

**Sensitivity, Screening, and Support:
Talking with Expectant Families about Substance Abuse**

Sarah: Good day, everyone, and welcome to today's Zero to Three Sensitivity Screening and Support Conference. Just as a reminder, today's call is being recorded. At this time, I would like to turn the conference over to your host for today, Ms. Amanda Perez. Please go ahead, ma'am.

Amanda Perez: Thank you. Thank you so much, Sarah; and hello out there to everyone. On behalf of the Early Head Start National Resource Center, welcome to today's audio conference on talking with expectant families about alcohol use. We are thrilled to have you with us today. And you're on the line with program staff from all over the country, as well as federal staff and training and technical assistance providers.

If you know folks who might want to hear this call at a later time, as Sarah said, this call is being recorded and will eventually be posted on the ECLKC where we can find it at a later time. I want to direct everyone's attention to the supplemental materials that we sent registrants by mail or email. So you'll see there the objectives for today's event which is on page 1. And you'll find information on our incredible faculty on pages 2 and 3.

I want to give those folks a chance to introduce themselves so you can connect names with their voices and their faces and their expertise. So let's start with Angie Godfrey, Infant/Toddler Program Specialist at the Office of Head Start. Angie, it is snowing up here. The federal offices are closed, but we are so glad to have you with us today.

Angie Godfrey: Thanks, Amanda. I'm really glad to be here and I'm looking forward to being on the call. And mostly I'm looking forward to learning today, so thank you.

Amanda: We're grateful to have you here. It's really helpful. Thank you so much, Angie. Dan Dubovsky.

Dan Dubovsky: Yes. Well, I think all of you have the bio information for all of us, so I won't take too much time. But just to say that I really come at the idea of both prevention and intervention around fetal alcohol spectrum disorders from the point of view of a parent and a professional, having been in the field for many years and having raised a son with fetal alcohol syndrome who wasn't diagnosed until 19 years old. And we really struggled with all of the systems. So getting the word out about, you know, not drinking during pregnancy is really important. Recognizing families you might be working with who may themselves have an FASD, we'll inform you about how to modify your approaches with them to be more successful. And I appreciate everybody being on the phone today.

Amanda: We're very glad to have you, Dan. Thank you for being here. Anne Reddy.

Anne Reddy: Hello, everybody. My name is Anne Reddy. I'm the director of the Real America Initiative's Head Start program. We are a program that serves Rapid City and the Crow Creek Sioux Tribe. And I am – feel fortunate to be a part of this today. Healthy families, healthy pregnancies, healthy children are my passion. So, I hope you enjoy today's teleconference.

Amanda: We're really thrilled to have a director here. Anne, you bring so much practical experience to this work and we're thrilled to have you. Thank you for being here.

Anne: Thank you.

Amanda: Nancy. Nancy Whitney.

Nancy Whitney: Hi, everybody. I'm Nancy Whitney, and I'm the clinical director for the King County Parent Child Assistance Program at the University of Washington. King County is where Seattle is located. The Parent Child Assistance Program is a state funded intervention that works with pregnant or new moms who have used drugs and/or alcohol during pregnancy. We provide three years of intensive case management with the goal of preventing any more babies being born that are drug or alcohol affected.

I've been at PCAP for 12 years. My passion is preventing FASD but also making lives easier for those people who are already here who have FASD as much as we can. I really thank all of you for being here today. I hope it's worthwhile for all of you; and thank you.

Amanda: And Nancy, we're thrilled to have you with your clinical sort of supervision experience in that program as well as with your direct practice experience with the mothers in that – in that program as well. Thank you for being here.

We have a lot to cover today. And we're going to get right into the questions for you. And we're going to start here with Angie. We want to begin, Angie, as we always do by talking about the Standards. And the ones most relevant to this audio conference are listed in the handouts on page 4. So Angie, if you look at these Standards, what is it that you want to highlight in particular?

Angie: Well, the Standards are 1304.40 and they're in the Family Partnership section of the Head Start Program Performance Standards. And the first one is (b), which talks about accessing community services and resources. And we know that programs spend a lot of time developing relationships with families and helping them to talk about what the issues are in their life and what their questions are in terms of resources that they want or need. And so, that first one is very important. It talks about appropriate interventions and making sure that families get the services that they need.

And then 1304.40(c) is specifically around pregnant women; ensuring that they get on early and continuing risk assessment, health promotion and treatment, and mental health interventions and follow-up, including substance abuse prevention and treatment services as needed.

And then number (ii), it talks about offering prenatal education to pregnant women and their families. And I think, though they're fairly broad – but I think what happens on these calls is going to happen today, and that's that programs are going to learn strategies for having conversations with families that will connect them with resources or connect them with information so that they can make decisions.

I, you know, always – when I look at the Standards, I think of how important relationships are and relationship building is. And it has amazing impacts with families if staff have the right information. And I know today they're going to get wonderful information, so thank you for having me here to introduce this. And I'm going to sit and learn with everyone else today. So thanks, Amanda.

Amanda: We're so glad you're here. And if those Standards questions come up, we're glad you're here especially. I also – that provides such a nice sort of tie-in to the NCPFCE Framework that's available for

folks on page 5. So, this is from the National Center for Parent, Family, and Community Engagement. We certainly are going to be speaking about family engagement today. We're going to be speaking about many of these elements here, particularly family partnerships, community partnerships, as Angie referenced in particular, family well-being, and families as learners. Pregnancy, we know is where all of that begins. And we really want to focus, too, on that purple arrow on the top that talks about the relationships that Angie mentioned.

We know that the Standards were developed by experts in this field. So I want to start with Dan by talking about why conversation about alcohol is so important during or even before pregnancy. What risks does maternal alcohol use pose for folks, Dan?

Dan: Okay. Well, thanks for asking. And I think that – I mean one of the key issues really in our society is that about 50 percent of all pregnancies are still unplanned. And most women don't know when they're first pregnant. And alcohol, more than any other drug of abuse, causes more serious lifelong neurobehavioral effects. And the effects of alcohol on a developing fetus really begin about two weeks after conception once the fertilized egg attaches to the uterine wall and the placenta forms; and that's long before most women know that they're pregnant. So, talking about the issues is important. Even when you're dealing with pregnant women, they may be women who get pregnant again.

And the – so the effects of alcohol are really pretty dramatic. And alcohol causes damage to a number of different systems in the fetus, like the limbs and the lungs and the heart. But it really exquisitely develops. It really targets a developing brain in ways that other substances of abuse don't. And so, what it does is it causes a lot of behavioral difficulties, a lot of learning difficulties, and a lot of behaviors that really look like they are purposeful, willful behaviors in people. So people really struggle with this throughout their lives.

Now the good thing about alcohol, if there is a good thing – about alcohol, the way alcohol causes damages, is it causes damage all the way through pregnancy so that any point during pregnancy, if women don't – if women stop drinking, it's going to be beneficial to the fetus. So it's not like, "Oh, I just found out I'm pregnant. I've been drinking. I might as well continue because I've already caused the damage." No, absolutely not. And that's why working with pregnant women at any point and just getting the message across in a way that is not judgmental and not blaming, because there is a lot of stigma we have to break through around this. But if we can do that and just bring it up as this is information that we have found out, that's really important.

So alcohol causes this damage. We may see infants who have a poor sucking reflex or failure to thrive or small in size, and then don't eat well and don't sleep well. And as they get older, they have trouble at home and they have trouble in social situations and trouble in school. So again, it has these lifelong effects. So again, it's getting the message across that the only proven safe amount of alcohol use during pregnancy is none. We don't know – we can't say that there is a safe amount of alcohol to use for everybody or a safe time during pregnancy, because again the brain is developing all the way through pregnancy.

So at any point during pregnancy, alcohol can cause damage. But not drinking can be beneficial. And I think that that's really, really important to get across. And the other thing that's important to get across is that it's the alcohol that causes damage to the fetus. It's not the mother that causes damage to the fetus; that this is not purposeful behavior on the part of women to harm their children. Although, you

know, again, a lot of women struggle with that kind of guilt and that kind of blame that we really have to overcome.

