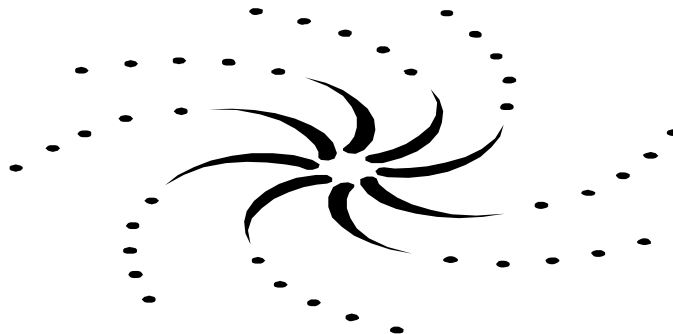


FETAL ALCOHOL SYNDROME

A ROLE FOR PROFESSIONALS In Providing Early Intervention And Other Support for Women



SASKATCHEWAN PROVINCIAL ALCOHOL AND DRUG SERVICES WORKING
GROUP

APRIL 2002

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FETAL ALCOHOL SYNDROME/EFFECT SUBCOMMITTEE

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A ROLE FOR PROFESSIONALS IN PROVIDING EARLY INTERVENTION AND OTHER SUPPORT FOR WOMEN

The Fetal Alcohol Syndrome (FAS) Subcommittee of the Provincial Alcohol and Drug Services Working Group recommended that practical strategies for engaging with women be provided to front line addiction services personnel in the province. Research into the issue resulted in the location of current materials that provide the desired information. The primary source is the 'B.C. FAS Community Action Guide 1998'. Additional information has been inserted that was identified by the subcommittee as being helpful to addiction personnel. It is recommended that the information first be read completely then reference be made to the sections most relevant to the reader's assigned role.

Fetal Alcohol Syndrome is a combination of mental and physical disabilities present at birth. FAS is a lifelong condition that can have devastating effects on the individual and his or her family. Fetal Alcohol Syndrome is caused by maternal alcohol consumption during pregnancy.* In this document, FAS refers to the spectrum of pre-natal alcohol exposure – Fetal Alcohol Syndrome [FAS], partial FAS [pFAS] or Alcohol Related Neurological Deficits [ARND]. For thorough information about FAS, readers are encouraged to contact the Saskatchewan Institute on Prevention of Handicaps or the Resource Centre at Saskatchewan Health. Resource contact numbers are located at the end of this document.

Purpose of the information:

Community-based addiction services, health and social service personnel have a crucial role to play in the prevention of FAS through early intervention initiatives, and as educators and advocates. Communities involved in comprehensive work on FAS issues frequently request material, which helps professionals and caregivers in their efforts to prevent FAS and intervene with pregnant women at risk.

The following is information useful for addiction services personnel and other helping professionals. It provides a comprehensive view of the approaches recommended to intervene with 'at risk' women and to maximize effectiveness. The information covers a range of engagement and intervention techniques proven helpful at initial contact through to addiction treatment for alcohol dependency.

A lot has been learned through the experience of programs that exist in Saskatchewan, such as, the 'Baby S.A.F.E.' and 'DEW' programs in Prince Albert, 'Food for Thought' in Saskatoon and 'Kids First Programs' in nine (9) designated communities throughout the province. Contact information for these programs is contained in the appendix.

Expanding the range of service and out reach activities has resulted in more at-risk women and their children accessing programs. Each community program has a variety of helping professionals involved and has developed protocols for accessing additional services in the community. The following information is relevant to the differing levels of services that may be accessed to assist at-risk women.

*Definition from: *Fetal Alcohol Syndrome: A Resource for Professional – Let's Find a Solution* P.1
Saskatchewan Institute on Prevention of Handicaps, 2000.

1. Making a commitment to take a role:

Below are four questions that relate to the values guiding our work on FAS issues that may clarify personal barriers to taking a role in prevention and support of FAS concerns:

1. How have I been impacted personally by the misuse of alcohol and other drugs and how does this impact on my work in this area?
2. What do I know and feel about women who misuse alcohol and other drugs during pregnancy? Can I practice respect, understanding, compassion and hope with them?
3. What do I know and feel about children affected by FAS? Can I practice respect, understanding, compassion and hope with them and their caregivers?
4. What can I do in my community to support action towards the prevention of FAS?

