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Megan: Hello, everyone, and welcome to this Ask the Expert webinar addressing fetal alcohol spectrum disorders in the context of Healthy Start. What do we need to know? I'm Megan Hiltner with Healthy Start EPIC Center. We have approximately 60 minutes set aside for this webinar. It is being recorded, and the recording, along with the transcripts and slides will be posted to the EPIC Center website following the webinar at healthystartepic.org.

Before I introduce our speakers for the day, I have a couple more announcements. We really want your participation. So at any point if you have questions or comments, please take a moment and chat them into the bottom left corner of your screen in the chat box. We only will be taking questions through the chat box, and like I said before, we'll be breaking throughout to get to some of your questions or comments. Also, we do want your feedbacks on this event today. So we will be following this, following the webinar on your screen, a poll or a survey will pop up, and we really wanna get your feedback. So please take a moment either right after this webinar or later on and complete that survey.

Our objectives for the webinar today are, first, to define fetal alcohol spectrum disorders, or FASD, and the impact on Healthy Start, describe approaches to preventing fetal alcohol spectrum disorders appropriate to Healthy Start staff and partners, and to outline an approach to identify and support parents who may have one of the fetal alcohol spectrum disorders. So at this point, I'm going to briefly introduce our expert speaker for today, and then I'm gonna turn it over to Miss Dawn Levinson at the division for a brief welcome. But our expert presenter, speaker for the day is Dr. Georgiana Wilton. She's a senior scientist in the Department of Family Medicine at the University of Wisconsin School of Medicine and Public Health. She's currently the principal investigator of several outreach education and research projects addressing prevention, identification, and treatment of fetal alcohol spectrum disorders.

She's the PI of the Wisconsin FASD Treatment Outreach Project, the Wisconsin ASBI Choices Tribal Initiative, and the Wisconsin Juvenile Justice AODA Program FASD Collaboration. She's taught classes on fetal alcohol syndrome and adolescent health in the Department of Medicine Medical Genetics, and provides training to clinicians and service providers both locally and nationally. Before Georgiana digs into her presentation, I'm gonna now turn it over to Dawn Levinson with the Division of Healthy Start Perinatal Services. She is the behavioral health

adviser, and she's gonna provide us just a brief welcome and introduction to the webinar. Dawn, are you there?

Dawn: I am.

Megan: Great.

Dawn: Thank you. Good afternoon, everyone, or good morning, depending on your time zone. This is Dawn Levinson, and I am so thrilled to be with you today for Dr. Wilton's presentation. I thought it would take just a moment while I have you to give some background on the FASD training initiative because this presentation today is connected to larger training activities through the EPIC Center. In October 2016, Maternal Child Health Bureau launched a three-year project to integrate FASD prevention into our existing PA services provided by the Healthy Start EPIC Center. Congress appropriated funds to title five Special Projects of Regional and National Significance, or SPRANS, to support this initiative.

The prevention project focuses on increasing knowledge and skills among grantees related to the prevention and early identification of fetal exposure to alcohol or other drugs that impact maternal and newborn health outcomes. It also will provide knowledge to support the needs of pregnant and parenting women who themselves are affected by FASD, which you will hear about more today. And given the increased public health burden that FASD places on many Native American communities, the project also has a special emphasis on providing culturally confident training and technical assistance to Native American communities and populations.

In order to provide the most useful training and technical assistance around prenatal alcohol exposure for our grantees, we need to have input from you, our grantees. And after Dr. Wilton's presentation, we'll hear briefly from my colleague at the EPIC Center, Miss Hannah Bablu [SP], who will tell you about an opportunity to be part of a grantee discussion group on FASD and other behavioral health concerns, and we're really hoping you participate. In addition to future webinars on other FASD-related topics, grantees may also wish to request targeted training on FASD prevention for their staff and community partners. If you think this additional training would be useful in your community, please contact Hannah Bablu or Janet Vanness [SP] at the EPIC Center, and their contact information will be provided at the end of our slides after Dr. Wilton, and you'll be seeing additional resources on

FASD prevention and other behavioral health topics and feature Healthy Start e-news on the EPIC Center website.

And finally, later in the summer we'll be rolling out a new community health worker module on substance use prevention, which will include FASD, opioid use, and other substances. Again, your input and feedback will be critical to ensuring these resources useful for the Healthy Start community. So, again, please engage with us. And without further ado, I turn it over to Dr. Georgiana Wilton, and thank you very much.

Georgiana: Thank you. I am so happy to be here today, and I wanna thank you all who are participating for giving up an hour of your very busy life because I know how that is, to learn more about FAS. At any time, if you can't hear me or if it's a little loud because as I previously said, I'm kind of in a path of [inaudible 00:06:10], so it might get louder at one point to another, just let me know, but we will just move along. Basically, what I'm gonna talk about is the effect of alcohol use on pregnancy. I'm just getting the continuum of this fetal alcohol spectrum disorder. So it's not just one condition, but it is a range of effects. We'll talk a little bit about strategies to prevent FASDs and brief alcohol intervention. And then sometime recognizing FASD in your client population, mostly the adults who are parenting the children that you're serving and how to best support those. So this is really intended to be kind of a sample platter, and we'll be providing follow up on specific topics as needed so you'll have opportunities to dig more into any one topic or other topics as the project moves forward.

So what's the research tell us about alcohol use in pregnancy? So we have effects on the mom and effects on the fetus. Increased health risks include liver disease. So women develop alcohol-induced liver disease over shorter time than men. It's much harder on our body. We don't metabolize alcohol as efficiently. Cancer, if you're looking at alcohol may also increase breast cancer risk. It tends to damage DNA and cells, and compared to women who don't drink at all, I'm just quoting the breastcancer.org, and it's supported by the research. Women who have three alcoholic drinks per week have a 15% higher risk of breast cancer, and that only goes up with additional drinking. So that's not even a very terribly high level.

