additional Concerns to be aware of that can influence a Safety Plan at any time:

• **A - Physical Health Risks**
  Prenatal substance exposure can be related to a variety of physical health problems, including premature birth, lower birth weight and head size, and other complex medical problems. Newborns may have tremors, irritability, muscle stiffness, inconsolable crying, and problems eating and sleeping. Further medical risks include for Fetal Alcohol Syndrome, Alcohol Related Birth Defects, Alcohol Related Neurological Disorders, and “crib deaths.”

• **B - Lack of Secure Attachments**
  Infants may have an inability to achieve a calm state or to tolerate touch, small amounts of stimulation, or separation from a caregiver.

• **C - Psychopathology**
  Particularly Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, anxiety, depression, and somatic complaints.

• **D - Behavioral Problems**
  Possible poor internal controls, low tolerance for frustration/stress, difficulty delaying gratification, tantrums, aggression, conduct disorder, oppositional defiant disorder.

• **E - Poor Social Skills/Relations**
  Poor social judgment, poor interpersonal skills, aggression, antisocial behavior.

• **F - Cognition/Learning Disabilities**
  Delayed expressive/receptive language development, poor expressive language, and poor memory.
Using substances can get in the way of safely and effectively parenting children. Therefore, I am writing this plan that will help to keep my children safe in the event that I may not be able to avoid using substances.

1. This Safety Plan is prepared for the following child(ren): ______________________________________

2. This Safety Plan has been shared with: ___________________________________________________

3. At this time, I am working towards (please describe efforts):
   - □ Not using any substances
   - □ Maintaining my sobriety
   - □ Keeping my children safe
   - □ Practicing Harm Reduction
   - □ Using occasionally and safely
   - □ Isolation
   - Other: ____________________________________________________________

4. The indicators checked below would alert me of a relapse or a desire to drink/use:
   - □ Depression
   - □ Irritability
   - □ Stress
   - □ Doctors appointment
   - □ Receiving money
   - □ Thinking about drinking/using
   - □ Testing the waters – putting self in risky situations, hanging around using people
   - □ Isolation
   - Other:____________________________________________________________

5. Prior to drinking/using I will:
   - □ Call a sponsor
   - □ Call a friend
   - □ Go to a meeting
   - □ Take a walk
   - □ Play with the kids
   - □ Call my counselor
   - Other ideas:________________________________________________________

6. Identified appropriate friends/family (caregivers) who have agreed to help, by taking my children, during my use:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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7. I will pack an overnight bag for my children to stay with a safe caretaker.

8. I will bring my children to the safe caretaker before I use. If I use before I am able to get my child(ren) to my safe caretaker, I will call my safe caretaker for a ride to their house or I will take a taxi to their house. I will not use substances and drive with my child(ren) in the car.

9. I will leave my children with the safe caretaker until I stop using and am no longer under the influence or detoxing from that substance.

10. I agree that my safe caretaker will refuse to allow me to take my children from their home until I am no longer under the influence of any substances. I agree that this safe caretaker can (call the police and/or my DCF worker), if I try to take the children while I am still using substances or detoxing from the substance.

We will look at this agreement again on ________________, to see how it is working or if the safety plan needs any changes to be made. I will notify my DCF worker if I add or take out any of my designated safe caretakers.

___________________________________________ __________________________________________
Client/Date   SW/Date
TREATMENT TECHNICAL ADVISORY #08

SUBJECT: Enhanced Women’s Services

ISSUED: January 31, 2012

PURPOSE:

The purpose of this advisory is to provide guidance to the field on developing an intensive case management program for coordinating agencies (CA) and their designated women’s programs. It is designed to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

SCOPE:

This advisory impacts the CA and its designated women’s programs provider network.

BACKGROUND:

In 2008, the Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (MDCH/BSAAS) was awarded a four-year grant from the Center for Substance Abuse Prevention (CSAP) to implement the Parent-Child Assistance Program (PCAP), an evidence-based program developed at the University of Washington. PCAP is a three year case management/advocacy program targeted at high-risk mothers, who abuse alcohol and drugs during pregnancy, and their children. The eligibility criteria for PCAP participation is women who are pregnant or up to six-months postpartum, have abused alcohol and/or drugs during the pregnancy, and are ineffectively engaged with community service providers.

Traditional case management services offered through designated women’s programs tend to be for the duration of the woman’s treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician, and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women’s Services are designed to encourage providers to take case management to the next level for designated women’s providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The PCAP model shares the same theoretical basis, relational theory, as women’s specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women’s growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important
aspect of PCAP. The PCAP model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

In September 2009, BSAAS embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing service delivery system from an acute crisis orientation to a long term stable recovery orientation. As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The PCAP model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives clients a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. PCAP also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the PCAP model, and in response to interest in the program by current non-PCAP funded coordinating agencies, this technical advisory has been developed to provide guidance on implementing enhanced women’s services in the state. This technical advisory identifies core components of PCAP needed for implementation of enhanced women’s services, and should be considered as a supplement to the BSAAS Women’s Treatment Policy (BSAAS Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

**Definitions**

**Case Management** – a substance use disorder program that coordinates, plans, provides, evaluates, and monitors services of recovery, from a variety of sources, on behalf of, and in collaboration with, a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

**Community Based** – the provision of services outside of an office setting. Typically these services are provided in a client’s home or in other venues, including while providing transportation to and from other appointments.

**Core Components** – those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.
Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Face-to-Face – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and providers, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Fetal Alcohol Spectrum Disorders (FASD) – an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client’s motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Peer – an individual who has shared similar experiences of parenthood, addiction, or recovery.

Peer Advocate (for Enhanced Women’s Services) – an individual with similar life experience who provides support to a client in accessing services in a community.

Peer Support – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

Recovery – a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being.

Recovery Planning – process that highlight’s and organizes a person’s goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the client.
Substance Use Disorder – a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

RECOMMENDATIONS:

Components Required for Enhanced Women’s Services Programming

1. Any Designated Women’s Program is eligible to offer Enhanced Women’s Services to the target population. Programs choosing to develop an Enhanced Women’s Services program will be required to follow the guidelines of the Women’s Treatment Policy (BSAAS Treatment Policy #12), as well as those outlined in this technical advisory.

2. The Enhanced Women’s Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug-exposed births:
   - The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women’s Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
   - The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
   - The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women’s Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women’s Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women’s Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer
advocate will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women’s Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women’s Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women’s specialty services.