Our barriers come from:

- ◆ Our personal relationship to alcohol and drugs;
- ◆ Our attitudes toward those who use alcohol and other drugs;
- ◆ Our lack of knowledge about the indicators of alcohol misuse and of FAS;
- ◆ Institutional barriers related to our medical or clinical practices;
- ◆ Our lack of knowledge about the range of treatment resources available to pregnant women with alcohol and other drug problems and the range of interventions which work to support those affected by FAS and their families.

Making a commitment to act means overcoming these personal and institutional barriers.

2. Principles involved in intervening with women at risk

The following routine of ‘Asking, Advising, Assisting and Following-Up’ was first introduced by the National Institute on Alcohol and Alcohol Abuse in their *Physicians Guide to Helping Patients with Alcohol Problems*. This process is recommended for all women. It is consistent with the understanding that change is a process that tends to progress through specific stages. The role of the helping professional is to identify these stages of change in their clients, to understand what motivates people to change and to effectively support this motivation.

Many health and social service professionals are uncomfortable with broaching the topic of alcohol and other drug use. They are often challenged to find effective language and approaches that work. Some of the principles involved in “motivational interviewing”, a technique that has proved effective in working with alcohol and drug-related problems, can be adapted for use by such professionals. These principles include:

Express empathy

Empathy, as a practice, ‘works’ with clients who are misusing substances.

Develop discrepancy

When people perceive a discrepancy between where they are and where they would like to be, they are more likely to be motivated to change.

Avoid argumentation

Argumentation conveys the message that the interviewer ‘doesn’t understand’ and often arouses defensive reactions. This principle suggests the use of techniques to evoke client statements about perceived problems and the need for change. It is more effective if the client, rather than the interviewer, voices the arguments for change.

Roll with resistance

How the interviewer responds to “resistance” is critical to enhancing motivation. Instead of meeting resistance directly, the interviewer “rolls with” the resistance, with the goal of shifting client perceptions in the process.

Support self efficacy

It is important to support clients to believe that they can create positive change in their lives and, specifically, that they have the capacity to change their alcohol and drug-related behaviours. This principle is simply about the importance of hope. An individual is more likely to engage in a process of change if she believes it is possible and can envision positive outcomes in her life.

- Source: Miller, et. al. (1992) *Motivational Enhancement Therapy: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence*, Rockville, MD: US Department of Health and Human Services.

(SMRS Principle #11)

3. Asking --Screening for alcohol and other drug problems

What is screening?

Screening provides a preliminary evaluation about whether or not key indicators of alcohol and drug problems are present.

Asking questions about substance use:

- ◆ Provides a context for educating women about FAS;
- ◆ Helps women with problems to identify their problematic use;
- ◆ Helps women with problems to discuss the need to change;
- ◆ Provides a context for discussing the need for treatment and for making referrals to treatment when necessary.

Recommendation for screening

The Joint Statement on Prevention of FAS and FAE in Canada, Health Canada (1996) includes the recommendation that health professionals inform women and their partners about the risks of alcohol use in pregnancy, do screening, make referrals and undertake other supportive intervention.

Who might be involved in doing screening and asking about substance use?

Health professionals – including family physicians, obstetricians, pediatricians, midwives, public health nurses, addiction counsellors, mental health personnel and nurses working in hospital obstetrical units—may all be involved in screening for alcohol and drug use with pregnant women. In fact, any professional involved in counselling women on self care may take a role in asking them questions about their use of alcohol and other

drugs. Asking questions signals to clients that you are knowledgeable and open to discussing alcohol and other drugs as linked to their health practices and to other issues they bring to counselling.

When to screen?

Substance use screening questions can be asked as part of routine intake, and as a part of any initial or follow-up interview. Routinely asking about substance use gives a woman opportunities to talk in a context which may help reduce denial and shame surrounding this topic. It is useful to intervene at any stage such as planning for the possibility of future babies or addressing the need for parenting skills needed for the current children.

Stopping alcohol use at any time during the pregnancy will result in a healthier baby.

Who to screen?

Always ask all women! While there may be physical signs of misuse of alcohol, you cannot necessarily tell by looking at a woman whether or not she is using or misusing alcohol or other drugs.