So – and it really is – this occurs in any community where women drink. Women who have alcoholism are certainly at higher risk of giving birth to a child with an FASD. But women who are social drinkers who have a responsible job and go out and party on the weekends, if they're pregnant, can also cause damage to the fetus. And so, we want to really recognize that; and that's why your role is so important in working with pregnant women and, you know, getting this message across that the safest amount of alcohol to use during pregnancy is none. And also, the safest thing to do while you're breastfeeding is not to drink because alcohol does get transmitted through breast milk as well. And the baby is still – the baby's brain is still growing and alcohol definitely affects the developing brain.

Amanda: And so we have some fact sheets in the materials, Dan, that are from the FASD Center for Excellence where you're working.

Dan: Right.

Amanda: And there's some really lovely resources for both staff, I think, and also for families in some situations. Just in terms...

Dan: Right. We put together a number of fact sheets. And there are more on our website that might be really useful. And we put them together, as you said Amanda, both for professionals and for families to be used – to use.

Amanda: Nancy, what would you add?

Nancy: You know, I think that there's some – you know, all of us who have a lot of contact with child welfare or with pregnant women, we get really worried about the fact that somebody's using meth or heroin or cocaine during pregnancy. And I know that the mothers that I talk to who have used crack and heroin and Percocet or whatever during their pregnancies, they have a lot of worry that they've – you know, that they're causing damage to their baby by using those substances.

And I really want people to understand that those substances – and we know this through animal studies for many years and maternal health study, lots of research to show that those substances are not a teratogen. That is, they don't cause birth defects in babies and they don't cause brain damage in babies. Certainly, those substances used during pregnancy are not good for the pregnancy. Moms don't eat right, sleep right, you know, they have a lot of stress when they're using those kinds of substances. And that means babies might come earlier, they might come small – and no baby should come early and small – or without their challenges.

But the baby who comes into the world who just got heroin or just got crack, if that baby has like a sort of a safe, stable life and good nutrition, they're not going to look any different at the age of 5 than a baby that was not exposed to those substances. Alcohol, legal and everywhere, is the only substance that – on this list of things that we worry about that is an actual substance that will cause teratogen effects or birth defects in children.

Amanda: And it's interesting to hear you talk. I mean, I think in Early Head Start programs, we're not necessarily seeing – commonly seeing, you know, families that are so involved with substances of any

kind. But certainly, there can be families that are coming in with sort of multiple addictions and those kinds of pieces. I think the piece around alcohol as a teratogen that can really affect any anyone, even in small doses as Dan was saying, as we're thinking about that CDC recommendation that women just don't drink at all during pregnancy. And it certainly highlights what staff can do as they're working with families in pregnancy.

Nancy: Yes.

Amanda: Right. So we know that FASDs are out there. You know, we certainly hear it in the stories that Dan and Nancy tell. And we know that they are frequently undiagnosed. When I spoke with the faculty about participating in this audio conference, it was so interesting to me because all of you were so positive about the possibility and opportunity that staff in Early Head Start have as they work with expectant families around this issue. And you all have spoken to that a little bit. Nancy, can you say a little bit more about why you were so enthusiastic to participate?

Nancy: Well, you know, I think that – you know, another sort of factoid that I think is really startling to me is the fact that prenatal alcohol exposure is the number one cause of mental retardation in the western world, So not Down syndrome, not cerebral palsy, not autism; it is prenatal alcohol exposure that is the number one cause. And here is something that is completely preventable. We just need to have one thing happen, which is a really hard thing, which is that women need to not drink during pregnancy. If we can improve that then we will improve the lives of so many children.

The other thing is that to raise a child with FASD to 18 years old generally costs about \$2.8 million in terms of what services they need, what – where they end up in terms of group homes, and things like that. So, this is a really – this is a huge public health issue. And it is completely preventable. And those of us who work with pregnant moms have the opportunity to really impact those numbers. And on a sort of, you know, more basic level, improve the lives of families and children.

Amanda: Anne, you had a really interesting perspective on this. Can you talk a little bit about your particular interest here?

Anne: Yes. I think FASDs, they are an issue in our community but in many communities across the nation. I just think and feel very fortunate to work with the Early Head Start and be able to provide some type of intervention and education for mothers as they join our program. I've always seen it as a real prime opportunity to establish a relationship with the mother and begin that education process with her. The earliest, you know, in the trimesters the better, of course. But sometimes, you know, that doesn't always happen. Sometimes we'll get mothers in the second trimester; but as soon as you can get that information and knowledge to her the better. I've seen all mothers really use pregnancy as a time to make some changes in their life and look at their life in a different way. And just for it to be an opportunity to do something different for their child that's coming and going to join their family.

Amanda: I love that you said that, Anne, because that's so clear in the research. There's so much research out there that concerns that, that pregnancy is a real window of opportunity for a families to make healthy changes. And you're certainly seeing it in your program. Nancy, you said that ideally we would get information to families even before conception.

Nancy: Yes. It's – you know, let's just get ahead of the problem. And there is a number that's completely startling to me. Maybe other people knew this number; I didn't know it until I came to PCAP. Fifty

percent of all pregnancies in the United States are unplanned. So not necessarily unwanted, but unplanned. And so, when you think about sort of even people who are social drinkers, who are doing Friday and Saturday night, having a few drinks or beers and watching football, and they're not actively sort of planning pregnancy and drinking.

How far into their pregnancy are they when they figure that out, especially if they're not really paying attention? You know, is it six weeks? Is it 10 weeks? Is it 12 weeks? Especially if people are actively using other substances that number goes up to, you know, 16-20 weeks sometimes. So if people are not planning a pregnancy and are drinking, then those are the women that we really worry about the most.

And I especially worry about young women. You know, we've seen some really scary numbers amongst young women, like 18 to 22, who are binge drinking. There's a significant rise in the amount of binge drinking in 18 to 20 year olds. [Inaudible] women, and they're trying to keep up with the boys. You know, so on Friday and Saturday night, they're getting hammered out of their minds with, you know, a half a gallon of this or a case of beer. And unfortunately, it's in – with that kind of drinking behavior that I think an unplanned pregnancy can certainly happen. And if they're doing that every week for the first six to eight weeks of their pregnancy, then we have a pregnancy that's highly exposed to alcohol. And so if we can start getting information to young women who are, you know, sexually active about the dangers of drinking during pregnancy, then that's really good.

And let's not forget the boys. Women don't get pregnant by themselves. And so doing education with young men, that if they're having sexual activity with women who are drinking, that they can play a part in this prevention as well.

Amanda: Well, and, you know, I think you would be the first to say, Nancy, that it's not every teenager that's out there, every young women that's out there, that's having those experiences.

Nancy: No.

Amanda: But it is certainly an unsettling trend. And what I think Angie would say is, you know, it's not the role necessarily of Early Head Start to come in and sort of provide all this education to, you know, all the teenagers that are out there or all the folks in the community. But I think what – one of the things that faculty have really pointed out to us is this – you all are serving a group of families who are of child-bearing age. And so, it's a really helpful time to provide some of this information to them.

Dan: Right. And I think that also it's – I mean, partly it's also all of you being able to recognize. And it's not diagnosing or it's not necessarily actually screening, but just getting a sense of, Gee, "you know, "could this be a family at risk?" And then, you know, where to refer them to for further services. So I think that that's one piece. And the other is that there's another piece that there's a lot of work that's been done on protective factors. And one of the things that's been found is that there are often deficits in certain essential nutrients and minerals. So that for women who are pregnant who might have been drinking – especially for those who might have been drinking but especially for those, let's say, in Early Head Start – getting the message across that – making sure that they are getting good prenatal care, that they are getting their prenatal vitamins, and taking their prenatal vitamins as they're supposed to is really very, very important.