As identified in the Individualized Treatment Policy (BSAAS Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client’s needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements

In addition to the services provided through Women’s Specialty Services, the following are requirements of Enhanced Women’s Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are “lost” or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client’s life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation
challenges. Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged.

14. Develop referral agreement with community agency to provide family planning options and instruction.

15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (BSAAS Treatment Policy #11).

16. Identify clients in Enhanced Women’s Services programming with the “HD” modifier.

Education/Training of Peer Advocates:

Individuals working and providing direct services for Enhanced Women’s Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)
- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)
  *Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)
- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another individual who meets the training requirements and is working within the program.
Documentation is required and must be kept in personnel files. Other arrangements can be approved by the BSAAS Women’s Treatment Coordinator. These hours are an approximation only, and based on P-CAP requirements and consideration of the needs of Michigan’s population.

REFERENCES:


APPROVED BY: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services
SUBSTANCE ABUSE TREATMENT POLICY # 11

SUBJECT:  Fetal Alcohol Spectrum Disorders

ISSUED:  August 24, 2009           EFFECTIVE:  October 1, 2009

PURPOSE:

The purpose of this policy is to establish the process and expectations for the screening and referral of children for Fetal Alcohol Spectrum Disorder (FASD) and the inclusion of FASD prevention in treatment programs that serve women.

SCOPE

This policy impacts coordinating agencies (CAs) and their provider network of treatment programs that serve women and are funded by Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services.

BACKGROUND

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

Each year, as many as 40,000 babies are born with a FASD, costing the nation about $4 billion. The cost to care for an individual with one of the conditions averages $860,000 per year according to Harwood et al, 2003. Some individuals’ care exceeds $4.2 million dollars.

Between fiscal year 2000 and 2004, 50% of Michigan women in treatment reported alcohol as their primary, secondary or tertiary substance of choice. In a recent match of those with a substance use disorder treatment admission and those giving birth in Wayne County; it was found that the average number of days clients were using in the thirty days before entering treatment was 10.33 days. It was also found that there were 2,144 births occurring to the 1,680 women who had a substance use disorder treatment admission. Of these women 48% listed alcohol as their primary substance of choice. When looking at the 2,144 births, 562 of these births were reported to the Michigan Birth Defects Registry with eight having the diagnostic code for FAS (3.7 – 7.8 per 1000 births).

REQUIREMENTS

Substance use disorder treatment programs are in a unique position to have an impact on the FASD problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have
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EFFECTIVE: October 1, 2009

contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services.

FASD Prevention Activities

FASD prevention should be a part of all substance use disorder treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes. It is also recommended that programs who serve men with children, consider providing FASD prevention information.

The IOM Committee to Study Fetal Alcohol Syndrome has recommended three prevention approaches. The universal approach involves educating the public and influencing public policies. The selective approach is targeting interventions to groups that have increased risk for FASD problems such as women of childbearing age that drink. The indicated approach looks at groups who have already exhibited risk behaviors, such as, pregnant women who are drinking or who gave birth to a child who has been diagnosed with FASD. This policy recommends using one of the FASD prevention curriculums for women in the selected or indicated group.

The Center for Disease Control (CDC) funds several organizations to develop and evaluate curricula for varied audiences about FASD. Information on the prevention programs developed can be found on the following websites:

Reducing Alcohol-Exposed Pregnancies Through the Use of Community-Level Guided Self-Change Programs  http://www.cdc.gov/ncbddd/fas/reduce.htm

Project CHOICES (Changing High-Risk Alcohol use and Increasing Contraception Effectiveness Study)  http://www.cdc.gov/ncbddd/fas/choices.htm

Project BALANCE (Birth Control and Alcohol Awareness: Negotiating Choices Effectively)  http://www.cdc.gov/ncbddd/fas/balance.htm

Preventing Alcohol-Exposed Pregnancies in Diverse Populations  http://www.cdc.gov/ncbddd/fas/diverse.htm

Increasing Public Awareness of the Risks of Alcohol Use During Pregnancy through Targeted Media Campaigns  http://www.cdc.gov/ncbddd/fas/pubawareness.htm


Improving Community-Based Fetal Alcohol Syndrome Prevention Efforts Using the Fetal and Infant Mortality Review Methodology  http://www.cdc.gov/ncbddd/fas/improvingprevention.htm
The Substance Abuse Mental Health Service Agency (SAMHSA) through the Center for Substance Abuse Treatment has funded the Fetal Alcohol Spectrum Disorders Center for Excellence. Congress authorized the Center for Excellence in 2000. The purpose of the Center is to:

- Study innovative clinical interventions and service delivery improvement strategies.
- Identify communities with exemplary comprehensive systems of care for such individuals.
- Provide technical assistance to communities to develop comprehensive systems of care.
- Train individuals in service systems dealing with persons and families affected by FASD.
- Develop innovative techniques to prevent FASD.

The FASD Center provides information and lists of resources on its website (www.fascenter.samhsa.org). SAMHSA has produced a video that is free of charge called "Recovering Hope." This video would be a good resource for use during FASD prevention or education sessions.

**FASD Screening**

For any treatment program that serves women, it is required that the program complete the FASD prescreen for children that they interact with during their mother's treatment episode. Substance use disorder clinicians do not need to be able to diagnose a child with any disorder in the spectrum of FASD, but do need to be able to screen for the conditions of FASD and make the proper referrals for diagnosis and treatment. The decision to make a referral can be difficult. When dealing with the biological family, issues of social stigma, denial, guilt and shame may surface. For adoptive families, knowledge of alcohol use during pregnancy maybe limited. The following guidelines were developed to assist clinicians in making the decision as to whether a referral is needed. Each case should be evaluated individually. However, if there is any doubt, a referral to a FASD Diagnostic Clinic should be made.

The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral:

- When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed.
- When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the primary care physician should document exposure and monitor the child for developmental problems.
- When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation for any one of the following:
  - Any report of concern by a parent or caregiver that a child has or might have FASD
  - Presence of all three facial features
  - Presence of one or more facial features with growth deficits in weight, height or both
  - Presence of one or more facial features with one or more central nervous system problems
  - Presence of one or more facial features with growth deficits and one or more central nervous system problems
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• There are family situations or histories that also may indicate the need for a referral for a diagnostic evaluation. The possibility of prenatal exposure should be considered for children in families who have experienced one or more of the following:
  - Premature maternal death related to alcohol use (either disease or trauma)
  - Living with an alcoholic parent
  - Current or history of abuse or neglect
  - Current or history of involvement with Child’s Protective Services
  - A history of transient care giving institutions
  - Foster or adoptive placements (including kinship care)

The attached Fetal Alcohol Syndrome (FAS) Pre-Screen Form can be used to complete the screening process. It also lists the Fetal Alcohol Diagnostic Clinics located in Michigan with telephone numbers for easy referral. These clinics complete FASD evaluations and diagnostic services. The clinics also identify and facilitate appropriate health care, education and community services needed by persons diagnosed with FAS.