We also know that Susan G. Komen Foundation that alcohol can change the way our body, a woman's body metabolizes estrogen, and how estrogen works in the body. And this can cause blood estrogen

levels to rise, and tends to be higher in women who drink alcohol than a non-drinkers. And that in turn can also contribute to the increased risk for things like breast cancer. We don't hear that a lot. When we're hearing about alcohol and the effects on women, and we learn about alcoholism and alcohol-related diseases that cancer has been very quiet, and it's one of those becoming one of the leading causes of breast cancer and or contributor to breast cancer and heart disease in women.

Great nutrition issues, mood disorders. We know alcohol is a depressant, so it can either cause depression or exacerbate depression. And oftentimes, women use alcohol to treat their own depression, and it actually just makes it worse. We have to think about learning and memory problems, and violence and injury, not that alcohol causes violence, but it increases our risk to be in violent encounters or to be injured because we're not functioning at full capacity. And we also have to consider the effects on the fetus. In the next few slides, we're gonna really address this in more detail, but low birth weight, central nervous system damage, facial dysmorphia, how faces look different. We'll look at how those contribute to help us make the diagnosis of fetal alcohol syndrome. We have to think about developmental delays, cognitive delays, and, of course, the behavior disorders that go along with the entire spectrum.

So what is fetal alcohol syndrome? It's a group of conditions. So you wanna really make it a point that it's not just fetal alcohol syndrome, and that fetal alcohol spectrum disorders itself is not a diagnostic term. It's really just simply an umbrella term that helps us categorize all of the conditions that can be diagnosed under...that are caused by female alcohol exposure. So in that we have fetal alcohol syndrome, partial fetal alcohol syndrome, alcohol-related neurodevelopmental disorder. Usually we talk about that as ARND, alcohol-related birth defects, and then the newer term that is coming out that is included in the DSM 5, the Diagnostic and Statistical Manual 5th edition, neurobehavioral disorder associated with prenatal alcohol exposure. And in the last section of the DSM has a very wonderful description of the behavioral concerns that we wanna look at when we're considering the spectrum of disorders.

So here's just a little way, and not that there's gonna be a quiz on this at the end, but it helps us to be able to recognize what we might be talking about. So we don't expect anyone to become diagnostician, so we're leaving those up to the MDs. But we have to look at the categories, confirmed alcohol exposure, facial anomalies, growth deficits, central nervous system abnormalities, neurobehavioral impairment, and major

malformation like cleft foot, cleft palate, heart problems, things like that. So for those of you who are interested, when we're done you can just kind of look at what it really takes to confirm a diagnosis on the spectrum of disorders. And this criteria, this is one schema that's widely in use in the United States.

Jim Hoyme and team adapted the Institute of Medicine guidelines, and they were updated just recently last year. And the interesting thing is for fetal alcohol syndrome, we don't need to confirm exposure history, that the criteria are specific enough to prenatal exposure that we still need some kind of reason to suspect it, but we no longer need a confirmation or medical documentation of that in order for us to move forward with the diagnosis, and more importantly, better support the family with targeted interventions.

Let me give you just a few pictures of what kids with an FASD or in this particular case, what fetal alcohol syndrome look like. And you can see the facial features, small eye opening, flattened philtrum, the area between your nose and upper lips, and have thin upper lips and a kind of a flattened cupids bow in the upper lip. He was an...I believe he was still an adolescent at the time. Maybe he was already an adult, but the facial features are there.

And, you know, we can all create the facial features of fetal alcohol syndrome in ourselves, and in our friends just by smiling and making someone laugh. So if we look at this particular face, it might seem like the philtrum area, the upper lip is even more flattened, but we can exacerbate already occurring features, or we can create them again just by smiling. So it's pretty important that as we think about or consider FASD, that we really look at a neutral expression at kind of a 90 degree, you know, flat on face view with a very neutral expression. But here you can also see her, her eyes are very small, and it kind of adds to this optical illusion that the eyes are wide set. And they're really not wide set as much as because the openings are small. It kind of creates that optical illusion.

And, of course, the bottom line is we can't only tell by looking. We have to confirm characteristics and all of the conditions required to make a diagnosis. But we want people to be aware of what it have to look like. And it might seem funny to say that alcohol is not the whole story when we're talking about fetal alcohol spectrum disorder, but we also wanna consider what else is going on. What other exposures there might be? It'd be great if it was straightforward. Then we wouldn't have any

misdiagnosis, and it would be just...it's much easier to quantify, but it's not just the alcohol exposure. There's lots of other stuff that's going on, and we're gonna touch just briefly about what some of that other stuff might be.

So we also have to consider the genetics of biological parents and grandparents, including their mental health disorders, because maybe mom was drinking to self-medicate. Maybe she had bipolar disorder, schizophrenia, or she had a substance use disorder, and she was drinking to treat something, and not just drinking. So we would also expect that whatever genetic components of the mental health conditions that she has could be potentially passed on to her child. So some of the behaviors and some of the characteristics that we see in the child may not be solely related to the alcohol. It could be genetics, too. And, of course, the alcohol could exacerbate some mental health conditions that would be normally occurring in that particular child.

We also wanna consider environment, socio-economic status. Is there access to nutrition? Is mom getting good...[inaudible 00:14:19] is she healthy? Is she a victim of domestic violence? Has she experienced trauma? Has the pregnancy experienced trauma? And really what the overall health condition and living condition of mom and the family is because we know that all of these can impact pregnancy as well.

We also wanna...and the other stuff consideration, consider other drugs, including illegal drugs and prescription drugs. And I just wanna give a nod out to neonatal abstinence syndrome here. So we often...people are oftentimes confused between fetal alcohol syndrome and neonatal abstinence syndrome. And with treatment, NAS usually, you know, clears itself up, with medication kind of goes away. Kids get the drugs out of their system. And oftentimes they're confused with fetal alcohol syndrome. They expect the children to grow out of that, too. And alcohol causes permanent brain damage in a child, so they're not gonna outgrow it, whereas neonatal abstinence syndrome is a group of problems that occur to newborn, and really just a newborn who was exposed to addictive opiate drugs when mom was pregnant, and that [inaudible 00:15:27] definition comes from that [inaudible 00:15:29] plus.