Amanda: Yes. So there are things that we can do. And we certainly want to come back to those a little bit later. I want to call everyone's attention to pages 6 and 7 in our materials where we list some tips

from faculty for talking about alcohol with expectant families. And I think our faculty really looked at this first one, which is to seize this moment, to really recognize the opportunity that's available as you're serving families in pregnancy, when they're really looking to offer the best start for their baby. So we want to start there. And we're going to move on now to talk about some of the strategies like Dan has launched us in for how we can really best serve these families. So as folks are sharing that information, one of the challenges that we want – one of the challenges that I think has come up, and certainly came up in the questions that we received from folks who were registering, is that we want to get this information to families as early as possible in pregnancy. But it can be a really hard subject to approach. And Dan, you already touched on this, but can you talk a little bit about why that is?

Dan: Yes. I think – as I said earlier, I think that there's a lot of stigma about women drinking during pregnancy. A lot of people view it as just willful, purposeful behavior, which we know that it's not meant to harm their child. So that women are sometimes reluctant to talk about it, reluctant to hear about it. And alcohol is a legal substance, which makes it more difficult in some ways than talking about, say, using crack or cocaine or meth or heroin during pregnancy, because it's a legal substance. So – and women often feel judged and blamed if they have been drinking during pregnancy. So we want to open the discussion so that we kind of lessen that sense of blame and judgment so that women are more comfortable in talking about it.

Of course, we also have to take into account the – for those of you in states who are – where you're mandated reporters, there are some states where using alcohol during pregnancy is, you know, mandated for reporting. And you need to know that in terms of how you approach women and talk about it. But we want to open the discussion especially, again, for women who may have found out they are pregnant and maybe they have been drinking. So we want to talk about that. Again, you know, many, many people – many women don't know when they're first pregnant. And if you can think back to maybe the three or four months before you became pregnant, you know, how much might have you been out partying. Because that gets to early pregnancy for some and it's a little bit less threatening. And then for those who may have addiction issues, that kind of sense of judgment and blame is even heightened.

So it's a tough thing to bring up sometimes. People are sometimes uncomfortable with it. But as Nancy said earlier, if we do this with everybody... Don't single out certain people where you think, "Oh, I think this woman might be drinking during pregnancy so I have to talk to her about this." But we should have this conversation with every woman who comes through, and then it just becomes routine and it becomes kind of normalized.

Amanda: Anne, you are one of those states. You live in one of those states that has this as a child welfare issue?

Anne: Yes, we do. It actually is a state law that women that are abusing alcohol while pregnant, they can actually be sentenced for that. It is difficult because we are mandated reporters. And when we work with mothers, you want mothers to have an open relationship with you, but knowing the state law, knowing the – you know, that we would have to report, I sometimes do wonder how, you know, that affects their ability to share.

The good thing is that all women are screened in South Dakota. Like Dan said, you just approach every woman with it and not single out those to, you know, I guess approach with the subject. It - with us, it's

just a part of our curriculum. And as we go through it, we cover it as we would with medications or smoking, tobacco use, and breastfeeding. I mean, it's just included in those list of topics.

Amanda: It's a part of the conversation, right?

Anne: Yes. And we do partner with our treatment facility. We do have a treatment facility here in Rapid City. Those women have already been identified or that is a part of their sentence to remain at that treatment center. And they live there while they also are a part of our program. And so that knowledge is already there, you know, why they are there. And we also have a partnership with that agency.

Amanda: Those community partnerships that Angie was talking about.

Anne: Very important.

Amanda: So in the face of that particular law though, you said that the relationship between staff and family, that purple arrow across the NCPFCE Framework, is really the key. But it can also be hard for staff to slow down with everything that they have going on.

Anne: It is. I think sometimes our staff get so caught up with paperwork – you know, the papers that they're doing and they're going to make sure they have this done or this signed or this covered, that sometimes they just forget to slow down, take a breath, and get to know that parent, get to build that relationship with them. The better relationship you have the more honesty that will come about.

Amanda: That's such an important message. I know we always hammer that one home. But it's just interesting to hear you talk about it, how important that is as we're talking about some of these very sensitive subjects that come up during pregnancy. Nancy, I know you use every opportunity to build those relationships from the very beginning.

Nancy: Well actually, relational theory is one of the foundations – theoretical foundations of our model. So, we spend huge amounts of time and energy in building relationships with clients. You know, these are the highest risk mothers that our community has to offer. And they have so much trauma and they have so much, you know, difficulty managing that they're very suspicious about outsiders or suspicious of providers. And so, you have to on day one start building that relationship. You have to be patient with it.

We get to do what I call car therapy. I think that when you put somebody in your office across from your desk and make eye contact with them, that can be really hard for people to talk about really difficult things. And so, it goes a lot easier if you put them in the passenger seat and you're driving them to an OB appointment or you're driving them to their – you know, their welfare appointment. And you just let them talk and they're not making eye contact and you're just driving. And it's amazing how much more comfortable people are and you can just sort of have that sort of casual conversation. And the more you listen, the more you learn and then you look for those opportunities for change. We're also trained in motivational interviewing, and we use it in everything that we do.

Amanda: And Anne, I know you do some similar things where you are.

Anne: We do. We – in Fort Thompson, it's a rural area. So we sometimes have to drive mothers an hour to two hours away to make an OB appointment. Car therapy works great. You can learn a lot about a

person just riding in the car and getting to know them. We also look at ways to help our prenatal moms by bringing fresh vegetables or fruit to try to just show them, you know, some food health; and just anything that would open that relationship up. That we aren't to be feared. We're there to be trusted. We're there to work in partnership with them and we care about them and their goals that they set for their life and during the time that they're with our program. Some have been with our program, you know, for a number of years.

In our prenatal program, we often get young mothers or first time mothers. So they really enjoy the education piece of that because they don't often know. All of a sudden they're told they're pregnant and they might go reach for some medication that they've taken all along. And they just, you know, consciously don't realize maybe they need to check with a doctor on that, you know, before using it. So I think the level of respect that – in our community, it's very small, and so the person that does the prenatal care has developed a very respected role in the community of trust. And that's just helped the program so much.

Amanda: Well, and as you talk, Anne, I mean, we know that not every program offers rides to appointments or is able to offer rides to appointments or chooses to do that or that's not necessary in their community. But the ways that you're looking to really build those early relationships with families and it really varies, we think, from program to program, as I talk with folks across the nation. But how important it is as we're talking about this particular topic.

And that gets us then to the second tip here, which is looking for those early opportunities to build relationships with families. So as you said, you know, wherever we can join with them in their goals. I think that's just such an important message for us as we go forward. So as Angie told us, one of the requirements of the Standards of course is that programs provide families with information on the impact of alcohol on fetal development. And faculty here have been really clear in saying that no amount of alcohol is safe during pregnancy. We certainly heard that from Dan this afternoon. So how can staff share this kind of education most effectively in a way that doesn't push families away? Again, we had a lot of questions about that at registration. How do we share that information in a way that is most motivating for the families that we serve? Dan?

Dan: Yes. And I think, first of all, it's exactly what both Nancy and Anne talked about, which is engaging with the family and recognizing that sometimes that takes a little bit of time. And, you know, as Anne said, the pressure of getting the paperwork and getting all the information out there. We sometimes lose that ability to just step back and get to know the family and have them get to know you so we can establish a more trusting relationship. So, that's a big first piece.

And the other is to really give the family a sense of control, because control is really huge. And many of the families we deal with, often there are many other agencies that are kind of controlling what they do in different parts of their life. And so it might be, you know, "We've learned a lot in the last 10 or 15 years about the effects of alcohol on the fetus." And, "Would it be okay to share that information with you?" So it's really asking their permission to have this dialogue with them. And, you know, most often the answer might be, "Sure." Because you're not – then you're not saying, you know, "You're pregnant. You have to stop drinking." We're not pointing the finger at anybody. We're sharing the information. And I think it's just – it's offering the information, which I think it's a really helpful way to, again, begin the conversation.

Amanda: And that piece of about offering control, and that gets us to the third tip here. Anne, you said that that information just in itself can be pretty powerful. So what do you see where you are in your program?