The context of asking screening questions

- ◆ Establish an environment that is comfortable, safe and private.
- ◆ Explain why you are asking the questions.
- ◆ Explain how the answers will be used, and ensure confidentiality.
- ◆ Ask questions in a non-judgemental, non-threatening, empathic, matter-of-fact and respectful manner.
- ◆ Discuss a woman's answers in a way that encourages her to talk about her perspective on her substance use, and related issues in her life.
- ◆ Emphasize her power to make choices, and your role in supporting her.
- ◆ Provide information on substance use as it relates to pregnancy.

Screening tools

A number of screening instruments for alcohol and other drug problems have been developed which are easily integrated into interviews by health and social service professionals. Suggested screening tools include the CAGE and T-ACE. (See Appendix A). Alcohol and Drug Services personnel, trained in the use of the screening tool Substance Abuse Subtle Screening Inventory (SASSI), may provide a more thorough screening for alcohol and drug use with this instrument.

Practical questions about alcohol and other drug use

The following are some sample questions which can be used to ask about the use of alcohol and other drugs. The questions underline how practical the approach to asking questions can be.

- ◆ How often do you have a drink containing alcohol? How many drinks containing alcohol do you have on a typical day when you are drinking?
- ◆ Are there days or times of the week when you drink more than usual? Have you ever driven after drinking?
- ◆ What kind/type of drugs have you used? (It may be helpful to review a list of drugs with the person.)
- ◆ How often have you taken drugs during the past year?

- ◆ Do you plan to use drugs again?
- ◆ How much do you smoke in a day?
- ◆ How many caffeinated drinks do you drink per day? Does your caffeine use make you feel jittery or anxious or keep you from sleeping?
- ◆ Are you currently taking any medication to help you sleep, for anxiety or depression, or for pain? How long have you been taking these medications? How often do you take them? Do you usually take the prescribed amount of medication or do you sometimes take less than, or more than, the amount prescribed?
- ◆ Would you like to make changes in your use of alcohol or other drugs?
- ◆ Do you have any questions or concerns about your use of substances?
- ◆ Do you find that you use alcohol or other drugs to cope with issues in you life (stress, negative feelings, relationships)?
- ◆ Have you ever experienced any problems or negative consequences (e.g. in your relationships, family, work, health or energy level) because of your use of substances?
- ◆ Has anyone ever expressed concern to you about your use of drugs?
- ◆ Have you ever tried cutting down or quitting? What was it like for you?
- ◆ Would you like to make changes in your use of alcohol or other drugs?

Questions adapted from 'Hidden Majority (1996),' Addiction Research Foundation of Ontario.

4. The process of change and building motivation for change

In recent years, research on the effectiveness of alcohol and drug treatment approaches has found support for 'change-based' approaches to working with people who either need to stop or reduce their use of alcohol and other drugs. In the past, alcohol and drug counsellors have assumed that a client was ready to take action on his or her behaviour. However, it is now known that the majority of those who need to change high-risk behaviours are not yet prepared to take action. A Model of Change developed by Prochaska, DiClemente and Norcross provides a useful framework for working both with clients who are ready to change, and those who are not. Rather than focus on the problem (i.e. alcohol use and other drug use), and all the factors that reinforce it, this model focuses on the process of change itself. The Model of Change recognizes that action is only one of the six stages of change, and outlines how to work with people who are not in the "action" stage. Key to the model's usefulness is that it outlines certain strategies that work best in certain stages. The lessons arising from this approach will help those working with pregnant women to be more focused, client-centered and successful when undertaking early intervention. Below is a summary of the stages and strategies from the Model of Change.

(Reference SMRS Principle #11)

The Stages of Change are:

Precontemplation

People in precontemplation have no intention of changing and typically deny they have a problem. Precontemplators usually show up for help because of pressure from others. They often express hopelessness about their situation.

Contemplation

In this stage, people acknowledge they have a problem, begin to understand it and to see its causes, and wonder about possible solutions.

Preparation

Most people in preparation are planning to take action in the near future, but may still need to resolve some ambivalence about making changes. Attention to planning at this stage may increase the likelihood of successful change.

Action

The action stage is where counsellors can most clearly see people change their behaviour. Many counsellors equate action with change, when it is only one stage in a process of stages—all of which need to be completed.