We know that withdrawal symptoms can vary from mild to severe. Some kids don't experience it at all. They can last from one week to three months. Oftentimes, we think, "Oh, they got past the first week, they're gonna be fine." And maybe 10, 12, 14 days later, they start exhibiting symptoms long after mom has been discharged. But, you know, babies

behave in their own way, and they respond to their recovery in their own way. And genetics and environment has a lot to do with that. So, again, there's still confusion about the difference between NAS and FAS, and really there shouldn't be that much confusion.

But what we'll do is a follow up to this webinar is send you a link to Dr. Randy Brown here at the UW Department of Family Medicine and Community Health, conducted a national webinar course last fall just on all the drugs, effects of all the drugs on pregnancy, and sorting those out, and really coming to the same conclusion with the evidence that alcohol is the drugs that produces the most brain damage and the long-term life effects. But it's also very important, especially [inaudible 00:16:32] opioid addiction, and we seem to be hearing in the news almost daily now, at least in Wisconsin, we do about parents overdosing with small children in the car, overdosing at parties or on planes, and needing to really pay some consideration to this series of occurrences as well.

We also wanna consider the effect of trauma on development, and there's actually some...lots and lots of research that talks about childhood abuse, extreme stressors, neglect that affect your brain, that affect your immune system, that affect our behavior, our ability to learn, and that we really...although this is not my particular area of expertise, I can never really do a talk without giving a nod out to assessing for trauma and assessing for what else is going on in a child's life and in the family's life. Because in sexual abuse in girls, we really see increased...they're [inaudible 00:17:33] hormones, and we're looking at suicide ideation, increased attempts. It's very potent. It's a very potent risk factor, and that even if we get to the point where no one's drinking during their pregnancy, we still have to look at all of the other stuff that's going on in order to have the healthiest birth outcome that we can.

All right. So, before we move on to prevention approaches for Healthy Start staff, I wanna check in and see if there are any questions about the FAS portion of it.

Megan: Georgiana, there are no questions in the chat box. I just wanted to let folks know that I will get that link for the webinar that you talked about from your colleague and make sure that that goes out to the folks on this participating here, and share that resource along with others that you may share throughout the presentation.

Georgiana: Wonderful.

Megan: So no questions from the chat box at the time.

Georgiana: Wonderful. And I did see that at least one person couldn't hear me very well. I hope that that's better now. You can keep posting if I'm not speaking clearly or loudly enough. Okay, so now that we've set the stage, we're gonna talk a little bit about prevention and how to really address and prevent this entire spectrum of disorders. So what do you call it? There's all kinds of acronyms. ASBI, alcohol screening and brief intervention, brief counseling. SBIRT is the screening, brief intervention and referral to treatment. And most of the SBI acronyms, the referral to treatment, the RT part of it is implied because we're not gonna do screening if we don't have a place to refer and to provide treatment. It just happens to be that SBIRT is the Stanford-branded acronym, and that's why it's used typically in a very specific context.

For those of you who are unaware or want more information about how to get something like this going in your community, the CDC has several publications out now. Here's a...I just have one of them in a picture up there, Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use. It's really, it's a step by step guide for primary care. They have one for emergency department. We've just adopted one that's going through clearance right now for Native American communities and Alaska native communities. So it's going through clearance, and we hope it to be published later this year. But it really talks about the how-to's, how to get a team together, what has to happen, what buy in is needed, and really how to tackle this in your community, and, oh, one of the best evidence-based ways.

You have lots and lots of tools at your disposal for screening. So you've got these wonderful screening tools for Healthy Start, and we're gonna go through these, not all your screening tools one at time, but just go through each of these topics, specifically alcohol screens and your ability, your observation, your access, and the trust that you develop with the families that can be very, very potent tools, and that you have right in your own toolkit. So you have lots of screening tools, and I think most of these have now been implemented I believe and have gone on live at the very latest by January this year, I believe, but someone can correct if I'm wrong in that, but you've got demographic screening tools. You're asking lots and lots of questions. So you have access to a lot of great data that will lend you to a conclusion or to a hypothesis that you wanna be able to ask a few more questions on.

So definitely start with the tools that you have. We hate, you know, we always hate to over-assess people, but there's such a need for asking the correct questions and collecting the correct data that's gonna help with this particular issue. A lot of what you need, you're already collecting. There might just be a few extra questions that you wanna confirm, but as you know and as you have been trained, you know exactly what these questions are. I would start with the pregnancy history and the preconception screening tool because that's really the best indicator, especially if the alcohol questions are asked preconception and then again prenatal to see what those differences might be.

There are also a lot of great brief alcohol screening tools, and what we recommend is to start with a single question. How many times in the past year have you had, five for men or four for women, drinks in a day? Any response over one should lead you to ask more questions, and look at if it's risky drinking or if you're looking more at dependence. And this is potent enough that it detects 98% of at risk drinkers. So it's a great question. I think it's actually, I believe, it's included in your questions, but it's a great one to start with because if they're not drinking, then you're pretty much done.

You can then ask they go on to the audit if you want more quantity and frequency, and it's really helpful to get a pattern, especially as you're walking into homes and you wanna know what you might be experiencing. So how often do you drink an alcohol, a drink containing alcohol? And as we talked about concerns about parents and parents' cognitive challenges, we also wanna be very specific that we're talking about drinks that contain alcohol and not just any drinks in general. How many do you have...how often do you drink? How many do you drink in a typical day? And then again that question about how often do you have five or more, four or more for women.

If they screen positive and they're drinking more than four drinks a day, four or more drinks a day for women, or five or more drinks a day for men, you're gonna wanna follow up with the longer audit, and refer them to get some more help. So the brief screens are gonna help us to brief interventions, such where people are drinking at a level as defined to be unhealthy, but we still see them as having control over their drinking. Once they start failing the brief alcohol screens that are more, you know, drinking well above recommended levels four, if they're not able to stop, then we wanna look at more treatment referrals because brief interventions only work if you still have control over your drinking.