Anne: Well, I think our mothers, you know, take that information. They really do absorb it and use it. I believe they have the best intentions for their babies. They want to have healthy children and they want to prevent any type of FASDs or other birth defects that they can. To me, I see the motivation in them to plan and build for their future for their child. I just think that, like Dan said, not using judgments and allowing them some control in that is very important. It just helps with that relationship.

Amanda: And Dan, can you share a little bit about the study that you were talking about just before this call started at WIC?

Dan: Yes. We – the SAMHSA FASD Center for Excellence supported some kind of in-service prevention approaches. There are three prevention approaches to alcohol exposed pregnancies that have been found to be promising practices. One of them is the Parent Child Assistance Program that Nancy works with; one is called Project Choices, which is a CDC funded project; and one is Screening and Brief Intervention. And there are a number of different ways of doing screening and brief intervention. There's a federal initiative called SBIRT, which is Screening and Brief Intervention and Referral for Treatment.

And what we found – and we funded some projects in Healthy Start programs and WIC clinics with pregnant women who have been using alcohol during their – early in their pregnancy. And what we found is that, even by doing one five- to 15-minute brief intervention, which is just sharing information about the effects of alcohol on a fetus and talking with women about, you know, "Would you be willing to stop drinking maybe for the next month?" And do it a month at a time, and that that helped dramatically reduce the risk of an alcohol exposed pregnancy for the rest of their pregnancy. And that's pretty powerful that even a brief – just brief discussion with the family can make a tremendous difference.

Amanda: That's awesome. And I think that's something that certainly folks are sort of positioned to do in Early Head Start programs. We'll talk a little bit more about brief interventions in a little bit. But I love that piece that a five-minute conversation can make such a dramatic difference. And we know that programs are already doing that, so I imagine just all the impact that they've already had. Nancy, what would you add here?

Nancy: Well, I think, you know, it's really important to, first of all, acknowledge that this information and knowledge about FASD is pretty recent stuff. You know, it – we didn't really name it until 1970-something. We didn't do a public health message until 1984. You know, what – we're dealing is something that is really new in the big scheme of things. And so, what people know about FASD or about alcohol exposure is often coming from other places, other sources. So I think that that's a good place to start with families, is to just ask them, "What have you heard? What do you know? What have other people said?"

And you'll hear that, you know, "Well, my mom drank with me and I'm fine. So, I'm not too worried about it." You know they might have a doctor who's saying, you know, a glass of wine a night is fine after the first trimester. But if they're not screening, they maybe don't know that that glass of wine for that woman is a Big Gulp from 7-Eleven. You know, so there are just different ways to sort of get people to

talk about what they already know. And that's where you start. I mean – and go from there in terms of more information. And then reminding them that the CDC and the Surgeon General are both saying that there's no determined safe amount, and so the safest thing is to not drink at all during pregnancy.

Amanda: And that gets us to this fourth tip, which is learning what families have heard. Anne, in your community and all that's happening actually in South Dakota around this issue, you feel like folks have a lot of information, but maybe, you said, not always the most recent information.

Anne: Right. I feel that the community, I guess, activism that's been going on around the alcohol issue, definitely they do know about the issues with alcoholism and how it has affected some of our Native American families, but might not be the most recent. They do have a lot of information. I don't think it's anything, you know, you could bring up in the community and the community not realize what you're speaking about. We also do follow our curriculum, and it's built into our curriculum to cover, just like I said, with smoking and medication. So it isn't – you know, every month it's just to focus on alcohol; it isn't like that. It's just built in as part of an education piece throughout the pregnancy. And it is – you know, it is something that just continues to come up in our local news and media. So it is easy to talk about. It's affected all of us.

Amanda: Yes. So it's a way to really sort of hook in, you know, some more conversation and sharing information that the CDC and now most recently the American Academy of Pediatrics has put out about sort of how damaging alcohol can be. The other thing you said, Anne, is that there are lots of opportunities in your curriculum to cover and sort of go back and reiterate this information, talk with families about it, open a new conversation.

Anne: Yes. And that is something we do with all moms, so it isn't just particular mothers. It would be something we would cover with every prenatal mom we have.

Amanda: That gets us then to this tip five about sharing that current information. Nancy, you talk about avoiding shame and blame. That's the sixth tip here.

Nancy: Yes. You know, I think that shame and blame is what drives women into the closet with their drinking and to not ask for help. If they feel like they're being judged by their family or their friends or their providers, then they're not going to talk about it. And if we're talking about women with addiction, you know, there's sort of this cultural thing that if you're a good mom, if you have this maternal instinct, you should just automatically do the right thing for your baby. And so when they can't stop drinking, they're already doing a lot of shame and blame on themselves for that. They want to stop. They're worried about it. They know that it's not healthy for anybody. And if we just come in and just sort of beat them over the head with that, nothing is accomplished.

So it's really important to sort of, again, normalize a little bit. You know, maybe this person doesn't have addiction. Maybe they didn't know they were pregnant when they were drinking and, you know, now we're at this point where let's talk about what's next. And for me, it's really important to say there are lots of reasons pregnancies go wrong. There are lots of reasons that babies have problems once they come into this world. And even if you do absolutely everything right and have the perfect pregnancy, things can still go wrong. It's a scary, scary thing. It's not useful to shame and blame. It's not useful to hurt. It's not useful to me in terms of building a relationship with her and helping her change.

What I emphasize on – is that this woman sitting in front of me right now wants to be a good mom. And so regardless of what's happened up until that particular day, I'm going to encourage her and support her in being the best mom she can be. And her job at this point is to do everything she can for her child. And if she needs help with that, then I'm going to help her do that. And in sharing that information, watching my language and making sure that there's not one shred of judgment or blame that is coming through in my language.

Amanda: Well, and you said so much there. One of the things you talked about was normalizing it. And I know that's a big thing for Dan as well. Dan, can you talk a little bit about that too?

Dan: Yes. And again, it's the normalizing. I think we've really covered a lot of it. The normalizing is really that notion that lots of people celebrate in our society, and lots of people use alcohol when they celebrate. And again because lots of people don't know when they're first pregnant, it's really – this occurs much more frequently than we really think. The estimates are that – for the last 10 years, the estimates in North America have been about 1 in 100 children are born with an FASD, which puts it at a higher rate than autism or Down syndrome or a number of other disorders. And the sense is it's probably even higher than that. And there are some studies going on in the U.S. now to really confirm that.

So that it really – you know, I really want to support what both Anne and Nancy have said to really work at cutting through the blame and shame and the stigma. And put it out there that there is a lot of stigma about this; that they may have felt a lot of blame or shame but that you really recognize that that's not the issue we need to address. That we really want to, you know, help people feel comfortable in talking about this and recognize that everybody wants to have the healthiest baby they can have.

Amanda: And I think it brings in again that piece that Anne, and Dan I think you also referenced as well, that we talk with everyone about this, that we're – this is – you know, this is such an important piece of information that we're sharing it with absolutely everyone. Nancy, you mentioned language just a minute ago. And I think there's more that you wanted to say about that.

Nancy: You know, you have to be really thoughtful I think. I mean, we can use sentences like, you know, "When you drink, you're going to cause brain damage to your baby." Think how many "you"s there are in that sentence, and you as an ownership, you know, thing. And I want to take that away. I want to say instead, "Using alcohol during your pregnancy can hurt the baby. Drinking during pregnancy can cause the baby's brain to not develop correctly." It really is just a matter of tense and it's a matter of really putting the responsibility of the damage on the substance and not on the mom. And the more you get used to that language it will become more familiar to you and easier. But it's really important in the beginning that we really keep those sort of pronouns like you out of this conversation.

Amanda: Well, and that might be something for people really to role play at their programs if they have that opportunity in staff training, you know. Just role play this conversation a little bit and see how that language comes to them. So we've covered now, I think, through tip eight, which is name the culprit – and alcohol of course being that culprit.