Maintenance

In this stage, people work toward consolidating the gains attained during the action and other stages, and work actively to avoid lapses.

Relapse

Relapse is defined as the process of becoming dysfunctional in recovery. Relapse is not uncommon during the change process and may vary from minor struggles to a return to problematic behaviours.

The Strategies (or Processes) for supporting change through the stages are:

- ◆ **Consciousness raising and emotional arousal**—these strategies work best in precontemplation and contemplation stages. Consciousness raising involves learning factual information, as well as uncovering hidden thoughts and feelings. Emotional arousal, also known as catharsis, works on a deeper, ‘feeling’ level. The goal of consciousness raising is to give people information to make informed decisions about their behaviour. The goal of emotional arousal is to increase awareness and depth of feeling to move people toward action.
- ◆ **Self Re-evaluation**—this strategy works best in the contemplation and preparation stages. Self re-evaluation enables people to see how their alcohol or drug uses conflicts with their personal values, feelings and thoughts about the self. The goal is that they come to believe that their lives would be better if they made changes in their alcohol or drug use.
- ◆ **Commitment**—this strategy works best with those in the preparation, action and maintenance stages, and requires accepting responsibility for changing within oneself and then telling others about one’s decision to change.

- ◆ Strategies that work well for the stages of action and maintenance are: substituting healthy behaviours for unhealthy ones (countering); making changes in one's environment which support change; receiving rewards from oneself and others; and enlisting the help and support of others who care.

It is important to note that few individuals progress in a linear way through these stages. A more typical pattern is that of a spiral—from contemplation to action and back to contemplation. This revisiting of stages is natural and necessary when work on that stage is not completed. When the contemplation stage is revisited, it is an opportunity to learn, to gain missing information, to redefine the plan and to take action again.

This model challenges us to think in new ways when working with women with alcohol and other drug problems. It helps those practising early intervention with women:

- ◆ To focus on supporting self change versus asking clients to rely on prescribed plans of change by us as 'experts';
- ◆ To focus on making change rather than focusing on alcohol and drug use;
- ◆ To focus on the stage where the client is, leading to successful action in the long term rather than using a unidimensional action-oriented approach in all situations;
- ◆ To tailor our approach to be most effective with the stage the client is in;
- ◆ To retain our clients' trust by supporting their change.

5. Advising, assisting and following up on information learned through asking questions

If she is not using during the pregnancy

- ◆ You may wish to reinforce this and offer her information to share with friends and those in positions to support her.

If she is using during pregnancy

- ◆ Create an atmosphere for discussing her use.
- ◆ Provide her with clear information on substance use in pregnancy.
- ◆ Help her to assess her risk.
- ◆ Stress the positive of abstaining or cutting down. Suggested positive statements may be: "If you stop drinking now, you have a better chance of having a healthy baby. Your concern for your baby will help you be a good mother."
- ◆ Remind her of the importance of nutrition and regular prenatal visits, which can reduce risk.

If she is motivated to abstain or cut down and she thinks she can achieve this on her own with minimal help

- ◆ Give her information on how to cut down.
- ◆ Help her to continue to monitor her use - under what circumstances, what situations trigger her use; how often does she use and what are the results of her use?
- ◆ Continue to create an atmosphere permitting discussion when she comes for prenatal care.
- ◆ Refer to a pregnancy outreach program.

If she is motivated to abstain or cut down and either you or she feels she needs treatment

- ◆ Continue with the motivational assessment process.
- ◆ Make referrals as appropriate and continue to create an atmosphere that invites discussion.

If she is not motivated to change

- ◆ Counsel her toward coming to the necessary motivation.
- ◆ Help her to see the effects of her substance use on herself (physical, emotional, social, spiritual), the risk to her developing baby, and the challenge of parenting a child with FAS.
- ◆ Continue to show interest in her point of view.
- ◆ Help her to explore and weigh the positive and negative effects of substance abuse.
- ◆ Help her to understand her mixed feelings about substance use.
- ◆ Help her to understand that change is possible.
- ◆ Help her to overcome the barriers she may experience toward change and develop strategies for making stopping use or cutting down a priority.
- ◆ Help her look at her life in new ways, and to focus on the positive aspects of change.
- ◆ Ensure she is referred to a service designed to maintain involvement with her.

Making referrals for assessment and treatment of alcohol and other drug problems.