You can...there are lots of ways to administer this. It can be self-report, face-to-face, interview screens, computer assisted interviews, or laboratory screen measures. There's some blood tests you can take, especially to confirm alcohol consumption to see if someone is really not drinking when they say they're not drinking. And then we [inaudible 00:23:59] just some screening tools, the timeline follow back. If not, a brief screen we have gone 90 days back starting. We start with the day before the meeting. So if I'm doing an assessment today, I'll start with February 20th, and I'll walk them back to a calendar for 90 days. And if they have their personal calendar with them, people can remember their drinking very, very accurately, and that's been tested and tested, and great evidence-based. But we don't need to do all that. We have a lot of short questionnaires at our disposal, and like the T-ACE, the TWEAK, the CAGE, the RAFLS is really the best one that's been tested with different racial and ethnic groups. But it also was letting us, lending us to assess for dependence, and that's when drinking is beyond our control, and that's what we need to do a referral to treatment.

All right. Some scoring cautions because oftentimes we get trained, and here's how we assess it, and it's how we score it, and it seems to be very black and white, but it's not. So we...[inaudible 00:25:08] those patterns isn't consistent across individuals. If I have a medical condition, if I have diabetes, if I'm under the age of 21, if I'm breastfeeding, if I'm pregnant, those recommended levels [inaudible 00:25:21] don't really apply. So we wanna scour the options, we want them really to be seen as guidelines. And we hear a lot about, "Well, I can't really alter the questions because I might mess with their reliability and the validity and all of the testing." And it's really important to ask the questions that are gonna get you the answers you need to be able to help the families that you serve. So if you're asking someone and you're thinking, "Wow, based on their answers, they're drinking an awful lot. They just reported drinking, you know, 35 drinks a week, but they're not answering the cage, you know, they're not answering one of the questions, do you have a drink first thing in the morning? And they're always saying no to that, and it just doesn't fit."

That's when I alter it and say, "When do you have your first drink in a day? Is it within an hour of waking up?" "Well, I guess." "Always within an hour of waking up? Well, what time do you wake up?" "I usually get up at 2 in the afternoon." So sometimes the questions that are asked are just, responses are gonna be very literal. "Do you have a drink first thing in the morning?" "No, I don't, because I'm still sleeping and I'm hung-

over." So those kinds of modifications, as long as, you know, you're not involved in a research study here. You have the freedom to ask questions in a way that's gonna help the person you're asking understand and answer in a very appropriate way. Does that make...I'm hoping that makes sense. I answered that kind of clunkily, but...

And this graphic really comes out of the implementation guide that I showed you the cover of before, and it's really just looking at an algorithm of what, you know, you ask a single question and there's no positive response. You still wanna have a conversation. I give them a brochure because that can change any day, and you want people to be educated about safe drinking. If they do screen positive, we wanna know, are they risky drinkers but still under control? Or are they dependent drinkers? So you would do a second screen, and then based on the response to that, you would either move forward to brief intervention, or you could refer them to a more formalized alcohol treatment program.

So brief interventions have been tested for, oh, gosh, 35, 40 years now. Lots and lots of evidence-based behind them. They're effective, low-cost, and it typically is four or fewer sessions. Once you get into more than four sessions, you're pretty much doing brief counseling or counseling. They're self-help. It's relying on the individual to make their own choices and make their own change. Again, it's for use of non-dependent individuals, or if they're dependent and they're not ready to take a referral to treatment, move forward with the brief intervention because it might increase their readiness to accept your referral. And that's...I've used that an awful lot. If people are like, "No, I really not. I don't wanna talk to anyone else, but, you know, as long as I'm here today, you can run me through it." You're gonna do one.

We go through the brief intervention, and some of the light bulbs are going off of really how alcohol is impairing, impacting their life, and that another step, a more formalized step might be more beneficial to help them and their families. It's typically before performed in non-treatment settings. We don't usually do this in an alcohol treatment program, although the Project CHOICES we'll be talking about has been tested in conjunction with a woman's treatment program, and it works just great. We wanna combine the techniques of motivational interviewing and cognitive behavior therapy. So my guess is many of you have been trained at least in motivational interviewing because so often we get that training first, and we'll also talk about when that needs to be modified a little bit.

We know brief interventions are quite as costly. They could be offered on a lot of different ways. I have done both face-to-face and individual and telephone. They've been tested in groups, and web-based is great. Interventions now that are text-based, and then, of course, Skype kind of just telemedicine types that are all working equally well. And there, you spend a lot of people, university staff, clinical staff, community helpers, religious professionals, and including Healthy Start staff.

So what we wanna do is use the alcohol screening and brief intervention to prevent FASDs. And as you're working with families who have a young child, they're also typically going any age where they may be having adult children, and you have perfect opportunity to know these things and to intervene. So when we wanna assess what we call as a risk for an alcohol exposed pregnancy or an AEP, we look at drinking above recommended levels. So if it's a woman, she's drinking more than seven drinks a week, or more than three drinks on any one day. That's gonna increase her risk. It's gonna increase her risk for a host of health problems.

We also wanna assess if they're sexually active, and specifically vaginal intercourse with a man, and that they're not using effective contraception or they're not using their former contraception consistently or as intended. So you have to have all of those in order to be at risk for an alcohol-exposed pregnancy. So not just drinking too much when sexually active. If they're on an effective form of birth control and they're using it effectively, then we wanna address their drinking, but we don't have to worry as much about their risk of an alcohol exposed pregnancy. We also know contraception can change. Contraception usage can change. So we always wanna continue to ask.

And then what do we do...how do we choose an intervention? So we wanna look at as dual focus interventions, not just drinking, not just looking at alcohol use, but also addressing pregnancy risk, especially for women who are not intending to get pregnant and don't wanna get pregnant right now. And there's a program, Project CHOICES that came out of the Center for Disease Control and Prevention. It has lots of great science behind it, and it's on Stanford evidence-based practice list, and it focuses specifically on avoiding an alcohol-exposed pregnancy in women who are not pregnant.