The other part about sharing information that was so key, I think, in our discussions is while there's no cure for FASDs, the earlier in pregnancy that families can think about the effect of alcohol use on their babies the better. I think you said that a few times, Dan. And here we come back to your piece about there are things you can do now. There are things that you can do even if you have been drinking

alcohol during your pregnancy once you realize that this has been an issue. There are things you can do. Can you just repeat those for us?

Dan: Sure. One of them is to stop drinking for the rest of your pregnancy. And if you have been drinking heavily, it would be really important to consult a physician about the safest way to do that. So that's one thing that can absolutely have a beneficial effect. The other is to get good prenatal care, get your prenatal vitamins. Take your prenatal vitamins. One of the things that some of the research is finding is that women who drink seem to have some deficiencies in certain substances like choline, which is an essential nutrient, and zinc and iron, and that those are really important in neurological development.

So making sure that their levels of those nutrients and those heavy metals are at normal levels, not over the norm because that can cause problems and can be toxic, but are at normal levels. And also that individuals with an FASD often have those deficiencies as well. So, we want to check those. And that can make a real difference. And what they're finding is that taking those prenatal vitamins that have those substances, eating properly, and proper nutrition is very, very important during pregnancy to really help support the health of the fetus. So there are definitely things that people can do.

And even if somebody has been drinking during pregnancy and let's say you're talking with them and they're later in their pregnancy and they begin to talk about, "Oh, you, know I have been drinking. I really would like to stop at this point," is that it would be really – it would be important to know to be able to refer them to somebody for follow-up who can really be supportive in checking on them and checking on the baby once they're born. Because we also know that the earlier we may recognize an FASD in a child and provide the right supports for that family, the better the longer term outcomes.

Amanda: Yes, so that early intervention piece is hugely important. So really affirming what families can do to support their children's health. That's here in tip nine. I think the other piece that really comes to me as you're describing that, Dan, is that this is comprehensive services. I mean this is what the Standards that Angie described for us earlier are sort of set up to do, is really to connect those families with the prenatal care, with the nutrition piece; that they need to support that healthy development. And it's a nice sort of full of circle experience to have you sort of say that can really make a difference for families that have maybe gotten off to not the driest start to their pregnancy.

Dan: Absolutely. Those partnerships – you know, and the community partnerships to address these issues are very, very important and getting the community partners onboard to understand, you know, FASD, again both the prevention and the intervention piece. Because the other part of this is also recognizing that some of the family members who you're dealing with may themselves have an FASD. So again, that will inform us that – how our approach needs to be a little bit more supportive, more directive, more broken down to one step at a time, and much more repetitive based on our knowledge of some of these effects.

Amanda: So let's talk about that for a minute, because we certainly don't want to say that every family in, you know, the programs that folks are serving are going to, you know, have children with FASDs. But we do know that FASDs are out there. And we also know that FASD is a generational kind of issue. So as you said, Dan, it's not genetic. It's not that children are inheriting, you know, the FASD. But they – but there is a tendency for adults who have FASD to perhaps drink and have – or they're at higher risk anyway for FASD. Yes?

Dan: They're at higher risk because often they don't have good judgment. They don't pick up dangerous situations and dangerous people. If they have an FASD as an adult, it's most often not recognized and really emotionally painful. And one of the ways they may deal with that pain is by using substances. So, you know, and they might have a genetic vulnerability also for alcohol use if their parent used alcohol as well.

Amanda: Right. And then for the – but for the child, the only way the child gets FASD is if that mother drinks, right?

Dan: Right.

Amanda: Okay. So Nancy, if staff are looking at personal history for families – not because they're in the business of diagnosing but because they're trying to provide really supportive services for families – so if staff are looking at personal histories of families they're serving they might get some clues, you said, about sort of whether they might have some of that organic brain damage that's related to FASD.

Nancy: Absolutely. I think when we are working with high risk populations or low-income populations, you know, we are doing sort of psychosocial history. We're going to be asking them about their school history, about their employment history. Those are things that could tell us, you know... If someone dropped out of school at a very early age. If someone isn't able to hold a job for more than, you know, six, eight months at a time. If they have spent a lot of time in jail. If they tend to do really stupid crimes like shoplifting over and over again from the same store, or probation violations because they never show up; go to jail on failure to appear on a regular basis because they just don't follow through with what they're supposed to do. If they get lost. If they're constantly late. If they ask – are asked to do something and they can't keep track of what they're supposed to do. If they were in Special Ed when they were kids. I think those are all huge red flags.

I also want to listen for the stories. You know, we – as we get to know our clients, they tell their stories. And part of their story might be, "I was raised by my parents who both did, you know, drugs all the time. They drank all the time." We all know somebody who was raised by alcoholic parents. One of my standard questions in an intake is: Did your mom have a drinking problem when you were growing up? Do you think that she drank when she was pregnant with you? And if the answer to that is yes and I have all these other red flags, then I have very likely a person in front of me who has an undiagnosed fetal alcohol spectrum disorder. And that gives me the opportunity to change the way I work with her and to support her in being more successful than she has been up until this point.

I also, you know, I mean we talked – we missed the part about babies. You know, when babies are – when we know that they are alcohol exposed, you know, they may not come into this world looking – you know, not okay. They may look – come into this world looking perfect. But at age 5 they're suddenly having issues, and at age 10 they're suddenly getting suspended on a regular basis. In high school, they're kicked out and they gave up because they can't do math and they can't pay attention. These are all things that are indicators that a person has brain development issues and neurobehavioral issues related to prenatal alcohol exposure. And they get missed all of the time.

Amanda: So, a couple of things you said there. I mean, what you – I think that piece around sort of we can provide some anticipatory guidance for families if we have some sort of – you know, if we have a concern that these children will – that a child will come into the world with an FASD, then there's a possibility for Early Head Start to provide some anticipatory guidance for that family so when that

happens there's – the blaming that can so easily happen doesn't occur and that there just gets to be support for this child.

I think, you know, some of the questions that you're asking, it may or may not be the position of the Early Head Start program to ask some of those questions. But we know that sometimes those issues do get raised in conversations and that folks can certainly be on the lookout for them. I think one of the things that particularly interests – that's particularly interesting to this conversation about working with adults with FASD, they're potentially working with adults with – with potential FASDs is that, you know, it helps offer a lens to consider what staff might be seeing with those families. And if we think about offering information and particularly prenatal education to adults with FASDs, what can you tell us about how to be most effective in delivering that information?

Nancy: First of all, stop talking as much as possible. We talk too long and we talk too fast, and we use big words. And at some point, we start to sound like the adults in Charlie Brown cartoons. Using multimodal information is key; using handouts, using visuals, drawing pictures, or at least setting things up in a very step-by-step kind of way using very concrete language. And what your definition of concrete is for – may be completely different about what that person is going to understand. And experience will tell you how that person is doing. But really check for understanding on a regular basis using calendars, using pictures.

You know, one of my favorite sort of examples is a woman with diabetes and her doctor kept asking her are you watching what you eat. And I want you to just mentally picture that for just a second. So she always said, "Yes, I'm watching what I eat." But her blood sugars were in the (800s). So she was so concrete in her language, as long as I'm watching the fork go into my mouth I'm totally watching what I'm eating. So it really had to be broken down in a much more simplistic kind of way for her to be able to make changes for her own health.

And I think that we all have opportunities to sort of really be mindful of that when we're working with families, to do step-by-step stuff, to lay out their schedules. And make sure that they understand where they're supposed to go, how they're supposed to do it, and not just assuming because they're grownups that they know how to do this. I also want to say that it's not just about people with FASD. How many of the mothers that we work with have histories of domestic violence and they also have traumatic brain injury that is causing problems for them that was undiagnosed and untreated as well?

Amanda: Yes. So that brain injury piece does get in. And it's an entirely different conversation.

Nancy: It is.

Amanda: Again, not the role for Early Head Start to do those diagnosis pieces. But I think what you offer us is sort of a clue to how we might be able to provide sort of the best possible services to families. You know, individual families that you all are seeing walk in the door. So, thank you so much for that.

Dan: And I think, just really briefly, the other thing is to always check with people about really true understanding for what you're talking to them about. Because often we think that people understand and we may say, "Do you understand?" and often they're going to say yes whether they understand or not because they don't want anyone to know that they don't understand.