REFERENCES


APPROVED BY: [Signature]
Deborah J Hollis, Director
Bureau of Substance Abuse and Addiction Services
Michigan Department of Community Health  
Fetal Alcohol Spectrum Disorders Program  
FETAL ALCOHOL SYNDROME (FAS) PRE-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This form is not intended to take the place of a diagnostic evaluation.

FACIAL FEATURES

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Sex:</th>
<th>Male</th>
<th>Female</th>
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<tbody>
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<td></td>
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Address: 

City/State/Zip code: 

Parent/Caregiver Name(s): 

Home Phone: 

<table>
<thead>
<tr>
<th>Bio</th>
<th>Foster</th>
<th>Adopted</th>
<th>Other</th>
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</thead>
<tbody>
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</table>

Work Phone/Cell: 

If 2 or more of the identifiers listed below are noted, the individual should be referred for a full FAS Diagnostic Evaluation.

<table>
<thead>
<tr>
<th>IDENTIFIERS</th>
<th>Check or explain if a concern exists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Height and weight seem small for age</td>
<td></td>
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<tr>
<td>2. Facial features (See diagram above)</td>
<td></td>
</tr>
<tr>
<td>3. Size of head seems small for age</td>
<td></td>
</tr>
<tr>
<td>4. Behavioral concerns: (any one of these qualifies as an identifier)</td>
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<tr>
<td>- Sleeping/eating problem</td>
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<tr>
<td>- Mental retardation or IQ below familial expectations</td>
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<tr>
<td>- Attention problem/impulsive/restless</td>
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<tr>
<td>- Learning disability</td>
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<tr>
<td>- Speech and/or language delays</td>
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<tr>
<td>- Problem with reasoning and judgment</td>
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<tr>
<td>- Acts younger than children the same age</td>
<td></td>
</tr>
<tr>
<td>5. Maternal alcohol use during pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

Any previous diagnosis: ____________________________________________

Screener ___________________________ Agency ______________________

Contact the nearest center to schedule a complete FAS diagnostic evaluation.

FAS DIAGNOSTIC CENTERS IN MICHIGAN

Detroit: 313-993-3891  Kalamazoo: 269-387-7073
Education on fetal alcohol syndrome/fetal alcohol spectrum disorders provided at women’s publicly funded treatment centers in the state of Michigan

O’Connor, B.C., Ehrhardt, J., Trepanier, A.

May 8, 2011
I. Abstract

Fetal alcohol spectrum disorders are the leading cause of preventable birth defects, neurobehavioral, and developmental abnormalities in the United States. Despite efforts to provide education to the general population about the risks of maternal alcohol use during pregnancy the prevalence has remained constant through the past few years with fetal alcohol syndrome in the United States reported to occur in 0.5 to 2 per 1,000 live births. The prevalence of fetal alcohol syndrome in Michigan is estimated to be 3.7 – 7.8 per 1,000 live births. Different methods for reducing the risk for alcohol-exposed pregnancies have been evaluated with a prominent one involving a motivational interviewing technique. The state of Michigan’s Bureau of Substance Abuse and Addiction Services issued a policy in 2009 (BSAAS policy) requiring all women’s publicly funded treatment centers to provide fetal alcohol spectrum disorder education to the women seeking services at the centers. This is the first study to review the policy’s implementation. All coordinating agencies and treatment centers in the state of Michigan were surveyed to determine what education policies they use, in what form education is being provided, and in what areas they could use assistance in education and counseling. The total number of usable responses received from the survey was 18 out of 42, (42.9% response rate). Eighty percent of respondents were familiar with the BSAAS policy with over half applying it at their center. The format in which the information was provided varied between each center with one third using individual and group counseling and a little less than a quarter of the centers providing
Education on fetal alcohol syndrome/fetal alcohol spectrum disorders provided at women’s publicly funded treatment centers in the state of Michigan

fact sheets. The majority of centers stated that having more client appropriate educational materials regarding the risks of alcohol-exposed pregnancies would be the most beneficial resource for enhancing education to the women receiving treatment at their center.

II. Background

Fetal Alcohol Spectrum Disorders

Alcohol has a teratogenic effect on the developing fetus, particularly the fetal central nervous system (Carmona, 2005; Floyd, et al., 2007; Mattson, Schoenfeld, & Riley, 2001). Alcohol has been shown to cross the placenta with the fetal blood alcohol level similar to that of the mother’s (Mengel, Searight, & Cook, 2006). The effects alcohol can have in pre- and post-natal development vary depending on when the exposure occurred in gestation, the amount of alcohol consumed and the length of alcohol consumption. Lifelong effects seen in children exposed to alcohol in-utero can include physical, mental, behavioral, and/or learning disabilities (Carmona, 2005; Fabbri, Farrell, Penberthy, Ceperich, & Ingersoll, 2009; Ingersoll, Floyd, Sobell, & Velasquez, 2003; Mattson, et al., 2001). The term fetal alcohol spectrum disorders (FASD) is used to describe the range of symptoms that can present in alcohol-exposed pregnancies. The most severe classification of individuals exposed prenatally to alcohol is called fetal alcohol syndrome (FAS). The three main diagnostic criteria for FAS are (1) growth deficiency seen in overall height and microcephaly, (2) central nervous system disorders,
Education on fetal alcohol syndrome/fetal alcohol spectrum disorders provided at women’s publicly funded treatment centers in the state of Michigan

Bridget O’Connor
May 9, 2011

and (3) distinctive facies (Mattson, et al., 2001). The central nervous system disorders of FAS can present as lifelong cognitive defects and behavioral problems. The cognitive defects involve language skills, visual-spatial functioning, fine motor behavior, nonverbal learning, executive functioning tasks and academic performance. Behavior problems in children with FASD typically include maladaptive behavior, psychiatric disorders, hyperactivity, poor socialization and communication skills. Many of the behavior problems interfere with tasks at home, school and in other social settings (Mattson, et al., 2001).