So I just wanna be really clear that we're not talking about pregnant women and trying to reduce the alcohol. We're talking about in a

conception of women who are not pregnant right now, but are drinking above recommended levels and at risk of a pregnancy because of the contraception use and their sexual activity. And we wanna start there and reduce their risk. So we tailor it to meet their needs. We can do it in a two or four session model, and actually there's a very successful one session that came out of Denver Health, Denver Public Health, and that we have adapted here Wisconsin as well, and many of the tribal identities that we've worked with at our CDC projects over the past four years are using as well. So the one session model is also very, very effective, and it's much more practical, I think, in terms of time and keeping people, women engaged in the program.

So I also wanna be clear that brief intervention is not for everybody. So if you're alcohol dependent, it's not gonna necessarily work as a treatment. But again, as I said before, it can work to help improve your readiness to accept a referral, which is huge. And any conditions that require medical management, if you have diabetes, if you certainly have a substance use disorder, that we wanna look at how alcohol can impact your disease as well and not just your other areas of your health. We also wanna look at individuals who have cognitive limitations. So, because of brief intervention, because they're brief and they rely so heavily on motivational interviewing, which is very abstract in its concept and really putting the understanding and the pressure to change on the individual, it's much...on a scale of one to ten, how ready are you to commit to? Or let's talk about what it would take for you to be ready, to be more ready?

And that's all really abstract reasoning, which is requires a lot of frontal lobe function, and if the parents or the individuals you're working with don't have that capacity or you suspect they don't, then a lot of the techniques of motivational interviewing, unless they're adapted very specifically, are gonna be lost and the intervention will not be as effective. But again, it can always be after the screening tool for referral.

Of course, there's other available tools, and as far as screening and assessment, if you have access, you are going into people's homes. You're meeting with people's families. You could see through informal screening. [Inaudible 00:33:57] keep bottles in the house. Do you have that smell of stale alcohol? Does someone seem hangover? Is there alcohol in someone's breast? If the house just got really...it's [inaudible 00:34:05], it's a lot more disorganized than you would expect. Are there constant conversations, you know, how we can work with families? And everything seems to be centered around the drinking activities and

going out on Friday night and getting drunk and making sure they have a babysitter so they don't have to drive home, and all of those kinds of conversations. So just by observing and paying attention is where we can get a lot of our information.

Do you also have access and trust? You're building the structure of the family. Do you have access to other family members? And the program that you have and the services that you provide, whether it's part of the Healthy Start program or part of the agency you serve, it's seen as a help and it's seen as something that's helpful to the family. And that trust is... You know, it's oftentimes it's clinicians that takes a long time to build, or social workers coming into the home, a longer time to build. But you're there specifically to help them, and you have this more broad understanding of the family. And so again, I think that what you do puts you in a prime position to be able to notice and act on, if you think the family is drinking above recommended levels and need some help.

So before we go into potential challenges, I did...actually I wonder, just one thing I forgot to bring out, and I think I forgot to bring it up. When we're doing screening, I usually get questions about, well, you know, when women are saying they're drinking X amount, we always know to double or triple that because people tend to underestimate their alcohol use. And then always those kinds of questions, it's like, "Oh, you know, that doesn't fit really well with me," because what we're doing is basically saying all women lie, and I'm really not comfortable putting that out there. So I always take the view of if I'm thinking based on the evidence I'm observing, and I ask the question, and I don't know if their response is accurate based on everything else that I have been observing. I'm taking that as that's my bad.

That's my not having created a strong enough environment of trust, that the woman I'm serving or the family I'm serving doesn't trust me yet. And I'm gonna work harder over the course of time to build that trust so that when we ask the questions again, that they're feeling more comfortable that the information will be used to help the family. So I'm hoping that makes sense because I know, I get that question a lot, and I just wanna... As I talked about the pre-screens, is that sometimes people aren't ready to answer and it's okay as long as we keep asking. And typically I'll say, "Oh, okay. You don't wanna talk about today, that's fine." But it's part of our program. So don't be surprised if I ask again and then move on to another topic.

So, again, before we move to other things to consider, are there any

questions about alcohol screening and brief intervention?

Megan: Georgiana, at this point, there are no chatted questions in the chat box.

Georgiana: Oh, great. Oh, great. So other things we wanna consider as you're going in and you're working with families, is that there are competing needs. There are lots of things that are going on, and I have definitely found that in all the brief interventions that I've done, is that they're really not gonna be effective unless the basic needs of the family are met first: food, shelter, safety, employment. Do they have money coming in? Do they have food on the table? Do they have a roof over their head, clothes on their back? Do the kids have underwear and shoes to go to school? Because working on plans to reduce drinking when all of that is hanging over your head, and you don't know, yeah, I can talk about reducing my drinking today, but I don't know how I'm gonna feed my kids tonight. That really becomes our priority.

And then I wanna move on to potential cognitive challenges of family members. Are they really...are they able to understand and carry out everything we're talking about? And that might become a parent especially if I'm moving forward with advice or conversations that tend to be very abstract in nature as motivational interviewing can be. So just a reminder that there are lots of children who have parents with disabilities, and of those 6.6 million children, 2.3% of them have parents with cognitive limitations. And those are only the ones that are diagnosed, and I think that many of the families that we serve didn't have parents with cognitive limitations, and some of that was due to genetic conditions. Some of it was due to alcohol, some of it was due to adult onset alcoholism and the impact on the brain.

We know that the families with cognitive challenges tend to have a lower income. And so they tend to qualify for services even though they may not have had a diagnosis or an understanding of why they need the services. So when we wanna dig deeper, we wanna look at a family who aren't just doing things, and they're not following, you know, outlined plans, and they seem to be really interested and engaged while we're there, but there's no follow up. And we wanna kind of as Diane Melvin talks about, we wanna reframe that from it's not that they're not, they won't do it. It might be that they can't do it, that they need more help to carry out complex processes. And it might not seem complex to, "When I leave, I want you to call. We're gonna make this appointment and try to get in before I see you next."

