Alcohol Use and Pregnancy

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The Arc®
Fetal Alcohol Spectrum Disorder Prevention Project

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Alcohol Use in Pregnancy

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Endorsements

- Association of Obstetricians and Gynecologists of Quebec
- Canadian Association of Midwives
- Canadian Association of Perinatal, Women's Health and Neonatal Nurses
- College of Family Physicians of Canada
- Federation of Medical Women of Canada
- Motherisk
- Society of Rural Physicians of Canada

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Why this guideline?

- Alcohol is a recognized teratogen
- Alcohol can cause maternal/fetal harm
- Acceptable common use, promoted as healthy
- Women worry and bring concerns to caregivers
- To provide clarity: currently inconsistent and uncertain messaging by caregivers and agencies
- Lack of screening/documentation
- Promotion of better lifestyle without alienating patient
- Facilitate access to care for women with problematic alcohol consumption

Why this guideline?

- Because the problem is multi-factorial
- Early intervention can change the outcome
- Health care workers can make a difference

Guideline Goal

- Provide a rational basis for caregivers to assess, counsel and intervene regarding the consumption of
  alcohol by women
- Focusing on use in pregnancy and those who may become pregnant
- Facilitate consistent messaging

Standard Drink

- In Canada, contains 0.6 ounces (17.7 ml) of pure ethanol, which equals to:
  - 12-ounce serving of regular beer (5%)
  - 5-ounce serving of wine (12%)
  - 1.5-ounce serving of a 40% ABV spirit

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Low-risk drinking

- Defined for women as ≤ 2 standard drinks/day; ≤ 9 standard drinks/week
- Does not apply to those who:
  - are pregnant, trying to get pregnant, or breast feeding
  - have health problems or are taking medications with alcohol contraindication
  - have a personal/family history of drinking problem
  - need to be alert and/or in control to be safe
  - are told not to drink for other reasons

Binge drinking

- Defined as 4+ drinks in about 2 hours for average-size female; usually produces a blood alcohol of 0.08% and above*
- Is not low-risk drinking
- Common pattern of alcohol use
- Alcohol metabolism in the fetus is slower than in the mother so exposure can be greater and longer

* The National Institute of Alcohol Abuse and Alcoholism. NIAAA Council approved definition of binge drinking; NIAAA Newsletter 2004;3:3.

Alcohol abuse

- Defined as a pattern of drinking that results in harm to one's health, interpersonal relationships, or ability to work

Alcohol dependence

- Defined as a chronic disease characterized by the following:
  - a strong craving for alcohol
  - continued use despite repeated physical, psychological, or interpersonal problems
  - the inability to limit drinking
  - physical illness when one stops drinking
  - the need to drink increasing amounts to feel the effects

Fetal alcohol spectrum disorder (FASD)

