The Northern Family Health Society
www.nfhs-pg.org

The Prevention of Fetal Alcohol Spectrum Disorder

The prevention of FASD is a complex area to address. It is tempting to adopt simple strategies that are directed towards holding the woman fully responsible for this Disorder however, this approach as well as being simplistic, is victim blaming and does not work (Lindesmith Center, 1997). Such a simplistic prevention solution fails to address the root causes that create substance misuse and tends to undermine women's health and well being. The threat of judgment and fear of losing their children deters women from seeking prenatal care or drug treatment, frightening them away from the necessary care.

In our work in Northern British Columbia, we have found that if we are to effectively address the prevention of this life long disability, our efforts must be directed towards all members of society in understanding the risk of drinking during pregnancy. We need to address the general public, universally, and those people who are at risk because they are part of a specific grouping known to be at higher risk (ie. substance using teens). As well, we need to address the smaller proportion of women who are at high risk for giving birth to FASD children due to their alcohol abuse and previous FASD births. All three of these areas form a continuum of prevention through intervention across the lifespan. This redefined continuum is most effective in forming a foundation of best practices for the prevention of FASD.

We have also learned that before we begin working with solutions that are too simple, we should first ask ourselves, who are the women that drink during pregnancy? What is the context of their lives?

According to the most recent literature (Clarren, 2002; Astley 1998) these women:

- Live at poverty level
- Come from all ethnic backgrounds
- Have a wide range of education
- Started drinking at about 15 years of age
- About half of the mothers with children with FAS have FAS related conditions themselves
- 100% have been seriously abused
- 90% have Post Traumatic Stress Disorder (PTSD)
- 90% have major depression problems and phobias esp. agoraphobia
- 80% live with partners who do not want them to quit substance misusing

They are fragile women who require our support not our further persecution.

One of the most common myths is that FASD is 100% preventable. Wars are preventable, poverty is preventable, environmental destruction is preventable but does that mean we are able to prevent them? No, and not because we don't want to, but because these are complex issues that require concerted public effort and dedicated political will.

If we honestly look at this simplistic adage of 100% preventability, we will begin to see assumption underlying the belief that women "choose" to damage their unborn child. First, is the assumption that women have control over their drinking. Many women self-medicate with alcohol and drugs in response to mental health problems and life circumstances such as violence, poverty and oppression. Some will say that this is an excuse and that will power is all these women need, however, have you ever tried to control an addiction? Have you ever struggled with mental health issues and been unable to afford medications? Remember, 80% of women who self medicate during pregnancy have a mental illness and 100% have serious sexual, physical and emotional abuse histories (Clarren 2002 and Astley, 1998).

We also make the assumption that these women have access to supports and resources at the same rate as others in the community, but this is not true. Women who drink during pregnancy have less than 4 supports in their lives (Clarren, 2002).

Another common assumption is that women are aware of their pregnancy. Unplanned pregnancies are very common in young women. Many women who are binge drinking are not planning their pregnancy, do not know they are pregnant or do not have access to birth control. From 1995 to 1999 rates of binge drinking among pregnant women remains substantially unchanged (Hankin, 2002). Programs such as Pregnancy Outreach programs that supply women with education are not widely available.

In continuing to simplify a complex issue we are doing women and children an injustice. Women who drink during pregnancy are very fragile, yet we know they do want healthy babies because 95% of women who drink while pregnant use the health care system. Research in Washington State has found that women who receive mental health treatment and have more satisfactory social support networks can achieve abstinence at a 96% higher rate (Astley, 1998).

Recent research on animals from Mother Risk in Toronto suggests that there may be some possibilities of therapeutic intervention for mothers that are substance misusing to improve the health of their fetus during the perinatal period. Recent studies using animals have shown vitamin C and E, beta-carotene, folic acid and plant-based nutrients called flavonoids can help protect against alcohol in the unborn animals (Citizen Newspaper, September 10, 2002).

Simplistic thinking leads to simplistic solutions, which are not working. If we continue to look for a solution that places the woman as 100% responsible then we are missing the bigger picture and we are failing to prevent FASD. Research so far points to the need for mental health interventions and more support from family, friends and community (Astley, 1998) as well as ready access to birth control for women of all ages (Giddeon, 2002) and the use of brief intervention groups when working with high risk mothers (Hankin, 2002). We must begin in early childhood to prevent the abuses that lead to self-medicating and we must begin to empower young girls to become mentally healthy and to build the social competencies they will require to lead healthy lives (Creating Solutions, 2000).

These interventions are in themselves also preventions. To decrease prenatal substance use, adolescents could be provided with information about the dangers of substance use during pregnancy before they reach childbearing age (Wagner, 1999). Preventing the abuses that create the mental health problems is another complex issue, but one that could stand more scrutiny as we continue to allow children to be sexually exploited on our streets. However, building social competencies and helping young girls to resolve important identity questions as well as maintain their authenticity are prevention pieces that demand a closer look.

The development of social competencies for young girls shows promise in prevention of FASD (Wagner, 1999). This type of intervention incorporates education regarding high-risk behaviors, victimization and offending as well as direct skill training for avoiding substance use and other high-risk behaviors while increasing confidence and self-esteem. For this form of prevention to be effective, it must take place before the problem behavior appears. For this reason it is important to direct our efforts towards individuals with the potential for high risk behaviors but who do not yet exhibit those behaviors. For youth to develop the behavioral and social skills needed to handle the high pressure to conform and engage in high risk behaviors, we will need to develop effective skill based interventions and not rely on education based interventions alone. We will need to make mental health services more accessible and applicable for youth and we will need to ensure that communities support women and their partners to avoid alcohol during pregnancy.

Finding successful ways to reach women at risk of substance use and misuse and being able to influence their behavior and promote healing, remains a challenge in these fiscally restraining times. Unemployment rates are on the rise and research tells us that pregnant women may drink more when they are unemployed (Hankin, 2002). Services are being cut and supports once thought to be permanent are disappearing. The changing face of our political and economic climate will force us all to look at support and intervention to women who are substance misusing in a more discerning way. The need for creative and responsive programs such as Pregnancy Outreach programs, more accessible community based treatment and mentorship programs will have to be fearlessly

examined. One thing that we know for sure is that what we are currently doing is not necessarily working.

December 2002

References

Astley, S., Bailey, D., Talbot, C. and Clarren S.(2000) Fetal Alcohol Syndrome (FAS) Primary Prevention Through Diagnosis: I. Identification of High-risk Birth Mothers Through the Diagnosis of their Children and II. A Comprehensive Profile of 80 Birth Mothers of Children with FAS. *Alcohol & Alcoholism* Vol. 35, No.5, pp.499-519. Medical Council on Alcoholism.

Citizen Newspaper (September 10, 2002). *Some vitamins could prevent fetal alcohol damage: doctors.* Prince George, B.C.

Clarren, S. (2002). Key Note Address. Tri-Prairie North Conference, Whitehorse, Yukon. Unpublished paper.

Institute of Medicine (1996). *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention and Treatment.* National Academy Press: Washington, D.C.

Hankin, J. (2002). *Fetal Alcohol Prevention Research*. National Institute on Alcohol Abuse and Alcoholism: Bethesda, Maryland.

Leischner, C. (2000). *Creating Solutions.* Northern Family Health Society. Available on line at http://www.nfhs-pg.org/research

Wagner, S. (1999). *Substance Use During Pregnancy: A Social Competency Intervention with Adolescents.* Masters Thesis: University of Northern British Columbia.