The prevalence of fetal alcohol syndrome in the United States has been reported to be 0.5 to 2 cases per 1,000 live births (Center for Disease Control and Prevention, 2009; Floyd, O’Connor, Bertrand, & Sokol, 2006). The clinical criteria used to establish a diagnosis of FAS vary and contribute to this range. The prevalence of fetal alcohol spectrum disorder is estimated to be three to four times greater than FAS, with most cases undiagnosed (Center for Disease Control and Prevention, 2009; Fabbri, et al., 2009).

Alcohol-Exposed Pregnancies

Since alcohol is a controllable substance, fetal alcohol spectrum disorders are considered the leading cause of preventable birth defects, neurobehavioral, and developmental abnormalities in the United States (Fabbri, et al., 2009; Floyd, Weber, Denny, & O’Connor, 2009; Ingersoll, et al., 2003; Tsai & Floyd, 2004). Many women do not realize they are pregnant until well into the first trimester, and as such may
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unknowingly expose a fetus to alcohol during a critical period of fetal development. It has been reported that 50% of women discontinue alcohol use once they realize they are pregnant; however some women continue to drink (Fabbri, et al., 2009; Floyd, et al., 2007; Tsai, Floyd, Green, & Boyle, 2007). Between 9% and 12% of pregnant women reported consuming any alcohol and 1.9% - 3% have reported binge drinking while pregnant (Anderson, Ebrahim, Floyd, & Atrash, 2006; Floyd, et al., 2006; Floyd, et al., 2009; Mengel, et al., 2006; Tsai, et al., 2007). The Behavioral Risk Factor Surveillance System defined any alcohol use as one drink per occasion and binge drinking as five or more drinks per occasion (Anderson, et al., 2006; Ingersoll, et al., 2003; Tsai & Floyd, 2004; Tsai, et al., 2007). The Behavioral Risk Factor Surveillance System found approximately 55% of women of childbearing age [18-44 years] who are not pregnant report consuming any alcohol and 13% report binge drinking (Anderson, et al., 2006; Floyd, et al., 2006; Floyd, et al., 2009; Tsai, et al., 2007), placing them at risk for exposing a pregnancy to alcohol, especially if the pregnancy is unrecognized. Of note, the reports of women who partake in binge drinking may actually be an underestimate. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) in 2004 approved the definition of binge drinking for women to be 4 drinks per occasion (Roa, 2004).

Interventions

In an attempt to help reduce the number of alcohol-exposed pregnancies, the Surgeon General in 2005 issued an advisory on alcohol use in pregnancy. The advisory urged all pregnant women and women planning to become pregnant to refrain from
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consuming any alcohol while pregnant (Carmona, 2005). The Surgeon General also stated that all health professionals should routinely inquire about alcohol consumption by women of childbearing age and provide them with information on the risks during pregnancy (Carmona, 2005).

A few studies have been conducted to determine effective ways to reduce alcohol consumption in women of childbearing age. A pilot study conducted in 2003 by the group Project CHOICES (Changing High-risk Alcohol Use and Increasing Contraception Effectiveness Study) tested the feasibility and impact of motivational interviewing to reduce drinking and/or increase effective contraception in women of childbearing age at risk for an alcohol exposed pregnancy (Ingersoll, et al., 2003). [Note: It is out of the scope of this study to examine contraception use and effective interventions.] At-risk women were described as drinking at risk levels [>7 drinks per week or >1 binge drinking episode (>5 drinks in a single day)], sexually active and not using contraception effectively. The intervention applied in this study involved four motivational interviewing counseling sessions and one contraception counseling session. The motivational interviewing counseling style is a client-centered approach that aims to motivate women by giving personalized feedback about risk, discussing ambivalence towards change, and addressing any disparity between goals and current lifestyle (Ingersoll, et al., 2003). The study used this counseling style when presenting the FASD and contraception information to the women at risk. The study was conducted in six community-based settings with high proportions of women at risk for
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alcohol-exposed pregnancies in three different cities. The results showed that the motivational interviews and contraception counseling were effective and feasible. Of the women who completed the six month follow up, approximately 69% satisfied at least one of the criteria for successful change. Of these individuals, about 13% reduced their drinking alone, about 23% reduced their risk with effective contraception use and about 33% reduced their risk through both measures. Only 32% of the women at the six month follow up remained at risk for an alcohol-exposed pregnancy. The study also reported that the success of the women in reducing their risky behaviors was not dependent on the women attending all four sessions. The study concluded that a brief motivational intervention can be integrated into primary care settings to help with early intervention and treatment options.

Floyd, et al., (2007) conducted a study to validate the Project CHOICES interventions (Ingersoll, et al., 2003) using a randomized control trial. In this study, half of the nonpregnant women at risk for an alcohol-exposed pregnancy were randomly assigned to an education only intervention. The other half was randomly assigned to a brief motivational intervention group. The motivational intervention used was based on the Project CHOICES study (Ingersoll, et al., 2003). Floyd, et al.,(2007) found that women in both the education only group and the intervention group did reduce their risk over the nine month follow-up. Of the women in the education only group 54.3% were reported to reduce their risk for an alcohol-exposed pregnancy, and of the women who were randomly assigned to the intervention group 69.1% were reported to reduce
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their risk. However the odds of having a reduced risk for an alcohol-exposed pregnancy was more than double for the women who received the motivational interview intervention as compared to the education only group. The investigators therefore concluded that a brief motivational intervention, resembling the Project CHOICES intervention (Ingersoll, et al., 2003), was feasible and most importantly able to reduce the risk of alcohol exposed pregnancies (Floyd, et al., 2007).

*The State of Michigan Substance Abuse Services*

Every year in the United States as many as 40,000 babies are born with fetal alcohol spectrum disorder, costing the nation $4 billion. The cost per individual with FASD is approximately $860,000 per year with total lifetime costs estimated to be $2 million (Bureau of Substance Abuse and Addiction Services, 2009b; Floyd, et al., 2006). In Michigan between the fiscal year 2000 and 2004, there were 2,144 babies born to women who were admitted to a treatment center with a substance use disorder [note: this is any type of substance use, not limited to alcohol, although 48% of women reported alcohol as their primary substance of choice] (Bureau of Substance Abuse and Addiction Services, 2009b). Five hundred and sixty-two of these 2,144 babies were reported to the Michigan Birth Defects Registry, eight with the diagnostic code for fetal alcohol syndrome, resulting in a prevalence of fetal alcohol syndrome in Michigan of 3.7 – 7.8 per 1,000 births (Bureau of Substance Abuse and Addiction Services, 2009b).