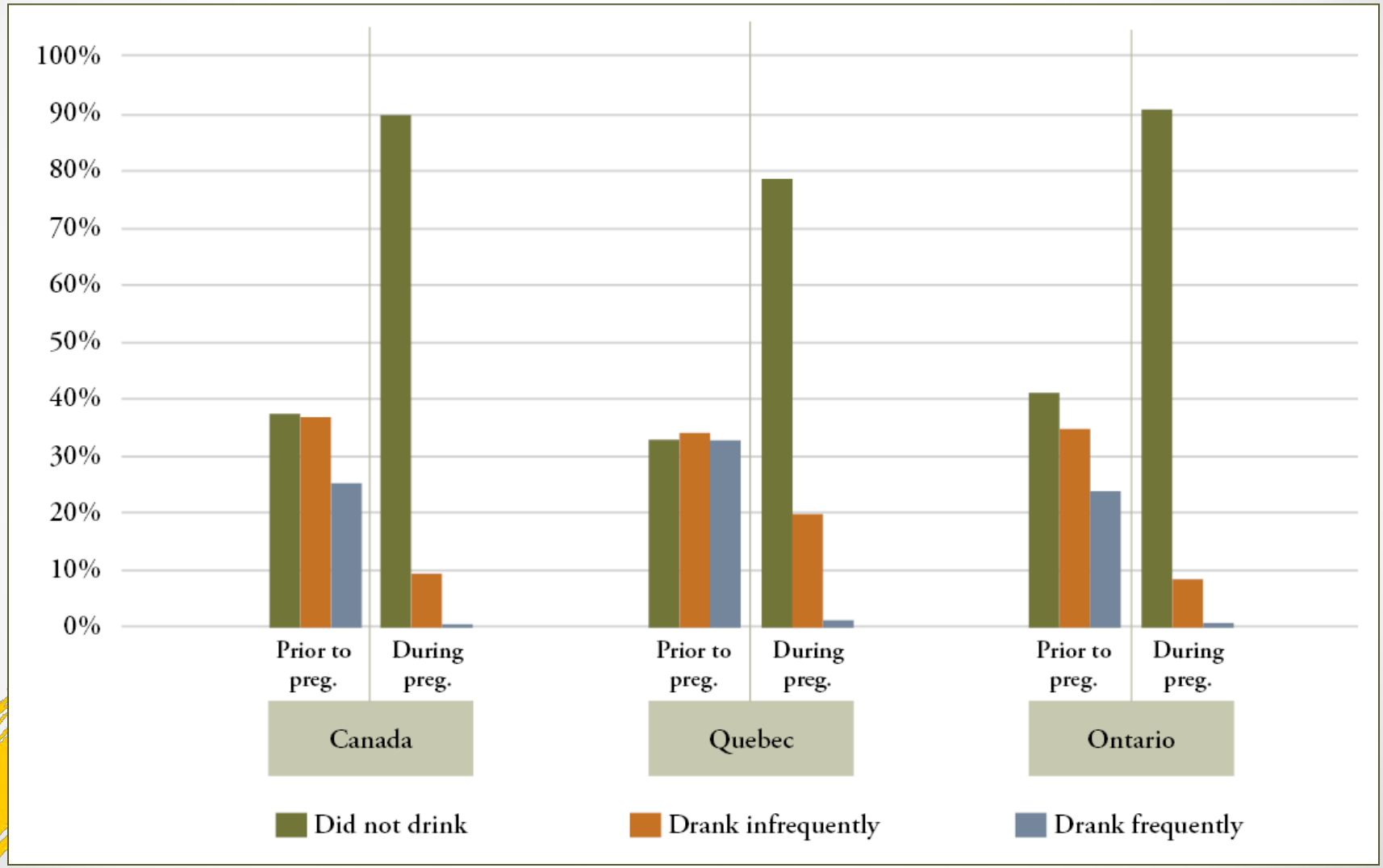
- Umbrella term that refers to the range of harms that may be caused by prenatal exposure:
  - FAS: fetal alcohol syndrome
  - pFAS: partial fetal alcohol syndrome
  - ARND: alcohol related neurodevelopmental disorder

Incidence of Alcohol Effects

- FAS estimated at

  1 to 3 per 1000 births
- FASD estimated at 10 per 1000 births. (some communities in Canada as high as 190 per 1000 births)

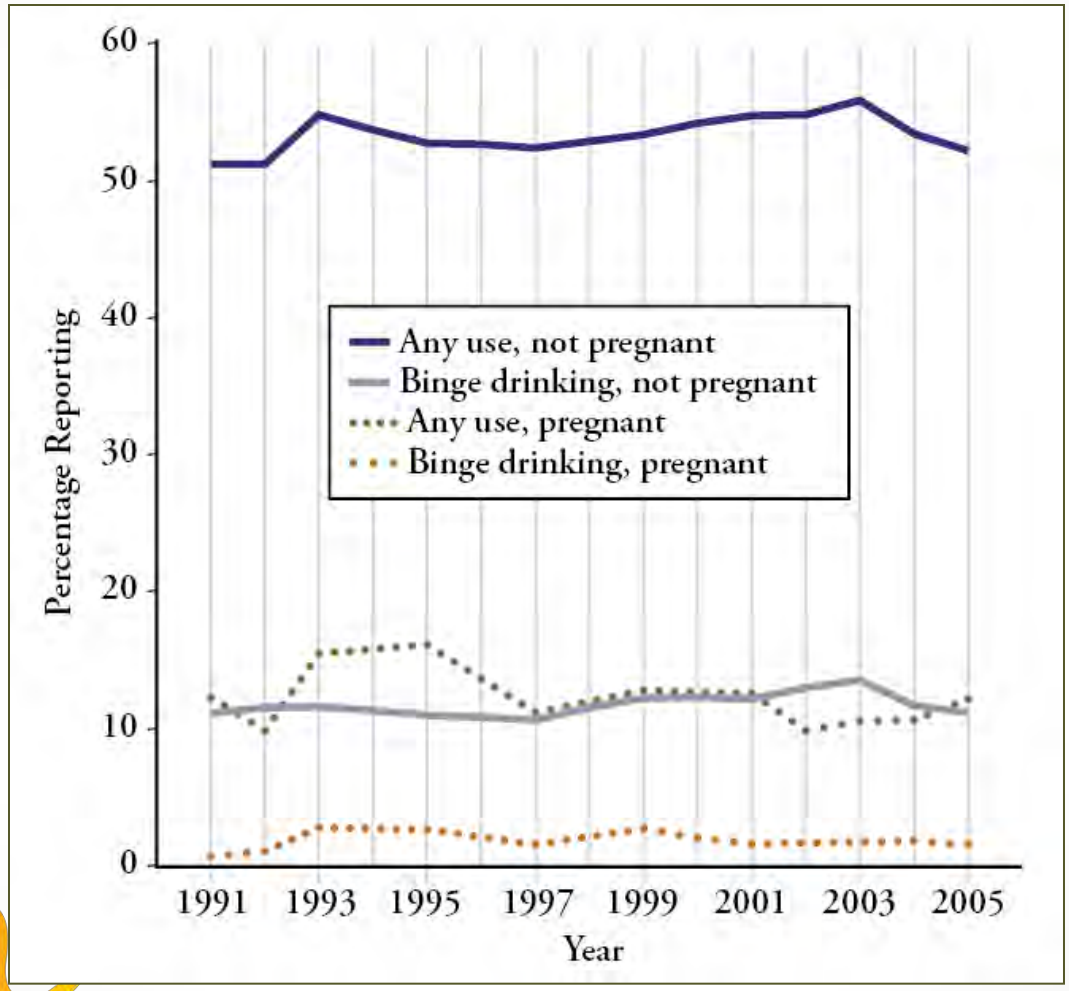
Distribution of alcohol consumption prior to pregnancy and during pregnancy, for Quebec, Ontario and Canada, 2006-2007