That's actually...if we've mapped that out, how many steps that would be? That's gonna be a lot of steps. And it might be cumbersome or challenging for someone with cognitive limitations. So we wanna observe informally. Are parents active participants or do they agree with everything? "Okay, that sounds fine. I'll sign it. I'll sign it." Or they're coming up with ideas of their own, because oftentimes the more complacent, the more, "Okay, I'm just gonna comply, and we'll grab, go, go, go along with it." It's because I can't come up with any alternatives. I might not understand it, but I don't wanna tell you I don't understand it. So I'm just gonna agree. I'm gonna sign it, and I'm gonna try to do what I'm told, even though I might not be able to carry it out.

Do they cook? What do they usually eat? Is it all microwaveable? Is there food in the fridge? And is there a variety of food in the fridge? Or is it a lot of boxes of mac and cheese that sometimes we assume they can afford more, but maybe we wanna also consider, do they know how to make anything else? Do they have strong social networks of people that can help them or, you know... People with strong social networks usually have higher cognitive abilities because they have to reach out, and they have to be able to have that, navigate that very intricate interplay with social networks, of when to contact, keep conversations going, keep families, keep friendships going, the give and take of friendships, that I was invited here I better reciprocate by inviting back. That's a good sign of more intact, you know, cognitive abilities.

Is the household organized? And not so much is it clean, because that can be anyone. But is it organized? Are the bills in one place even if they're on a pile on the table? Is the laundry in a basket or is it kind of everywhere? And are bills paid on time, and really above and beyond financial constraints? Is there an understanding of timeliness, and is there an understanding of, you know, making sure that these get done by a deadline? Because if it's not, then making appointments and making up the call and getting a kid to a doctor may not happen. And not because they don't want it to happen, because they don't know how to make it happen.

So we have lots of screening tools that we've adapted our screening tools that we've used. It's pretty simple, you know, one page, and [inaudible 00:41:46], and then the back is just kind of open-ended challenges, strengths, weaknesses, things they don't wanna consider. But what we do is collect birthdate and maternal alcohol history, developmental milestones, physical and cognitive diagnosis, any

neuropsych exams. And again, as I was going through your Healthy Start tools, you have a lot of that information, at least for the child already in there. But we also wanna consider the parents. So there are simpler ways to screen, and then those who wanna get into formal screening as much as noticing and having those conversations.

Unfortunately, if you're thinking, you know, there might be an adult with FASD. Few diagnosticians assess adults. There's few enough that assess kids, but most clinicians who diagnose FASDs are not comfortable going into adolescents and adults. So there are really long waitlist in there. Our states called our toll-free networks and said they can't identify even one who have diagnosed over the age of 12. So while you're saying, okay, so why am I even bringing this up? Because we don't want, really want that to stop us and to be as big a barrier because we wanna employ the support strategies anyway. If you're suspecting it, start employing the support strategies. A little extra structure is not gonna hurt anyone. That's not gonna [inaudible 00:43:05] relationship, as much as it might really help the families that you're serving.

And so The Arc, formally known as the Association for Retarded Citizen has a wonderful HRSA-funded FAS initiative. Plus they've been doing FAS before anybody else was. And they have lots of great training and resources on supporting families. And if you think about this, as we're looking at like women's treatment that we're looking at supporting kids, it's really the same kinds of things. We wanna meet parents where they're at. In women's treatment, we meet the women where they're at. When kids who are doing assessments and who are doing early intervention, we're meeting them where they're at. Why wouldn't we do the same thing with parents? So I meet the parents where they're at, adapt our training, our interactions with them to accommodate their learning style. We wanna maybe extend it a little longer appointments or longer services to build in that extra time.

Anything we teach, we wanna teach in a real environment, like the home, like the community. If they're gonna be taking the child on a bus or if they're gonna be taking to the doctor using this method, we wanna teach it using that method. When I was in the special ed, we had...this used to bug me. We would take kids, and we would teach them how to use laundry machines. And then we go into their homes, and it's like, well, they've got stack machines. So they don't even... We taught them on something that is totally foreign now and they can't apply the knowledge. Or they're going to a Laundromat and we never showed the kid where to put the quarter in, and probably not even a quarter

anymore.

So we wanna be able to do as much as we can in real environments, or at least bring as much of the environment into the location that we're providing our services, whether that's with the laptop or that's with the, you know, Skyping whatever we have to do to make it as real as possible. And we wanna be inclusive, the parents, and support their increased interaction in the communities. The more we can get people interacting with their community, and other people, other peers, the more we're able to strengthen families.

We can quickly assess the support needs. Maybe as easy as budgeting or shopping and meal preparation, bringing in someone to talk about simple meals, sponsoring some cooking classes, getting...really talking about easy ways to do more complex actions. You just wanna be very careful. There's emergency preparedness, including mental health. We've seen lots of new commercials coming up about, you know, making sure you have a plan in your family if there's a fire, if there's a tornado and you're separated and you're not all home, where...how are you gonna get in contact each other? Well, that's equally...it's even more important for the family that we serve to make sure there are emergency plans in place, whether it's a tornado coming in the summer seasons in certain areas of the country or if it's one parent family, parent being released in jail. We wanna really look at coordinating services and play groups, and maybe supporting play groups not just for children but to support the interactions with the parents as well. Because we know kids can benefit from that, but parents who are socially isolated benefits just as much from play groups and interventions with their children in groups of other parents as to the kids.

And now we of course wanna adapt parenting skills training to really meet their needs. And there are some supportive parenting kinds of curriculum where the parents have actually mental retardation. But we don't often have to go...we don't often have to adapt at that much as really looking at what the sticking points are. Taking really good notes and knowing where they tend not to be following through, finding those patterns, and then changing the way that we interact with the families to fill those gaps. And it doesn't have to be always, but you'll be able to see when you can start easing off and not relying on such, you know, planned strategies.