In 1999, Michigan established the Fetal Alcohol Syndrome Program. The goals of this program were to reduce the number of children born in the state with FAS, to
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provide timely diagnosis, and to assist those diagnosed with the support needed (Michigan Department of Community Health, Health, & Program, 2009). In this initiative, the state designated five Centers of Excellence for the diagnosis of fetal alcohol spectrum disorder and care planning of affected children and adults (Michigan Department of Community Health, 2009; Michigan Department of Community Health, et al., 2009).

In 2005, a State FASD Taskforce was developed to help address the current issues with prevention and fetal alcohol spectrum disorder services. One of the taskforce’s objectives was to collaborate with substance abuse treatment services in order to inform women at risk for an alcohol exposed pregnancy about the risks of FASD statewide (Michigan Department of Community Health, et al., 2009). Currently there are a total of 16 coordinating agencies for substance abuse in the state of Michigan (Bureau of Substance Abuse and Addiction Services, 2009c). The coordinating agencies have the task of providing an appropriate case management program that will aid in coordinating, planning, providing, evaluating and monitoring services for a client with a substance abuse disorder (Office of Drug Control Policy, 2008). Women’s substance abuse programs were recognized as an area for prevention services by the Taskforce; there are 49 designated local women’s programs throughout the state (Bureau of Substance Abuse and Addiction Services, 2009a).

The Bureau of Substance Abuse and Addiction Services (2009b) created a policy for substance abuse treatment centers that requires these programs to include fetal
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Alcohol spectrum disorder prevention as a routine service provided to at-risk women. Prevention should include education on the risks of drinking while pregnant, fetal alcohol spectrum disorder detection, and the services available for children with FASD and their families. The programs are also required to follow up on children born to women who have used alcohol. These children are to be screened for FASD and referred for further diagnostic services if needed.

In summary, fetal alcohol spectrum disorders represent a common, preventable group of disorders and as such are an important public health concern. To reduce the number of alcohol exposed pregnancies and the subsequent incidence of FASD, more interventions need to be provided to at-risk women of childbearing age. A few studies have evaluated the effectiveness of various interventions for prevention of alcohol-exposed pregnancies (Center for Disease Control and Prevention, 2003; Floyd, et al., 2007; Ingersoll, et al., 2003). Data is lacking regarding how interventions are actually being implemented. With the Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services’ policy (2009b), a framework was created for treatment centers to model their polices on education about fetal alcohol spectrum disorder. To date there has been no systematic review of if and how this policy has been implemented. The purpose of this study is to assess whether the women’s publicly funded substance abuse treatment centers and coordinating agencies in the state of Michigan are aware of the BSAAS policy, to determine whether they are implementing this policy or alternative educational policies, to identify in what formats education is
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provided to at-risk women, and to identify areas where assistance with education and counseling is needed.

III. Methods

A survey was developed to send to the women’s publicly funded substance abuse treatment centers in the state of Michigan. The survey consisted of a total of 33 questions that contained both open-ended and multiple-choice questions. A subset of these questions (12 in total) was optional. These were opened ended questions that allowed respondents to elaborate on their answers to previous questions if desired. The survey included questions regarding the knowledge and use of the MDCH BSAAS policy, what type of client education regarding FASD was provided, whether services to screen children were available, information on those providing the FASD education, and what FASD prevention resources were available to the centers. Additionally demographic questions about the treatment centers and the population of women served were included. The survey was piloted on two individuals unfamiliar with the MDCH policy or with fetal alcohol spectrum disorder in general. The survey was edited based on these individuals’ suggestions and a final web-based version was created.

The study population consisted of the 16 coordinating agencies and 49 local women’s treatment programs in the state of Michigan that were designated as the publicly funded centers by the Michigan Department of Community Health. Coordinating agencies were included in the study since they support the treatment
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centers, and therefore should have a good idea of the treatment centers’ FASD policy.

Each agency/center was contacted by telephone in order to identify the person most familiar with FAS education and to obtain this individual’s contact information and email address. Once the contact list was developed, an invitation to participate, with a link to the web-based survey and a study information sheet, was emailed to potential participants. Follow-up emails were sent at two and four weeks after the initial invitation. A tracking system was implemented to determine which centers had not yet completed the survey and required the additional follow up. The survey contained a question about which center was completing the survey; this information was used for tracking purposes only and was deleted from the data set once the survey was closed. Descriptive statistical methods were used to analyze the data. This study was approved by both the Michigan Department of Community Health Institutional Review Board and the Wayne State University Human Investigation Committee.

IV. Results

All 16 coordinating agencies and 49 treatment centers in the state of Michigan were contacted. Of the coordinating agencies, six agencies were not reached or if reached, contact information was not provided (Table 1). In contacting the treatment centers, six of the listed centers did not have working telephone numbers. One treatment center and one coordinating agency each provided two individuals at their centers to contact. There were also two individuals who manage two treatment centers
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each, managing a total of four treatment centers. Two of the coordinating agencies had additional programs that provide information on FASD/FAS to women and an individual from each of these programs was invited to participate in the survey. With some treatment centers no longer available, not being able to contact all centers/agencies, and the addition of the new programs, the total number of invitations to participate that were issued was 42.

A total of 22 surveys were collected after a four week follow up email was sent; however two surveys did not contain any responses. Thus the response rate was 47.6% (20/42). Two respondents only completed the first two questions, which reduced the number of usable responses to 18 (42.9% of the sample).

Of those participating in the survey, 44.4% of respondents provided the FASD/FAS education themselves (Table 2). Over half of the respondents also received certification for their job (Table 2). A large portion of the respondents reported working in their current position for 20-30 years; Figure 1 shows the distribution of year’s experience.

The number of women served per month and the demographic profiles of these women varied between centers. Five centers (27.8%) serve between 20 and 50 women in a month and one center (5.6%) serves over 200 women a month (Figure 2). Figures 3-6 describe the demographic profile of the women seeking services, including races/ethnicities, ages, education level, and health insurance coverage. White women were the largest ethnic/racial group served at the treatment centers (Figure 3). The
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majority of the women receiving treatment were between 36 and 45 years of age (Figure 4) and had some college background (Figure 5). Medicaid was the most common payment method reported by the treatment centers (Figure 6).