Missed drinkers/missed opportunities

- Women most likely to be missed as drinking during pregnancy:
  - women over 35 years of age
  - “social” drinkers
  - women who are highly educated
  - women with a history of sexual and emotional abuse
  - women of high socioeconomic status

Alcohol Use Among Women Aged 18-44, 1991-2005



Behavioural Risk Factors Surveillance System (BRFSS) surveys, United States

Why alcohol use is a problem

- Alcohol is a recognized teratogen
- Can negatively affect maternal and child health
  - High risk sex, violence, unplanned pregnancy
  - Mask underlying mental and social distress
- "Telescoping" of arc to harm in women
- Children/youth with FASD
  - Have lower health and quality of life
  - depression, anxiety, difficulties in social interactions/relationships

Why alcohol use is a problem

- Can result in characteristic abnormalities of development, including neurodevelopmental effects
- Subtle long-term cognitive and behavioural effects
- Costs per individual with FASD related to health care, education, and social services in Canada estimated to be $1.4 million

Evaluating the evidence

- Low dose alcohol exposure during pregnancy—does it harm? A systematic review. Stockholm: Swedish National Institute of Public Health; 2009.

Findings	Effects
Landesman-Dwyer (U.S.) = less attentive; shorter "longest attention episodes"	Adverse effects
Olsen (Denmark) = scores not statistically different	No effect
Sayal (England) = some problems in girls	Unsure effects
Rodriguez (Denmark/Finland) = no effect all cohorts	No effect
O'Callaghan (Australia) = no effects	No effect
Streissguth (U.S.) = short-term memory; attention	Adverse effect

Summary Statements

1. There is evidence that alcohol use in pregnancy can cause fetal harm. (II-2). There is insufficient evidence regarding fetal safety or harm at low levels of alcohol use in pregnancy. (III)
2. There is insufficient evidence to define any threshold for low level drinking in pregnancy. (III)
3. Abstinence is the prudent choice for a woman who is or might become pregnant. (III)

Intended vs unintended pregnancy

- Age groups of unintended pregnancies:
  - highest rates:15 to 19 years (82% of total pregnancies in this age group)
  - lowest rates: 35 to 39 years (29% of total pregnancies in this age group)
- Highest risk of binge drinking:
  - Ages 15 to 19 years (illustrates the need for reliable contraception)

Why screening?

- Can improve maternal-child health outcomes through:
  - promoting awareness
  - early identification and reduction of problem maternal drinking
  - early identification of exposed infants
  - earlier diagnosis of FASD

Recognition, Screening and Documentation

- Level 1 – effective single questions:
  - Do you ever enjoy a drink or two?
  - Do you sometimes drink beer, wine, or other alcoholic beverages?
  - Do you ever use alcohol?
  - In the past month or two, have you ever enjoyed a drink or two?
  - When was the last time you had a drink?