Some of the basic things we could do is to use very concrete language. You know, say what you mean, mean what you say, avoid acronyms,

avoid idioms, things like that, that are...can be confusing. And we wanna reduce stimulation in the environment. And if people can get really...I mean, I know a lot of people can get really overwhelmed by chaos in their house, but they may not have the skills to organize it. That's why personal coaches and house organizers are, you know, all over the country now. You can call the number, tell them to come in and organize your house. They charge a lot of money, but it's a great service. This could be really helpful for a lot of the families that you serve is just look at how can we help improve, make your environment easier to navigate. Because when you have still pass that, I'm so overwhelmed, I don't know where to start, that's where we can be helpful.

Allow extra time. There are things that have to be done. Maybe not visit with them and say, "Finish it. Okay, we're running out of time. Finish it before I get back next week," or however often you're there, as much as, "You know what, let's just make this the focus of today's visit. Let's finish this." And we always want to start and end with the family, and bringing everybody's viewpoints and everybody's needs into consideration. And that's it.

So [inaudible 00:48:46] and leave time for questions, but I wanted to check in and see.

Megan: So folks, chat your questions or comments in the chat box here in the lower left corner of your screen for any information that Georgiana has presented or any topics you wanna hear that...any additional, because again this was kind of a sample. It was very brief in each of the areas, but if you're interested in one more, one particular area, there's lots of existing archives, webinars out there, too, that we can point you to.

Here's one question for you, Georgiana. Can you give more information around the differences in both short-term and long-term impacts of fetal alcohol spectrum disorder as well as compared to neonatal abstinence syndrome?

Georgiana: Yes, yes. So, again, as I said earlier that lots of people mistake the two, and I did some pretty targeted training in Wisconsin last year, and it still is a challenge for us. Neonatal abstinence syndrome is specific, pretty specific to the effects of opiate drugs. And if a baby is born affected, not all kids go through withdrawal, but there are medical protocols with weaning babies off of different replacement drugs until they're better. Sometimes they don't have the benefit of those drugs, but

it can start anywhere from hours to even a couple of weeks later, can last anywhere from one week to three months. But when it's done, the drugs are out of your system. There's very little research to show that there's long-term impacts on the brain. So the kids grow out of it.

It's a tough couple of weeks. It doesn't have to be as hard when they're medically managed and they're weaned off the drugs, which is the way to do it. And they are, you know, logically dictating how children has to be treated, who have neonatal abstinence syndrome. And, you know, it is kind of a one-and-done. With fetal alcohol syndrome, the babies can also have...they can have both. Absolutely, mom can be using more than one drug. They can have FAS and have neonatal abstinence syndrome, which also gets a little bit confusing at first because we're not necessarily sure what we're looking at. But you can test for drugs in a baby system, in an infant system. Well, you can't really have any kind of blood test or genetic test for fetal alcohol syndrome. But for FAS, the alcohol impacts the brain, and oftentimes, those impacts are not seen until later, until they start missing developmental milestones or they start falling behind in school.

So oftentimes, after a baby leaves the hospital, the first couple of months, they seem to be doing okay. It's like, wow, okay, so the alcohol didn't impact them. And then right about second, third grade at school gets a little bit harder and a little bit more independent. They start having significant behavior problems, and that's when some of the symptoms and their behavioral and cognitive signs of FAS can start showing up. So really for the facial features of FAS, there's no facial features associated with neonatal abstinence syndrome. Is there drug in their system? Are they going through withdrawal? Can we support them through that withdrawal? When they're done, they're done. Of course, they have to go home to an environment that's clean, that parents are trained. They know how to work with kids. But the effect is gone.

With FAS, if there isn't facial features, if you don't see the facial features, which really happen in the first trimester. So mom has morning sickness and is unable to drink during the first trimester until she's feeling better in the second trimester. The child, chances are, won't have any of the facial features associated with FAS. Those are kids who fall through the crack, don't get diagnosed earlier and don't get diagnosed until later in elementary school when all the benefits of the kinds of programs that you do are lost on them.

So two distinct things, different drugs involved. There certainly can be

overlap. One of them is lifelong, involves brain damage, one of them doesn't. Does that help or not...?

Megan: That's great. I'm sure you could do a full talk on that whole topic right there. So thank you.

Georgiana: It is a whole talk, and it's really where so much of the federal funding is going right now. And we would look at the prevalence of FASDs now, the entire spectrum. It's like 3.5% to 4.8% of kids. That's [inaudible 00:53:23] percent of kids are affected. That's huge. That's huge. And it certainly talks autism, which is another incredibly important condition. But we're not looking at a very low number condition that we're talking about. There's a lot of people affected. Still in my opinion, many of them go undiagnosed for long periods in their life. A lot of the families that we've started working with later in my career and the women in treatment who already have had children, they're the ones who are getting the diagnosis of FAS. You know, struggling through life and finally understanding what some of those struggles was coming from. And then the change from diagnosis on, it's just watching that changes and the better effectiveness of treatment when we're meeting their needs has been...it's made for a very rewarding career.

Megan: So here's one more question for you. Can you say more about what happens in a CHOICES session?

Georgiana: Oh, yes. Yes, I can. So CHOICES session, there is an assessment to see, you know, what the drinking pattern is. And then we kind of walk through exercises. So decisional balance. What are the good things you like? You know, again, some motivational interviewing. What are the good things about your drinking? What are the not so good things about your drinking? So it's motivational interviewing. We don't tend to say good and bad, unless the adult has the kind of a challenge, then we wanna be more concrete. But good things and not so good things. What are the not so good things about changing your drinking behavior right now? And then what are the good things about changing it?

And we ask in a very particular order so that we end on the positive with them making the case for what the good things would be about changing their drinking behavior. Do the same thing with contraception. What are the good things about your current use of contraception? What are the not so good things? You know, not so good things about changing, or good things about changing. And then we talk. We try to

assess on a scale of one to ten, I'm not at all ready to make a change and completely ready. And then how confident they are that they could make the change that they wanna make, and how willing they are.