To understand how the MDCH BSAAS policy is being implemented, agency/center representatives were asked how familiar they were with the policy and then whether they utilize it. Eighty percent stated they were familiar with the policy (16/20) and 58% (11/19) reported that they followed the policy at the center. Four of 19 (21.1%) respondents stated they were unsure if the policy was followed at the center, while the other four (21.1%) stated they did not follow it. One respondent that stated they did follow the policy further explained that the MDCH BSAAS policy had been adapted to create a center specific policy. Two respondents (one who reported the policy was not followed and one who reported they were not sure if the policy was followed) stated they were coordinating agencies and therefore could not correctly answer the question but that their treatment centers should be following the policy. Participants were then asked about the FASD/FAS curriculum provided for the women seeking services. Fifty percent (9/18) of the respondents stated they used the MDCH BSAAS recommended curricula, 22.2% (4/18) developed their own curriculum [one that was adapted from the MDCH BSAAS recommendations], and 5.6% (1/18) that did not follow a specific curriculum. One center stated they used the curriculum provided by the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), called Recovering Hope.
Participants were next asked questions about how FASD/FAS prevention education is provided to the women. In asking how the women seeking services at the center are identified as requiring FASD education, 33.3% (6/18) stated that all women receive education. A large number of centers also identify women through screening and assessment (5/18; 27.8%). The other responses included the use of a questionnaire (1/18; 5.6%) and from referring workers (1/18; 5.6%). Those identified as requiring FASD education are distributed fairly equally among many life stages including, before pregnancy (12/18; 66.7%), during pregnancy (14/18; 77.8%), and after childbirth (13/18; 72.2%). With regard to when during the treatment program information about FASD/FAS is provided, approximately 33% (6/18) reported that information is given at the time of first admittance, 22.2% (4/18) at a follow-up session, 11.1% (2/18) were not sure, and 55.6% (10/18) responded ‘other.’ Other responses included individual counseling sessions, group counseling sessions, at intensive outpatient services, and throughout the treatment regimen. For 44.4% (8/18) of the centers, this information is included as part of the treatment which therefore assures it is given. Two of the centers (11.1%) reported that the information is provided only if deemed necessary. Two other centers (11.1%) stated they were unsure that there was any verification that the information was given before the women were discharged.

The format in which the FASD/FAS education is provided to the women varied at each treatment center. The two most common formats were individual counseling sessions and fact sheets (each with 4/18; 22.2%). The other formats included group
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Counseling sessions (3/18; 16.7%) and media formats such as CDs and videos (5/18; 27.8%). All three centers that provide group counseling also use individual counseling. Of the five centers that use a media format, three of them use the media format as the only source of information provided. For the remaining two centers, one also uses individual counseling and the other provides a fact sheet and has signs located throughout the building.

The job classifications of those who are providing the FASD/FAS education varied between centers (Table 3). Therapists were identified as the individuals who provide this information most frequently across all treatment centers (4/18; 22.2%). The training provided to these individuals also varied between the treatment centers. Four centers use accredited sources, such as the Southeast Michigan Community Alliance (SEMCA) and Michigan Department of Community Health, two centers provide formal training through a trainer, and one stated that they are given general knowledge. Table 4 shows the distribution of training and requirements.

The MDCH BSAAS policy includes a requirement that treatment centers with access to the children of the women seeking services provide screening for FASD and referral to diagnostic centers if necessary. Therefore, participants were asked whether this was being done at their centers. One third (6/18) were screening the children of the women seeking services at their center and another one third of the centers (6/18) were not doing so. Three centers were unsure if this was being done and one reported that children were rarely seen at their center. In asking if the children who screened
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Positive were referred to a diagnostic center in the state, 50% (9/18) of the centers, including some centers that did not indicate screening children, reported referring the children for a diagnostic evaluation, 16.7% (3/18) were not referring the children for further evaluation, since they were also not screening them. Additionally, 16.7% (3/18) reported not knowing if referrals are made; one center stated they have never had a positive screen, another center reported not having the proper training to screen the children and the third center reported that referrals were made but not kept since appointments at the diagnostic centers were difficult to make due to long waiting periods or being turned down.

Lastly the survey inquired about the center’s resources to provide the education to the women seeking treatment. In asking about the perceived barriers the most common responses were limited time (10/18; 55.6%) and limited educational materials (9/18; 50%). Other responses included funding (5/18; 27.8%), limited knowledge of FASD/FAS (4/18; 22.2%) and limited staff (3/18; 16.7%). Participants were also asked what resources the centers thought would be most helpful in providing education to the women. The majority of centers responded that client educational materials would be the most helpful (15/18; 83.3%). Staff training programs (9/18; 50.0%) and more time in treatment (7/18; 38.9%) were also reported as important resource needs. Specifically the centers requested more client friendly and up-to-date materials in video formats and fact sheets. Participants indicated that it would be important for these materials to be free and easy to access. Two centers also requested speakers with personal
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experience with FASD. One center recommended an increase in community education with FASD information provided on the radio and in television.

V. Discussion

The Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services created a framework in 2009 for treatment centers to model their policies for client education on fetal alcohol spectrum disorders. This is the first study to review the policy’s implementation. The great majority of the responding coordinating centers and treatment centers were familiar with this policy and over half followed the policy at their center or modified it to fit their center’s needs. Centers are not required to use the curriculum included in the policy, however, they are required to provide women seeking services education on fetal alcohol spectrum disorder, prevention of FASD, and resources for individuals with FASD.

The fetal alcohol spectrum disorder education that is provided by treatment centers varied in terms of in what format it was provided and when during treatment it was provided. A subset of centers (27.8%) provided the FASD information in an educationonly format, while a larger subset (33.3%) used a counseling format. The Bureau of Substance Abuse and Addiction Services 2009 policy does not require one particular method to be used but instead encourages the centers to focus the curriculum for the women based on their particular characteristics. The BSAAS policy offers seven different formats to serve as models that vary based on the characteristics...
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of the client. These different formats are aimed at different target groups. For instance, one model is designed for women who are not alcohol-dependent but are problem drinkers, another model is aimed at women between 18 and 24 years of age who are moderate to heavy drinkers and an additional model emphasizes education to the general population via a media campaign for communities with a diverse population of women seeking services. The policy does not specifically state any use of motivational interviewing techniques as part of the curriculum (Center for Disease Control and Prevention, 2009), although the MDCH Office of Drug Control Policy (2006) emphasizes the importance of individualizing the treatment and counseling service to the needs of the client. Both education only and individual counseling were proven to be effective in reducing the risk for alcohol-exposed pregnancies as demonstrated in the Project CHOICES study (Floyd, et al., 2007; Ingersoll, et al., 2003). Of note, the Project CHOICES study did not investigate group counseling methods versus education only methods. Therefore no conclusions can be drawn on the effectiveness of this format alone. The most important aspect in reducing alcohol-exposed pregnancies was that the FASD prevention information was provided, which the large majority of publicly funded treatment centers in the state of Michigan surveyed report doing.