How to ask

- Try to pose questions in the past tense
- Preferable to ask open-ended questions
- In cases of confirmed/suspected dependency/abuse, the following questions are suggested:
  - Have you ever had a drinking problem?
  - When was your last drink?
- Avoid statements that increase guilt

Recording: risk/benefits

- Raise awareness
- Earlier recognition and intervention for problem drinking
- Maternal record may be only record of fetal exposure
- May be used pejoratively
- May raise custody issues

Recommendations

1. Universal screening for alcohol consumption should be done periodically for all pregnant women and women of child-bearing age. Ideally, at risk drinking could be identified before pregnancy allowing for change. (II-2-B)
2. Health care providers (HCPs) should create a safe environment for women to report alcohol consumption.(III-A)
3. The public should be informed that alcohol screening and support for women at risk, is part of routine women's health care.(III-A)

Associated factors/confounders

- Other substance use and/or risky behaviours:
  - may modify the chance of success in achieving abstinence or harm reduction
  - may alter (usually ↑) the chance of alcohol consumption and so may produce additional adverse effects
- SOGC guideline on Substance Use in Pregnancy: April 2011

Recommendation

4. Health care providers should be aware of the risk factors associated with alcohol use in women of reproductive age. (III-B).

Counselling & Communication

- Brief interventions:
  - **Assessment** and feedback after assessment aimed at increasing awareness
  - **Advice** including provision of pamphlets and discussion of strategies for reducing or eliminating problematic alcohol use
  - **Assistance** in the form of eliciting ideas about change strategies, goal setting to reduce or eliminate alcohol use, positive reinforcement, and referrals to supportive services.
  - **Reassess**

Counselling & Communication

- Brief interventions (BI) do make a difference:
  - ↓ overall (13-34%) in number of drinks/day
  - ↑ reporting (10-19%) on reducing their drinking to safe levels
  - reduction in risky drinking at 6 and 12 months

Counselling & Communication

- Research has shown that BI in non-pregnant women of reproductive age not only reduces at-risk drinking behaviour, but also increases effective contraception use (helps reduce unplanned pregnancies)

BI — pre-conception

- Women visiting HCP's pre-conception is on the rise – BI can reduce:
  - problematic alcohol use over a 48-month period
  - possible alcohol-exposed pregnancies with low/medium/high-risk drinkers in pre-conception
  - Subsequent alcohol-exposed pregnancies

BI — pregnant women

- Evidence shows in BI groups:
  - report 5 times more likely to abstain from alcohol
  - Infant mortality rate was 3 times lower
  - Newborns had greater birth length and weight
- More effective in reducing alcohol use when a support person chosen by pregnant woman is present during BI

Motivational Interview

- Evidence based interviewing technique
- Based on psycho-linguistics
- Increases likelihood of change

Harm reduction

- Involves assisting women
- Establishing realistic & achievable goals as they work towards abstinence
- Shift away from stigma, guilt, confrontation, shame; towards empowerment and strength-based, respectful, non-judgmental approach
- Maintain engagement

Summary statement

4. Intensive cultural-, gender-, and family-appropriate interventions need to be available and accessible for women with problematic drinking and/or alcohol dependence. (II-2)

Recommendations

5. Brief interventions are effective and should be provided by health care providers for women with at-risk drinking. (II-2-B)
6. If a woman continues to use alcohol during pregnancy, harm reduction/treatment strategies should be encouraged. (II-2-B)
7. Pregnant women should be given priority access to withdrawal management and treatment. (III-A)

Pregnant women who have consumed some alcohol

- Low level exposure not uncommon
- Woman may be concerned about possible harm to fetus and some may seek pregnancy termination – evidence about the effects of low level consumption does not warrant acceding to such a request

Recommendation

8. Health care providers should advise women that low-level consumption of alcohol in early pregnancy is not an indication for termination of pregnancy. (II-2-A)

Pregnant women who are alcohol dependent

- They find it more difficult to stop drinking
- Need medical support during the process of withdrawal
- Need support to access alcohol dependency treatment – when making referrals, indicate that she is pregnant to ensure she is provided priority access to treatment

Communicating about women's drinking

- Drinking remains highly stigmatized
- Roles as mothers/caregivers often create barriers to accessing treatment
- Women report they fear child apprehension and professional judgment

Communicating about women's drinking

- Communication of women's drinking history and current status is sensitive
- Documentation in child's record may be the only source of information when diagnosis of FASD is being considered
- Important to recognize that information about maternal alcohol use may be used unfairly

Conclusion

- Acceptable social norm that may have harmful consequences in pregnancy
- Burden of disease that can be prevented/mitigated
- Consistent message based on best evidence

Conclusion

- Care provider can make a difference in routine practice by:
  - Screening and documenting
  - Recognizing information is sensitive
  - Realizing brief interventions work
  - Helping in harm reduction
  - Maintaining engagement

Thank You

Questions?

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Upcoming Webinar

Local and State Action to Prevent Fetal Alcohol Spectrum Disorders

- *Thurs Aug 28, 2:00-3:00 p.m. EST*

www.thearc.org-FASD-Prevention-Project

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