So there's lots of... It's really manualized because, you know, there's a nice, little manual. It's available, downloadable free from the CDC website. And that's the four session model is, I think we can certainly share a one and two session model with you that we've used. But it's really the same kind of component of you do an assessment, you provide personalized feedbacks. So this is your information. So we don't talk a lot about national statistics, but we do compare them to other drinkers in their state, their region, their clinic, whatever lowest level, I mean, the tightest amount of data that we can provide that's closest to them, to their reality.

And then talk about other health risks, and then look at how we can make a change plan. Oftentimes, we'd look at extra calories. A woman who is saying "I wanna know about the calories," we change it in a cheeseburger equivalence. We'd look at how much it costs. So when we calculate that out, there's some kind of standard formula of whether you drink at home, whether you drink out in a bar. And some women they're realizing, you know, one of the first interventions I ever did, they were spending, you know, $28,000 a year on alcohol. And that impact, when the light bulb went on. That was it. Okay, ready. I'm ready now. I didn't even think about the money, that aspect of it.

We look at other health concerns they're having. But it all kind of gears towards everything is they're making their own choice. It's their own self-efficacy. So we assess that along the way. How ready are you? How willing are you? What would need to happen for you to make that change? How can we support that? So I do encourage you to just go to cdc.gov and put in the search engine Project CHOICES. You can look at the manual, and if anyone is interested, you can either email me or I can just send it to you to distribute some other options of it.

Megan: Sure, I'd be happy to share that info. And actually, Georgiana and another colleague of her, did a wonderful poster presentation at the [inaudible 00:57:30] on this training. So I posted a link here, but if there's other information we can share, we'll do that. And Georgiana also included a couple of references for her talk. And with the last couple of minutes we have, I wanna give my colleague Hannah Bablu, she's a consultant here at GSI and one of our teammates on the EPIC Center who's really doing a lot of the work with the FASD initiatives that Dawn

Levinson spoke about early on, an opportunity to share some upcoming support training, learning opportunities. So Hannah, I'm gonna turn it over to you.

Hannah: Sure. Hello, everyone. My name is, again, Hannah Bablu, and as Megan mentioned, I'm working with Janet Vanness who's also on our team, as well as our other team members who are here on this call, on the FASD project. I'm [inaudible 00:58:13] for New Mexico. I'm very excited that you all joined this webinar to learn more about fetal alcohol spectrum disorders. As Dawn Levinson mentioned earlier, as Megan just mentioned, we'll be having discussion groups based to...well, discussion group to further learn more from you all about what your interest and needs are around fetal alcohol spectrum disorders, and more generally around behavioral health.

This information that was just provided in the webinar is just the tip of the iceberg for topics within this area. And so we'll be offering trainings and technical assistance options on different topics, and these discussion groups will really give us a great opportunity to learn more about your programs and your specific needs around fetal alcohol spectrum disorder and behavioral health. These discussion groups are being held based on the communities we work with and the type of program we have, and so there will be rules, these rules currently [inaudible 00:59:08] and communities, and the native [inaudible 00:59:11]. So meaning that if your organization serves large populations of Native Americans, either urban-, rural-, or reservation-based, that will be another discussion group. And then also on border communities, urban communities, and then those grantees that work within community health [inaudible 00:59:28].

Megan, I think just chatted about each of the Doodle polls, links to Doodle polls to indicate your availability to these [inaudible 00:59:36] in these discussion groups. So we would love your participation. Click on the link. Let us know when you're available, and we will greatly look forward to chatting with you, and we also welcome your engagement. And our contact information will be provided in a couple of slides as well.

Megan: Okay. And Hannah, by the way, did you wanna do just a quick poll of everyone, kind of just to get a sense of which discussion groups, at least the folks participating on this webinar might be interested in participating in?

Hannah: Yeah, absolutely. So please, just click on your...on the

discussion group on your screen that you may be interested in participating in based on the communities that you work with and what you would like to contribute around the discussion for fetal alcohol spectrum disorder and behavioral health, and then we'll bring up that poll once you finish up.

Megan: Great. So if you have a second, if you can click more than one, too, if you're, you know, you serve different...if you're in a community health center but you say you work mostly with your border serving organizations. You could click both. So we just wanna kind of get a sense of demand at this point.

Hannah: And I also wanna mention that same thing with the polls, the discussion groups that we'll have, if you feel your community or your program serves more than one community, we welcome your interest in more than one of the discussion groups. So feel free to participate in more than one, if you feel your community reflects that.

Megan: Great. All right, we'll...here I'll show you the result at this point Hannah, and we'll track that, and then wait for folks also to weigh in on the Doodle polls. I'll send the Doodle poll out to check availability out with the other resources that have been shared from the presentation today. Here's the contact info for all of the folks that are really moving this initiative forward. Hannah Ba and Janet from the GSIN, Dawn Levinson from the division's perspective, and our amazing expert presenter, consultant, Georgiana Wilton. Her contact information is listed here as well.

And, you know, on a similar topic to building off of some of the information that Georgiana had shared, there is an upcoming webinar. It's actually next week, really going through the screening tools initiative, how...talking participants through the Healthy Start screening tools. So that is actually scheduled for February 28th, and it's an Ask the Expert webinar with Dr. Jean Shepherd. So really building off of some information, not just focused on fetal alcohol spectrum disorder, but really overall the screening tools that you'll be using but so relevant to what Georgiana was sharing today.

So with that I know we are a couple of minutes over time, but I just wanna give a sincere thank you to Georgiana Wilton for the expert presentation today and all the wonderful information you shared. We really do appreciate it.

Georgiana: You are so welcome. Thank you.

Megan: And this concludes our webinar for today. Thanks for your participation, and we look forward to engaging with you more on this topic in future webinars, discussion groups, and other training opportunities. So thanks so much.