In asking where centers felt more support was needed, the large majority stated a need for client education materials on FASD. For many centers there is limited funding for the women seeking treatment and the amount of time spent in treatment is relatively short. These issues combined with the fact that client educational materials
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may be outdated or written at levels not appropriate for the women, contributes to difficulty in providing such information. Having up-to-date fact sheets, videos on CD/DVD and/or other media resources could help satisfy this need. Such resources would have to be easy to access and available at no cost to the center. Despite the stated need for such materials, no study to date has looked at the effectiveness of these client educational materials. These materials may aid the centers with the funding issue and the limited amount of time in treatment but may actually not be the most effective resource to reach those at risk for an alcohol-exposed pregnancy.

In addition, to assure that all those providing FASD education are giving the most current information, staff training programs should be offered. These staff training programs were requested by half of the survey respondents. The training program should not only cover information on FASD education and prevention but may also consider including instruction on motivational interviewing, particularly for the centers that provide individual counseling. As revealed in the Project CHOICES study (Floyd, et al., 2007; Ingersoll, et al., 2003), this technique is easy to implement and does not require multiple sessions with the women to be effective. In the Project CHOICES study, the individuals providing the information and using motivational interviewing techniques were all masters-level or above counselors who were specially trained by experienced motivational interviewing trainer (Ingersoll, et al., 2003). Soderlund, Madson, Rubak and Nilsen (2010) reviewed the studies that involve motivational interviewing training. Soderlund, et al., (2010) report the average length of training was
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nine hours, ranging from a 20-minute video to a two-day workshop. Training typically involved the basic motivational interviewing skills, recognizing and reinforcing talk on change, and discussion of resistance (Soderlund, et al., 2010). This training can be applied to many different types of health care related needs with alcohol abuse being the original use for such a style. There are potential barriers in applying this type of training for the providers in the state of Michigan that should be carefully considered. One such barrier may be the availability of an experienced motivational interviewing trainer. There may be a limited number of individuals who are capable of providing training in the state and may have a limited amount of time to do so. Additionally, the Project CHOICES study’s counselors had a minimum of a master’s level education, while the providers in the state of Michigan may not have this level of educational background. Most FASD providers appear to have a master’s level education, but some do not, therefore more information on the educational qualifications of this training must be considered in determining the most appropriate course.

Despite the policy requirement for FASD screening of children of the women receiving treatment, many treatment centers reported not doing this. The policy states that the treatment centers, which have contact with the children, are to screen them for FASD and refer them for further diagnostic services if appropriate. This study did not specifically inquire as to how many centers have contact with the children. Obviously, if screening is not done and referrals are not provided then these children may go unidentified and therefore not receive the appropriate interventions.
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looked at intervention methods for individuals with FASD (Bertrand, 2009; Paley & O’Connor, 2009). Historically, the intervention methods applied to individuals with FASD have been adapted from those used for individuals with other disabilities. Unfortunately, this has not been the most effective intervention strategy for individuals with FASD (Bertrand, 2009). Interventions that focus on the specific cognitive deficits and behavioral problems in FASD have been shown to have greater efficacy. Additionally, early interventions have been shown to have a greater positive effect on the brain damage seen in individuals with FASD (Paley & O’Connor, 2009). Therefore it is vital for the children at risk to be screened and referred for diagnostic evaluation. The fact that one center, which is screening and referring children, reports long delays in getting the children into diagnostic centers for evaluation, reveals a lack of resources at many levels.

This study investigated the publicly funded treatment centers and coordinating agencies in the state of Michigan and the implementation of a state policy. This is the first study of its kind. Therefore the study findings are specific to the centers in the state of Michigan and may not be applicable to treatment and coordinating centers in other states. The Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services policy was not compared to other state policies, therefore we are not able to determine how applicable the findings of this study are to the policies and practices in other states.

Study Limitations
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A limitation of this study is the participation rate. Responding centers may be different than non-responding centers in important ways. For instance, it may be that those unfamiliar with the MDCH BSAAS policy or who do not follow it were less likely to participate. Additionally, since both treatment centers and coordinating agencies were invited to take the survey, the data may be biased. This is inherent in that the coordinating agencies are not directly involved in providing treatment and therefore may not be completely familiar with the policies and specifics of the education that the treatment centers provide. The assumption that coordinating agencies have an understanding of the treatment centers’ FASD policy and curricula may not be valid.

Conclusions

This is a study of the current knowledge and practice of publicly funded substance abuse treatment centers in the state of Michigan regarding the provision of fetal alcohol spectrum disorder education to women at risk for an alcohol-exposed pregnancy and services to children at risk of FASD. The majority of respondents report being aware of the Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services 2009 policy. The respondents report providing FASD prevention information consistent with the policy to the women seeking treatment at their center, though a large majority of respondents report not screening children for FASD. Many treatment centers report barriers to providing this education and state the need for more client appropriate materials. Barriers to referral of children at risk for FASD to diagnostic centers were also identified.
Future Directions

This study investigated the implementation of a state policy supporting FASD prevention; there are also federal policies in place. Since no study of another state’s policy on women’s substance abuse treatment services has been reported, the needs and issues stated here are specific to Michigan. More studies can be conducted to better understand the impact of these different policies on risky drinking behavior in women of childbearing age and the occurrence of FASD in different states or areas of the country. This would provide a greater understanding of where further resources are required at both a state and federal level. Furthermore, this study did not look at the effectiveness of the Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services policy in providing patient care and preventing FASD. Further studies to investigate whether the implementation of this policy is reducing the incidence of alcohol-exposed pregnancies are needed. More specifically, studies that investigate the most effective way to educate women about the risks of alcohol in pregnancy are needed. The large investment required for the creation of public service announcements, fact sheets and educational videos, underscores the importance of understanding how to make such resources effective in achieving stated objectives, such as reduction in FASD. We found no studies that have evaluated the effectiveness of different types of FASD educational materials (e.g., fact sheets, videos, websites). As demonstrated, group counseling, education only and individual counseling sessions, along with a combination of these were used widely by the treatment centers in the
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state. Therefore future studies should be done to understand the efficacy of these formats and their various combinations. Since many of the centers report limited time in treatment, understanding the most efficient and effective method of providing the FASD prevention education would be critical to creating policies that would maximize the reduction of alcohol-exposed pregnancies.
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Tables and Figures