Many health and social service providers are reluctant to ask questions about the use of alcohol or other drugs if they feel there is not enough help available. Learn about the services, groups and resources in your community, and the service providers and caregivers who work for them.

The addictions field is grounded by a strong self-help movement. It is useful to have a listing of local recovery clubs and open meetings of self-help groups to provide support to women. These programs can be an alternative to treatment, an adjunct to treatment and/or a place to find immediate support while waiting for treatment.

There exist many barriers to women receiving effective, non-judgemental counselling on reducing or stopping substance use in pregnancy and referrals to treatment where needed. Some of these barriers have to do with a woman's fear of losing her children if she speaks of having a problem, shame about her use, depression which holds her back from seeking help, a lack of support from partner/family and denial about having a problem.

Another key barrier can exist among professionals themselves, who may have their own barriers that prevent them from making commitments to supporting women involved with substance use.

6. Counselling approaches and models

Since we do not know what a safe level of alcohol use in pregnancy is, it has always been recommended that women not drink before and during this period, and while breast-feeding. In keeping with this, programs have operated from a strong focus on women achieving complete abstinence from all drugs. This is still the optimal outcome. However, with this approach, we may “drive away”, “turn off” or otherwise not reach many of the women at highest risk of having children affected by FAS—women who are still using alcohol and other drugs, who have significant problems with their use and have difficult lives. Such women may find more flexible support useful—support which is not conditional on abstinence from alcohol and other drugs.

Service providers in the addiction field are expanding the range of counselling approaches and models that support the varied needs of those seeking help. Several of these approaches are outlined below. Knowing that there are a range of options available may encourage women to seek help and encourage professionals to make referrals.

Statements from the BEST PRACTICES document on FAS support different approaches to the treatment of women. *There is some evidence and a consensus among experts that treatment services employing a respectful, flexible, culturally appropriate and women-centred approach that is open to intermediary harm reduction goals, based on client circumstances, are effective in engaging and retaining women in supportive programming and in improving the quality of their lives. (Best Practices: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy. Health Canada 2001 P.46)*

Relapse Prevention

This approach is geared to those with addiction problems for whom abstaining from all use is the best option. In this approach, it is recognized that those with alcohol and other drug problems who have previously stopped drinking are likely to struggle in recovery and may return to these former habitual patterns (relapse). In general, relapse prevention strategies help people to anticipate and cope with the possibility of relapse, to reduce their exposure to high risk situations and to strengthen their day-to-day coping strategies. Relapse, when it happens, carries a message, which the person can learn from and refine their strategies for staying sober.

Learning relapse prevention strategies is only one component of addressing the special recovery needs of women with substantial problems with alcohol and other drug use. However, the practical nature of relapse prevention strategies makes them useful for any counsellor (addictions or other) to introduce when women are considering changes in substance use patterns. Introducing people to relapse prevention strategies, even before they have decided to seek treatment, has been found to be useful to give a sense of what is involved in making life changes, which support non-use.

(SMRS Ppls. # 4 & 8)

Self Help Groups

Self-help groups include Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Ala-Teen and cultural awareness groups. Some First Nations and Aboriginal communities have established self-help groups grounded in the principles of traditional spirituality. Participation in self-help groups provides immense ongoing support for helping people recover from substance abuse. The Saskatchewan Alcohol and Drug Services (ADS) Program Guidelines (January 2001) states ADS programs offer current information on self-help groups to clients.

An initial understanding of self-help groups is presented in a brief description as written by Alcoholics Anonymous:

“ALCOHOLICS ANONYMOUS is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

- *The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions.*
- *A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.*
- *Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.*

The A.A. preamble is reprinted with permission from the A. A. Grapevine, Inc.

Additional information about self-help groups may be obtained by contacting the websites listed in Section 9 of this booklet.

Moderate drinking approach

The use of self-change models has been pioneered and exists in varying forms. They are for those who are not sure if they wish to stop drinking, but may want to reduce their use. It is another strategy that may be used as a means of engaging with women and achieving abstinence or significantly reducing the consumption of alcohol for the term of the pregnancy. *Note that these programs are not appropriate/recommended for individuals with serious addiction problems.* They provide a very practical framework for stopping or reducing use. The interesting feature of a self-change program is that it is less threatening for many to commit to a moderate drinking program, rather than having to commit to completely stopping. An initial period of recommended abstinence helps people to consider what their long term relationship to alcohol use needs to be.