So I really often like to say, you know, "Can you help me –" you know, "Tell me what you, you know, just heard me say and what it meant because sometimes I'm not as clear as I want to be. And I want to be sure that I was clear. Not because you have trouble getting it but because I'm not as clear as I want to be. So I want to be sure that I was clear in what I was talking with you about". Because you want to get a true understanding, do they really understand what you're saying? You know, don't drink during pregnancy might mean to some people who are really literal don't drink water, don't drink soda. So again, we want to really check that out. And I think it's just that little piece of asking that that can be really, really useful.

Amanda: Check. Yes, absolutely. So let's talk about screening here for a minute. I have an eye on the time. And we know that Standards talk – that the Standards talk about referring families for risk assessments, which could include, you know, risk assessment for alcohol use I think, certainly talking about – you know, going back to what Angie was saying about those important community partnerships. We do know that some programs may not have resources in their communities. And if they look at their community assessments, if they look at their approaches, their priorities, they may choose to kind of think about screening as a part of the work that they're doing there. Anne, what happens in your community?

Anne: Well, in our community, the medical providers do handle the screening. They take care of it during the office visit. However, we're using a multitude of providers across the state. We do use a four – questionnaire – it's four questions and it's called the CAGE Questionnaire – in our program for screening. So we can do those referrals also to the best possible agency that we might connect that mother with if they're – you know, if she answers accordingly that she is having some issues with alcohol abuse.

Amanda: Some programs might decide that that screening is important for their program and they don't have options for referring for those screenings. And there are a number of free public screenings that are available out there, including the CAGE. We don't want to make any recommendations here at all. But if you look at the resource list on page 14, the first link under Articles and Books there leads you to a resource that offers a chart on the most commonly used alcohol screens – many of them alcohol use screens. Excuse me. And they talk about when and how they are most effectively used. So that resource is available to you. Some of them are targeted to pregnant women. Some are available right from the Web. We just want to stress here how important training is for folks who are using those tools. That's a really critical part. We know lots of programs don't do formal screenings. Again, it's not required. But Dan, you thought it might be helpful to try and figure some things out about a family's history.

Dan: Right, right. And as Nancy said before, it's just asking a few of the questions. And even if you ask, you know, "Can you tell what I just said before? Can you tell me, you know, what you heard me say and what does that mean to you?" And you get that they didn't really get it. That to me is a – we call them red flags. So, that's a real red flag.

Amanda: Well, and Dan, I think here we're talking about screenings for alcohol use during pregnancy.

Dan: Yes. Because – okay. Well, it's still the same thing because one of the things we have to be careful of is that all of these – like the CAGE and the TWEAK and the TAs that have been validated have not been validated for people who are really literal in their thinking. And they may be literal in their thinking because they have some subtle cognitive impairments. They may be literal in their thinking because they have an FASD, because they have schizophrenia. All – in all of those we see a lot of literal thinking. So if

we say to somebody as one of the questions in, you know, the TWEAK or the TAs asks, you know, how many drinks can you hold before you feel high? Somebody who is really literal is going to say two because they can hold one in each hand. That's not what the question really means.

So, we really want to – the screening is really helpful, but we need to take into account what might be going on and clarify to be sure that there – you know, that the questions are asked in an appropriate way, that we check true understanding. And again, I think the earlier we may identify a woman who may be at risk, the earlier then we can intervene and support the family. And that can make dramatic change. So the screening is really useful. And whether, you know, it's – you know, whoever does it, I think that early screening is really important for longer – for better long term outcomes.

Amanda: Yes. Well, and Nancy, you talk less about formal screenings. And as you were, I think, starting with this conversation a little bit earlier, you offered some questions that you use that can be helpful in simple conversations with families. And those are available to folks on page 12.

Nancy: I have to do it as just a conversation. I mean, usually I'm doing my initial screening for coming into PCAP over the phone. My moms have to self-report substance use, heavy substance abuse to be eligible for my program. And if you just ask the question, "Did you drink during pregnancy?" the absolute knee jerk response is going to be, "Absolutely not. I would never do that." And so, that's not helpful to me in terms of getting people enrolled in my program. And it doesn't mean if it's alcohol, because I also, you know, oh no, I didn't do this or I didn't do that, crack or heroin. I need to know about all of that.

And so, I start the clock back farther. And I'll say, "Did you – before you knew you were pregnant, before you were pregnant, what substances were you using?" And they're going to tell me weed, and they're going to tell me heroin or crack or whatever. They'll usually leave alcohol completely off the list. And I have to ask, "So what about alcohol? Do you – you know do you drink? Do you ever drink?" And then they'll say, "Oh yes, I do this or I did this, you know; or six pack a day or, you know, whatever it is, you know." And I'm taking notes.

And then my next question is, "How far into your pregnancy were you when you figured out that you were pregnant? And that might be six weeks. It might be four weeks. It might be 12 weeks. And so in their mind, as long as they didn't think that they or know that they were pregnant, then they weren't using during pregnancy. The pregnancy starts the day they knew. So that's why I go back in time. And then I say to them, "So up until 12 weeks you were drinking a six pack every day and you were smoking crack every day." And they'll go, "But I didn't know I was pregnant." And I'll go, "Absolutely, I totally get that. And so now, please tell me how has your drinking changed since you knew you were pregnant?"

And that's giving me an opportunity to – they might say, "Oh, I've totally quit now." They might say, "I'm really having a hard time. I really want to quit but I'm having a hard time." And it really gets very conversational and it's very nonjudgmental. And I have this conversation with every single mother who calls my program.

Amanda: Yes. So – and I think, you know, programs will need to look at sort of what you've offered us here and kind of think about whether it's useful in their program, whether it's something they want to do, whether they do it in relationship with a partner. But I think that it's – you know, it offers us some really important clues about sort of how you can approach this in the most sensitive, respectful way and get that kind of openness from families.

Dan: And the other thing to recognize, and especially if you're dealing with young women, teenagers who are pregnant, teenagers tend to recognize their pregnancies later than adults do and tend to drink more in early pregnancy than adults do, and tend to binge drink more in early pregnancy than adults do. So, you know, as Nancy said, if you're, you know, asking how far along in your pregnancy were you before you realized you were pregnant, and you know, with teenagers it might be they might have been five months pregnant before they knew. And that's not unusual.

Amanda: Well, and I think all of you are sort of saying, you know, really consider in your programs whether these are questions you want to ask. I know this is important information. What I hear you all saying is, if you can get this information, it really can be helpful in sort of moving forward and supporting this mom in doing the best that she can for this baby, and getting them in treatment if that's – you know, if that's something that's going to be important. We know that's part of the Standards as well. I think it's important to say that no one expects Head Start staff, certainly, working with prenatal families to be their substance abuse counselors. I don't think that that's the goal here.

Dan: No. No, not all.

Amanda: I think Angie said that as well. And it's important that folks not be asked to do more than they are trained and supported to do as well. But in the context of the Standards, as I think about what we heard Angie say earlier, there's a real opportunity here for community referrals. And Anne, I wish you would just – can you just very briefly describe the interesting partnership that you have there in South Dakota that you referenced a little bit earlier?

Anne: Yes. We started this partnership when our treatment center opened and mothers started going in and residing in there. And we actually connected with them to offer full day services for their children so that the children could be in a location where they could learn and play and be kids while their mother, you know, was spending the day working themselves through that treatment program. And it's just developed over the years to where now we will get prenatal referrals. We'll get Early Head Start referrals and we'll be partnering with this treatment facility during the course of the mother living there, which we've seen to be up to two years. And so it's very interesting. It's a great partnership. They're a wonderful resource. We've gotten to know their staff well. We recruit from there. We're just well connected. We share plans.