Table 1. Survey Invitations Sent

<table>
<thead>
<tr>
<th></th>
<th>Contact Information Provided</th>
<th>No Response</th>
<th>Disconnected Numbers</th>
<th>Additional programs</th>
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<tbody>
<tr>
<td>Coordinating Agency</td>
<td>10/16 (62.5%)</td>
<td>6/16 (37.5%)</td>
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<td>--</td>
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<td>Treatment Center</td>
<td>27/49 (55.1%)</td>
<td>17/49 (34.7%)</td>
<td>6/49 (12.2%)</td>
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<tr>
<td>Total</td>
<td>37/65 (56.9%)</td>
<td>23/65 (35.4%)</td>
<td>6/65 (9.2%)</td>
<td>42/65 (64.6%)</td>
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</tbody>
</table>

Designated coordinating agencies and local women’s treatment programs were contacted by telephone to obtain contact information and email address for those most familiar with FAS education at the center/agency.

Table 2. Respondents Providing FASD/FAS Education

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
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<tbody>
<tr>
<td>Provide education yourself</td>
<td>8/18 (44.4%)</td>
<td>7/18 (38.9%)</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Received certification</td>
<td>11/18 (61.1%)</td>
<td>2/18 (11.1%)</td>
<td>5/18 (27.8%)</td>
</tr>
</tbody>
</table>

Figure 1. Years Experience of Respondent

NR = No Response
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**Figure 2.** Number of Women Served per Month

<table>
<thead>
<tr>
<th>Number of Women Served/Month</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>&lt;20</td>
<td>16.75%</td>
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<tr>
<td>20-50</td>
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<tr>
<td>51-100</td>
<td>0%</td>
</tr>
<tr>
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<tr>
<td>&gt;200</td>
<td>5.60%</td>
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<tr>
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<td>44.40%</td>
</tr>
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</table>

N/A = Not Applicable
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**Figure 3. Races and Ethnicities Served at the Centers**

The race/ethnic groups are color coordinated (White – blue, Black/African American – red, Hispanic – green, and Other – purple). Participants were able to pick the proportion served at their center (X-axis). The Y-axis demonstrates those most served. Therefore more centers have 1-20% of all race/ethnic group. The individual breakdown of the columns demonstrate the actual proportion reported to be served in that population. For instance, the White race is served at two treatment centers (11.1%) as 1-20% of the women. The Black race is served at five treatment centers (27.8%) as 1-20% of the women.
Figure 4. Age Group of Women Served at the Centers

The proportion of age groups served are color coordinated (1-20% – blue, 21-40% – red, 41-60% – green, 61-80% – purple, and 81-100% -bright blue). Participants were able to pick the proportion served at their center. The X-axis shows the age groups. The Y-axis demonstrates those most served. Therefore six centers (33.3%) report 18-20 year olds to be 1-20% of their population. Two centers (11.1%) report 18-20 year olds making 21-40% of their population. And two centers (11.1%) also report 21-35 year olds to make up 61-80% of their population.
Education on fetal alcohol syndrome/fetal alcohol spectrum disorders provided at women’s publicly funded treatment centers in the state of Michigan

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**Figure 5. Education Levels of Women**

The proportion of education levels of the women served are color coordinated (Never finished high school – blue, high school – red, GED – green, Some college – purple, and college/graduate school – bright blue). Participants were able to pick the proportion served at their center (X-axis). The Y-axis demonstrates those most served. Therefore nine centers (50%) report 1-20% of their population of women served to have some college. Three centers (16.7%) report 1-20% of their population having never finished high school. And two centers (11.1%) also report 81-100% of their population to have never finished high school.
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Figure 6. Health Insurance Payment

The proportion of health insurance payment of the women served are color coordinated (Medicaid – blue, Medicare – red, Private – green, Out of pocket – purple, and Other – bright blue). Participants were able to pick the proportion served at their center (X-axis). The Y-axis demonstrates those most served. Therefore two centers (11.1%) report 1-20% of their population served to use Medicare. Four centers (22.2%) report 81-100% of their population using Medicaid. And three centers (16.7%) also report 0% of their population using Medicare, Private insurance and out of pocket payment.
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Table 3. Job Classification of Those Providing FASD Education

<table>
<thead>
<tr>
<th>Job Classification</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>4/18 (22.2%)</td>
</tr>
<tr>
<td>Physician</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Master level staff</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Case Manager</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Substance Abuse Counselor</td>
<td>3/18 (16.7%)</td>
</tr>
<tr>
<td>Bachelor level staff</td>
<td>2/18 (11.1%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2/18 (11.1%)</td>
</tr>
<tr>
<td>Director</td>
<td>1/18 (5.6%)</td>
</tr>
<tr>
<td>Intake Staff</td>
<td>1/18 (5.6%)</td>
</tr>
<tr>
<td>Do not provide information</td>
<td>2/18 (11.1%)</td>
</tr>
</tbody>
</table>

Physicians, nurses and substance abuse counselors were identified as the second most common job classification of those providing education after therapist. One third of the centers list three or more different classifications of individuals who provide the FASD/FAS education at their treatment center. Twenty two percent of treatment centers only report one job classification for those providing the education.

Table 4. FASD Training for Those Providing Education

<table>
<thead>
<tr>
<th>FASD Training</th>
<th>Yes</th>
<th>No</th>
<th>Encouraged</th>
</tr>
</thead>
<tbody>
<tr>
<td>FASD Training</td>
<td>9/18 (50%)</td>
<td>7/18 (38.9%)</td>
<td>--</td>
</tr>
<tr>
<td>FASD Training Required</td>
<td>3/18 (16.7%)</td>
<td>5/18 (27.8%)</td>
<td>5/18 (27.8%)</td>
</tr>
</tbody>
</table>