Self-help empowerment approach

Some women, especially those with a history of violence, may seek gender-specific, empowerment-oriented care. Empowerment gives the woman the opportunity to define her own needs, have her choices respected and uses intervention strategies relative to her stage of change.

The harm reduction approach

Harm reduction is a term that entered the lexicon of the alcohol and drug field in North America only recently, and has fundamentally changed the field. Harm reduction involves being practical in how we help people reduce the harmful consequences of their use. The term initially referred to interventions aimed at injection use—such as needle exchange, education on safer injection practices and substitution of methadone for heroin. Harm reduction can also apply to helping people moderate their use of alcohol and its consequences—and in this context, it has definite applicability in the prevention of FAS.

A harm reduction approach involves supporting people in making:

- ◆ Whatever change is possible in their use of alcohol or other drugs.
- ◆ Changes in behaviours related to their use so that harm to themselves and others is reduced.

(SMRS Ppl. # 12)

A harm reduction approach with pregnant women may involve any or all of the following support:

- ◆ To *reduce* (if they can't stop) their use of alcohol.
- ◆ To stop or reduce the use of any or all *other drugs* being used with alcohol.
- ◆ To access good prenatal care and health care overall.
- ◆ To eat well during pregnancy.
- ◆ To reduce their stress and/or stabilize their living situation.

A harm reduction approach emphasizes:

- ◆ Assistance toward improving women's health in a holistic way.
- ◆ The right to non-judgemental, non-coercive services.
- ◆ Reducing the harm arising from use, rather than focusing on the drug itself whether legal or illegal.
- ◆ The involvement of the women who use, and their communities, in jointly coming up with strategies that will work.

On paper, harm reduction and motivational counselling sound positive, pragmatic, humanitarian and desirable. There are, however, challenges to making these approaches work. These include:

- ◆ Modifying our attitudes toward women who use so we can truly provide nonjudgemental, caring assistance. This includes recognizing that “disruptive” behaviour is related to the impact of drug use, and “tuning up” our communication and conflict resolution skills.
- ◆ Getting over *our* ideas about how a woman needs to change her alcohol and drug use so we can support her self determination and plans to change, and so that we can truly provide non-coercive, caring services.
- ◆ Increasing the scope of our services, so that needs such as helping women find housing, protection from HIV infection, etc., can be addressed.
- ◆ And, of course, staying hopeful ourselves and finding ways to engender hope in those with alcohol and other drug problems.

7. Summary: A recommended approach for helping professionals when counselling about risks in pregnancy

- ◆ Provide information about the effects of alcohol and other drugs on herself and her baby.
- ◆ Keep the message clear, simple and realistic.
- ◆ Stress the positive- “If you stop drinking now, you have a better chance of having a healthy baby.”
- ◆ Develop a respectful, non-judgemental approach.
- ◆ Don’t predict the outcome of a particular pregnancy.
- ◆ Deliver personal and individually tailored messages.
- ◆ Help women assess their risks.
- ◆ Help women develop motivation for risk reduction and provide ongoing hope.
- ◆ Recommend alcohol and other drug abuse treatment when goals for abstinence/reduction in substance use are not easily achieved.
- ◆ Offer information on family planning and choices (including abortion and contraception).
- ◆ Provide support and encouragement for women to see a doctor.
- ◆ Be sensitive to the range of issues which may be related to a woman’s substance use, such as legal or custody problems, housing instability, poor health, depression, a history of violence and sexual abuse, sexually transmitted diseases, etc.
- ◆ Be sensitive to women’s fears of losing children if they admit to having a problem, and their shame and denial about having alcohol and drug problems.
- ◆ Be sensitive to lack of childcare, transportation and other logistical barriers to accessing treatment.

*Adapted from P.S. Cook, R.C. Petersen and D.T. Moore in ‘Alcohol, Tobacco and other Drugs May Harm the Unborn’ US Department of Health and Human Services, 1990.