They're making goals with the treatment center. They actually have very detailed plans. And so, we, you know, even partner and share with that. So we're not recreating the wheel for those families. And it's just been a great partnership, I think, to see families reunited. and, you know, eventually sometimes they'll start living there and don't have custody of their children but then later their children will join them. So it's just been a great resource for us. And really I strongly encourage everybody to know the resources in your state if they're not local, because statewide there are usually those resources for families. They might not be in your area but they're near your area. And they're of great help to refer moms and also recruit from.

Amanda: You're sure to have those relationships for those folks. We have included in your resources on the Resource Page some links from the National Center on Health that we thought might be helpful to you. They offer some insight on kind of identifying and making referrals to community partners related to issues like substance abuse or substance use. And I think they might be helpful to folks. Nancy, what did you want to add here?

Nancy: I – what I love from Anne's description is how she built that relationship. And certainly if you're in a rural or small area, if you don't have anybody or, you know, or not quite sure then, you know, building that relationship is really key. But also, like even in an urban area. Here in Seattle I have 26 different substance abuse agencies and 25 mental health providers. And guess what? Not all of them do a really good job. And some of them treat my moms terrible. I don't want my moms going anywhere near those people. So by finding the people in your community that share your values with mental health treatment and chemical dependency treatment and in building that connection, it does become a reciprocal relationship and it does benefit the client. And it builds your community's capacity to be able to serve clients. So even if there's some little tiny agency that's, you know, 10 miles, 15 miles, whatever it is, and they have the potential to be this partner, then do what you can to build that relationship because in the end it will benefit your entire community.

Amanda: Absolutely. And I think one of the other things that you said, Nancy, is how important it is to have a plan. That, you know, no matter who's available in the community, once you start asking these questions of families, how important to have a plan for them as we say in tip 12 here.

Nancy: When we've surveyed doctors around why don't you screen about alcohol use during primary care visits and that kind of thing, the number one answer that comes up is, "If the answer is yes, I don't know what to do." And if that's the fear that's keeping us from doing this, then let's take that off the table. Let's find out what the plan is so that if the answer is yes, we know exactly what to do.

Amanda: And how important for staff – I mean, we cannot put staff in situations where they don't know what the next step is. So, one important piece for mental health specialists there on-site with programs for administrators to really be thinking about. What is our plan if there seems to be a concern for a family?

Dan, you raised brief interventions earlier. You talked about how important that can be. Again, we know that staff are not therapists necessarily. But we know that those brief interventions can be incredibly effective in supporting mothers and stopping or reducing alcohol use. So programs might have an interest in looking into and supporting staff in developing some skills around brief intervention. Can you talk – can you define those again and just give us a little definition of what those might be for staff?

Dan: Sure. I mean it really is – it's basically motivational interviewing strategies that were developed through motivational interviewing. And it's asking families if they would be open to hearing some information and sharing information about the effects of alcohol use on the fetus and on their baby. And then asking them if they, you know, are able to stop drinking if they are drinking. Or if they're not drinking, you know, what would be helpful. You know, what would they need in order to help them not drink for the rest of their pregnancy? What kind of support would they need? Because that's what we want to identify.

And then that's where the links come in with the community agencies or the partnerships, is, you know, how to get that support for them. You know really a key question is how do we help this family be successful? What do they need in order to be successful? And how can we as a community get that for them? So I think that that's really the core of screening and brief intervention. It's screening to identify this is a person or a family at risk; and if so, then doing that brief intervention.

Amanda: And there's lots of resources here listed that can give you some more information about brief intervention if that's something that interests you. I also want to note that on June 11, there will be a

webinar as part of the Virtual Birth to Three that offers just a taste of motivational interviewing. So it's more complicated I think than we make it sound, although it is – these are simple sort of five minute kinds of experiences with families that can really make a difference. And I'll give you a little bit more information on Virtual Birth to Three in a minute.

At this point though, I want to have our operator come on. I have to have Sarah come on and teach us how to call in with a question. Sarah, are you there?

Sarah: Yes, I am. To the phone audience, if you have a question or comment today, please press *1 on your touch-tone phone. For those of us joining us today via a speakerphone, please make sure your mute button is turned off to allow your signal to reach our equipment. A voice prompt on the phone will indicate to you when the line has been open. Once again to the audience, it is *1 if you have a question or comment today. We'll pause for just a moment.

Amanda: Well, and actually I think if it's all right with you, Sarah, we're going to go ahead and try and get to this 13th tip here – tip 13, which is about social supports. So we've talked about community partnerships. So I think we also have to talk about the incredibly important informal network for families and friends who are such a key here. We haven't talked much about dads here, Dan. There's some interesting new research that suggests that they biologically may have a role, but they certainly have an important role in social support for the mom.

Dan: Absolutely. It's very, very difficult for a woman to not -- you know, especially if she's more of a heavy drinker or a consistent drinker, drinks a lot. It's much, much more difficult for a woman to not drink during her pregnancy if her partner is drinking. So we absolutely have to get the partners involved. They're a key component of social support for these women in having an alcohol-free pregnancy. And also, yes, there is this, you know, genetic component, not for an FASD at this point, but for other difficulties that a child may have if a father is drinking before conception. So, you know, letting them know that is important as well. But it really is the social piece that's really essential. So, dads aren't off the hook at all. You know, and sometimes they say well this is her problem. This isn't mine. No, it isn't. It's everybody's problem. It's everybody's issue, not really problem. It's everybody's issue. So it's very, very important. And also identifying who are, as you said, Amanda, who are the social supports for this woman? Who's kin for them? Family, friends, neighbors, who really are there, who can support them. And sometimes they haven't really thought about that. They haven't identified those people.

Amanda Perez: Anne, what would you add here?

Anne: Well, I agree. Often in our homes we have extended family members living with mothers, and so we do include grandmothers, aunts, uncles, cousins, sometimes friends who they identify as their main support. And also, continuing to help provide a safe environment for the mother in that support of not drinking. Also, some of our mothers that, you know, leave the treatment center and return back to environments, it's very important to have a supportive environment for them to continue working on their sobriety and raising their children in that. So, social supports are very important.

Amanda: Helping women identify who those folks are.

Anne: Yes.

Amanda: Families identify who those folks.

Anne: And sometimes that's us as Head Start staff. Sometimes we are their sober support and sometimes they're here all day long. They'll help out in the office. They're in the classrooms. They're wherever they can be.

Amanda: So, to be open to that experience for them.

Anne: Yes, be open and inviting to your families.

Amanda: Sarah, do we have any questions that have come in?

Sarah: We do have a couple of questions in the queue. We'll go to our first caller. Please go ahead.

Amanda: Hi.

Caller 1: Okay. I just wanted to ask... Unfortunately, I got on this phone call a little bit late. I was wondering if it was going to be available for delayed hearing.

Amanda: Yes. We are taping the phone call and it should be available on the ECLKC. We're not sure how quickly it can go up, but we are -- that is the goal here.

Caller 1: All right, thank you.

Amanda Perez: Absolutely. Is there another question?

Sarah: There is. We do have another question from the phone line. Please go ahead.

Caller 2: Okay. Where would we go to find out what the law is in our state on alcohol drinking while pregnant?

Nancy: My recommendation is to check with your -- like a child welfare agency. If you have like a supervisor or somebody who's trained on mandatory reporting, those are the folks that are going to best know what your state laws are.

Caller 2: Okay, thank you.

Nancy: You're welcome.

Amanda: Other questions, Sarah?

Sarah: Again to the audience it is *1. We'll go to our next caller. Please go ahead.

Caller 3: Okay. Hi. We just want confirmation of what heard because we're all a little -- looking at each other here perplexed that, first of all, other illegal drugs do not have the similar -- any kind of impact on the child once it's born. Long term effects like alcohol does, you know, including crack and cocaine and all those heavy duty street drugs. There's no long term serious effects?

Nancy: That's exactly right. It -- they don't cause -- so they're not a teratogen. They don't cause birth defects and they don't affect the development of the brain. So, you know, if that's the only substance that that baby is exposed to, you're not going to see any long term effects. There's some research projects out there that will say these children are more likely to have learning disabilities or have things like ADHD. But they often don't do sort of what does mom and dad look like. And learning disabilities and ADHD are highly genetic and very much correlated with the use of substances in adulthood.