8. Other roles for health care providers in the prevention of FAS

There are many other ways in which health and social professionals can contribute to the prevention of FAS. Examples are:

- ◆ Working in coalition with others in your community to create opportunities for public education about FAS, early identification of women at risk, and supportive services for those affected by FAS and other alcohol and drug related birth defects.
- ◆ Promoting and supporting linkages among services providers and caregivers of individuals affected by FAS in the community.
- ◆ Raising issues surrounding FAS with other professionals and sharing experiences and approaches.
- ◆ Advocating for the education and training of professionals on screening for alcohol and drug problems, counselling about alcohol and other drug problems, diagnosing FAS/E and treating those affected.

- ◆ Advocating for paraprofessionals to be supports for women as described in the *Seattle Birth to Three Program*. The role has been researched and proven effective through strong evaluation. The role is identified in the Best Practices document on FAS/E (p. 40).
- ◆ Being receptive to opportunities to be an educator and advocate on FAS issues as they arise.

RESOURCES AND REFERENCES

Source

B.C. FAS Community Action Guide, British Columbia Ministry for Children and Families -- B.C. FAS Resource Society, October 1998 -- Section 4 Pages 55 to 65
Printed with permission.

Website: www.publications.gov.bc.ca

References:

Definition: Fetal Alcohol Syndrome – Sask. Institute on Prevention of Handicaps
Permission is granted.

Health Canada 2001 - BEST PRACTICES: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy ISBN 0-662-30212-5
<http://www.cds-sca.com>

Saskatchewan Health (2001) - MEETING THE CHALLENGES: The Saskatchewan Model of Recovery Services

IF YOU ARE A PROFESSIONAL...” A.A. General Service Conference-approved literature. Copyright 1986, Alcoholics Anonymous World Services, Inc. 475 Riverside Drive, New York, NY 10163

Resources:

Saskatchewan Institute on Prevention of Handicaps, 1319 Colony Street, Saskatoon, Sk. S7N 2Z1

Phone: (306) 655-2512

Fax: (306) 655-2511

Email: skiph@sk.sympatico.ca

Internet: www.PreventionInstitute.sk.ca

Provincial Program Support Unit, Addiction Services, 2003 Arlington Ave.
Saskatoon, Sk. S7K 2H6

Phone: (306) 655-4510 Fax: (306) 655-4545 Email: madillg@sdh.sk.ca

SASKATCHEWAN EXAMPLES:

Prince Albert Baby S.A.F.E (Substance Abuse Free Environment) Program is designed to offer support to pregnant women in their effort to maintain abstinence from harmful substances in order to prevent life long handicaps to their babies.

Telephone: (306) 763-0760 Fax: (306) 763-8165

Food for Thought, Saskatoon District Health - Contact person Pam Woodsworth

Tel: (306) 655-4634 Fax: (306) 655-4718 email: woodsworthp@sdh.sk.ca

Saskatchewan Health Resource Centre - Print and Video Resources

Tel: (306) 787-3090 Fax: (306) 787-3823 email: library@health.gov.sk.ca

Saskatchewan Health (1998) Women's Day/Evening/Weekend Treatment Program

Contact: Sask. Health, Community Care Branch, 3475 Albert Street, Regina, Sask. S4S 6X6 Tel: (306) 787-3862

New Beginnings ... promotes healthy births by supporting moms who desire a healthy lifestyle, including those who want to reduce their alcohol or drug use. ... supports families and children who are affected by maternal alcohol and drug use.

LaRonge Health Centre, Box 925, 227 Backlund, La Ronge, S0J 2P0

Ph: (306) 425-4837

Kids First Programs - List of the Designated Communities and Program Managers is attached -- Appendix B

Discovering Empowerment for Women - The community partners for this program are Prince Albert Council on Alcohol and Drug Abuse (PACADA), Kids First, Saskatchewan Justice Community Operation Division.

Contact Telephone: PACADA (306) 765-6550

ADDITIONAL REFERENCES - Ask questions – interact with the experts

Motherisk: Information regarding alcohol and other drugs during pregnancy and breastfeeding. Toll free number: 1-877-327-4636

<http://www.motherisk.org>

FAS Tool Kit

Request access to this website by sending an email message with contact information (agency, address, phone, fax) to murrayr@inforamp.net. You will then be set up with a password to access the site.

Alcoholics Anonymous

www.alcoholics-anonymous.org/ AA Home Page

Canadian contact numbers are contained on the website and grouped by province.

Al-Anon/Alateen

www.al-anon-alateen.org/ Al-Anon/Alateen Home Page
Canadian contact number (613) 722-1830

Canadian Centre on Substance Abuse

FAS/E Information Service 1-800-559-4514
www.ccsa.ca/fasgen.htm

Health Canada (2001). *Best Practices Treatment and Rehabilitation for Women With Substance Use Problems*. Ottawa: Minister of Public Works and Government Services Canada, Cat. No. H49-153/2001E
<http://www.cds-sca.com>

APPENDIX A SCREENING TOOLS

THE CAGE

The CAGE is one of the oldest brief screening instruments. It is a simple 4-item yes/no alcohol screen that focuses on the consequences of drinking rather than the quantity or frequency of alcohol consumption.

The questions for the CAGE are:

- C** Have you ever tried to CUT DOWN on your drinking?
- A** Have people ever ANNOYED you by criticizing your drinking?
- G** Have you ever felt GUILTY because of something you did when you have been drinking?
- E** Have you ever had a morning EYE-OPENER? (Taken a drink first thing in the morning)?

One positive answer is considered an overall positive screen.

The possible advantages of CAGE:

- ◆ It is brief and has good validity, sensitivity and specificity.
- ◆ It is easy to administer.
- ◆ It can be modified to include drug use and for differing circumstances and clinical styles.

The possible disadvantages of the CAGE:

- ◆ It does not assess quantity or frequency of use, nor consequences related to use of other drugs.
- ◆ It is not time bound, so it can be unclear if the problem is current or historical.

Ewing, J.A. (1984) Detecting Alcoholism: The CAGE Questionnaire in CSAP
1993 Maternal Substance Use Assessment Methods Reference Manual

T-ACE

The T-ACE is a widely used screening tool. The T-ACE questions are:

Tolerance – How many drinks does it take to make you feel high/feel the effects of alcohol?

Record the number of drinks _____

Annoyed – Have people annoyed you by criticizing your drinking?

Yes _____ No _____

Cut Down - Have you felt that you ought to cut down on your drinking?

Yes _____ No _____

Eye Opener – Do you ever have an eye-opener – a drink first thing in the morning - to steady your nerves or get rid of a hangover?

Yes _____ No _____

T question: ___ score 2 points if the woman indicates 3 drinks or more.

A, C and E: ___ score 1 point for a positive (yes) response.

Two or more points equal a risk of a drinking problem which may pose a risk to the fetus/offspring.

APPENDIX B

KIDS FIRST PROGRAM MANAGERS – KEY CONTACT LIST

Community			Contact Information
MEADOW LAKE	Program Manager	Myrna Roy	Northwest Health District 205 – Centre Street MEADOW LAKE SK Ph: (306) 236-1560 Fax: (306) 236-5801 Email: myrnaroy@hotmail.com
MOOSE JAW	Program Manager	Krista Bakke	455 Fairford St. E MOOSE JAW S6H 1H3 Ph: 691-2604 Email: kbak.mjtchd@shin.sk.ca
NIPAWIN	Program Manager	Linda Spice	Box 389 NIPAWIN SK S0E 1E0 Ph: (306) 862-7238 Fax: 862-0763 Email: lspice.nehd@shin.sk.ca
NORTH BATTLEFORD	Program Manager	Gary Shephard	c/o Community Health Services #204 – 1146 – 102 nd Street NORTH BATTLEFORD SK S9A 1E9 Ph: (306) 446-6012 Fax: (306) 446-6432 Email: gshepherd@bathd.sk.ca
THE NORTH	Program Manager	Wendy Lemaigre	<i>Kids First</i> North Box 970 LA RONGE, SK S0J 1L0 Ph: (306) 425-4650 Fax: (306) 425-4515 Email: wlemaigre@sk.sympatico.ca
PRINCE ALBERT	Program Manager	Sylvia Gent	1521 – 6 th Avenue West PRINCE ALBERT SK S6V 5K1 Ph: (306) 765-6656 Fax: (306) 765-6624 Email: pfinney@pahd.sk.ca
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SASKATOON	Program Manager	Marcia Clark	102, 506 25 th Street East SASKATOON SK S7K 4A7 Ph: (306) 655-5804 Fax: (306) 655-5555 Email: clarkma@sdh.sk.ca
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