So I can't say that if a child who had a lot of crack exposure has ADHD at the age of 6 and there was no alcohol exposure, I can't say that the crack caused it because it may be both of her parents or one of her parents or her uncle have ADHD. So there are -- which is not excuse or I should say permission to use these substances in the sense that if you're working with addicts you know how chaotic and horrible their lives are if they're doing these substances. They're not sleeping. They're not eating right. Crack elevates, meth elevates blood pressure and heart rate. Heroin has other problems than sort of blood pressure and heart rate. They're not healthy pregnancies.

Caller 3: Right.

Nancy: And not healthy pregnancies can have babies with problems.

Caller 3: Okay. Yes.

Nancy: But they don't cause brain damage.

Caller 3: Okay.

Dan: And I think the other piece... Go ahead.

Caller 3: And then... Go ahead. Sorry.

Dan: The -- so it's not that the other drugs of abuse don't cause any problems at all. But as Nancy said, they don't cause the neurobehavioral effects that alcohol causes. But certainly with crack use or cocaine use or heroin use, there's also a higher increase in sudden infant death syndrome, in premature birth. So there are -- and those illegal drugs often result in an infant being born with what's called neonatal abstinence syndrome. Kind of that [inaudible].

Nancy: And that's only with opiates.

Dan: Right. And that -- but that -- again, that's an immediate thing. You don't see that typically with alcohol use during pregnancy. But that's more of -- that's a shorter term issue.

Caller 3: Okay. And then a second part to our question was to confirm that if father is a heavy alcohol user and, you know, his sperm doesn't have the same kind of effect on the fetus, right? On the development?

Nancy: It really doesn't. So sperm and -- you know, this is an interesting field of research that people are starting to look at is does alcohol exposure change the sperm? You know, I think what we're talking about here is what Dan talked about in terms of genetic predisposition. There may be risk factors or protective factors that the father contributes to whether or not that baby will be more or less affected

by the alcohol. But when we talk about FAS and FASD, we are talking about, to put it plainly and simply, a baby developing in a pickled environment. And mom is the only one who has control over that.

Caller 3: Ah-huh. Okay, thank you very much.

Amanda: Sarah, I think we have time for one more question.

Sarah: Thank you. We'll take our next caller. Please go ahead.

Amanda: Hello?

Caller 4: Hello?

Amanda: Hi.

Sarah: Hello, caller? It appears we have lost the caller. They have disconnected. As a final reminder, *1 for one final question.

Amanda: One out there. Dan, I do have another question. So I think what we'll do, Sarah, is I have a question for Dan that did come in. And the question was about whether -- you know, sometimes families will -- sometimes staff will work with families who have already had pregnancies and they're saying, "You know, I drank during my first pregnancy. It doesn't seem to affect my baby. Why should I worry about alcohol now?" Can you talk a little bit about that, Dan?

Dan: Sure. There are a number of factors that affect the effects of alcohol on the fetus. We know some of them. We may not even know all of them. But for example, if a woman were to consume the same amount of alcohol during all of her pregnancies, her later child would tend to be more affected than the earlier children. Some of the risk factors include nutritional status, the ability of delivered a process alcohol over time, really often decreases. How many -- how old she is. How many live children she's had. All of those are factors that come into play. So a woman might very well have said "Well, you know, I drank during my first pregnancy. My child is fine." Now first of all, that child -- she may see that child as fine. I remember talking with a birth mother who said, "In my culture, if a child is born with ten fingers and ten toes they're fine. And all of my friends who drank during their pregnancy said my kids are fine." Well, they have learning problems. They have some behavioral problems. But they didn't connect it with the alcohol. But again, then it's the later children who are going to be more affected. So even if you don't see a lot of effects with an early child, doesn't mean you won't see more severe effects with a later child.

Amanda: And I think that was such an interesting piece of research that you brought in that I hadn't heard before; that, you know, it does seem to be that consequent pregnancies, there seem to be more effects with those babies. I want to give each of our faculty an opportunity to sort of say a goodbye message, a concluding message. And I want to start I think here with Nancy. Nancy, why don't you go ahead and give your conclusion here?

Nancy: Oh my God. That's so hard for me to narrow this down.

Amanda: I know.

Nancy: Prevention and intervention. So from a prevention standpoint, I think that as much opportunities we have to help women who are drinking to not have an unplanned pregnancy. And while that might be hard to do in your agency or whatever, family planning is a part of this. If women are drinking then they -- you know, the motto is: If you can get pregnant, don't drink; if you drink, don't get pregnant. And then intervention is getting to these kids as soon as humanly possible. You know, we didn't talk a lot about FAS diagnosis and what that looks like. And certainly the FASD website can have a lot of support if you think a child needs more assessment and referral for diagnosis. But what we know and what you know as Early Head Start people is that these brains are very malleable at this age once this baby comes into the world. The first five years of life gives us amazing opportunities to perhaps change the entire life course of this child if we can figure out what the problem is and get early intervention in place.

Amanda: Nancy, thanks so much for being here. Anne.

Anne: I would like to say to all Early Head Start workers out there, connect and engage with your families. Work on building that relationship of trust with them. And also, look to your communities and know your resources. We used our community assessment to help us build our programming and partnership that we have. It exists because of that community assessment and information in our local community and the need.

Amanda: And who am I missing? Oh, Dan. Sorry.

Dan: Yes. I think my closing would be that you all in this field are so important in this work and have such a wonderful opportunity, you know, as Anne said, to engage with these families; to listen to them; to provide support; to give them an ear, which they might not have from anybody else who will really listen to them. And there's a huge difference between listening and really listening. And that, you know, in terms of the prevention piece offering the information can be so important in changing a whole family and a whole generation's life. As well as recognizing, you know, how to help these -- each individual family be successful. And that might be changing what you do, referring them to the right place. But you really -- you have, you know, the power and the ability to do that. And I celebrate every one of you for you do every day.

Amanda: Thank you so much, Dan. Angie, I didn't talk about -- talk with you about this beforehand, but I certainly want to give you an opportunity to give a final message if you want to do that.

Angie: I would just say thank you, Amanda. And can you hear me?

Amanda: Yes.

Sarah: Yes.

Angie: Okay, good. I just want to say thank you to the panelists. And really for understanding how hard the work is that staff does and how much they need. The tips you gave, I love the 13th tip. I thought it was great to really, you know, kind of walk staff through such an important process. So, thanks to everyone. And thanks to everyone who joined us.

Amanda : Yes. Definitely. I do want to thank our faculty. Thank you so much. I think all of you gave us lots of strategies, lots to think about as folks are working so hard to make the most of that window of opportunity we discussed in the beginning for families in pregnancy. As you move forward in that work,

we hope that you can use some of the other materials in your packet. So on page 13, you'll find some questions that you can use in team meetings maybe or a reflection to help you really think about how you can use what you heard today, how you can apply it where you are. And again on pages 14 and 15, you'll see some additional resources we hope will be helpful.

Finally, I just want to encourage you all to send us your evaluations, either electronically or in hard copy. As we make plans for our next events, we really look to the feedback that you give us to guide us. And we have some events coming up. I particularly want to let you know that there's a new page on the ECLKC that describes the Virtual Birth to Three that we have coming up in May and June. That's our Annual Institute. It's going to be virtual this year and it's coming up in May and June. So if you go to the ECLKC and search for that Birth to Three Institute, you'll find that page and can start marking your calendars for the events that draw you and that you can participate in right from your home offices. We talked about the webinar we're doing as a part of that on motivational interviewing. The health track this year is focused on services to expectant families. So, I hope that will be helpful to a lot of you out there.

Thank you. Thank you so much again. Thanks again to our faculty and to all of our participants for being here today, and to echo Dan, for the powerful work -- and Angie as well, for the powerful work that you do at the earliest possible moment with these children and families. I'm going to turn it over now to Sarah to end the call.

Sarah: Thank you. And again, that does conclude today's conference. And we thank you all for joining us.