COLLABORATIVE APPROACHES IN PREVENTION OF FETAL ALCOHOL SPECTRUM DISORDER (FASD)

→ Explanatory Guide for the FASD Prevention Collaborative Practices Checklist

Montreal Diet dispensary

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EXPLANATORY GUIDE FOR THE FASD PREVENTION COLLABORATIVE PRACTICES CHECKLIST

Produced by the Montreal Diet Dispensary and Rond-Point

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The views expressed herein do not necessarily reflect the official position of the Public Health Agency of Canada.

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INTRODUCTION

OBJECTIVES OF THE CHECKLIST AND THE GUIDE

The checklist and this guide are designed to provide support to health and social services professionals during interventions with pregnant women who consume alcohol. The guide provides the technical and theoretical details behind the approach outlined in the checklist.

These tools were created to prevent an irreversible health problem: Fetal Alcohol Spectrum Disorder (FASD). The only way to prevent FASD is to avoid drinking alcohol during pregnancy.

Experienced health professionals who work closely with families that have problems with addiction to alcohol and other drugs were consulted to develop and validate the contents. These health professionals use collaborative approaches: consultation techniques that are recognized for their effectiveness.

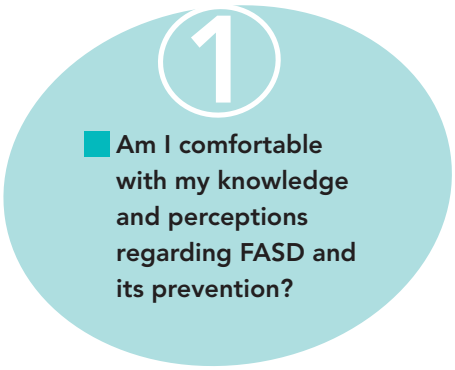
« With alcohol, it's not just the way it makes you feel, it's a way of life. »

– A Rond-Point participant in a discussion group on FASD pamphlets

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

FASD is an umbrella term to describe the effects of prenatal exposure to alcohol. The only way to prevent it is to avoid drinking alcohol during pregnancy.

FETAL ALCOHOL SPECTRUM DISORDER (FASD)



Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that describes the effects of prenatal exposure to alcohol, which, in combination with other risk factors, may cause permanent and significant damage to the brain of the fetus and child. FASD can permanently affect ten brain domains; motor skills; language; cognition (IQ); memory; attention; academic achievement; adaptive behaviour/social skills; regulation of affect (anxiety, depression); neuroanatomy/neurophysiology; and executive functioning. It is estima-ted that one in 100 people in Canada suffer from FASD. This translates into 330,000 people.

Alcohol has various toxic (teratogenic) effects on the embryo and fetus throughout their development. Observational studies on the subject have not made it possible to predict the amount of alcohol that will have an effect on the fetus, the highest risk period during pregnancy, or the impact of the pregnant woman's biology (alcohol metabolism, nutrition).

New guidelines for diagnosing FASD were published in 2015. A diagnosis is made when the woman states that she used alcohol during her pregnancy AND when three of the previously mentioned neurodevelopmental disorders are present. If the sentinel facial features of Fetal Alcohol Spectrum DIsorder (FASD) are present, the diagnostic can often be made even if the alcohol consumption is unknown.

The standardization of FASD diagnosis has made it possible to establish guidelines for diagnosing the condition and to demonstrate the importance of considering alcohol consumption during pregnancy. The diagnosis should be established by a multidisciplinary team through a complex physical and neurodevelopmental assessment.

RECOMMENDATIONS REGARDING ALCOHOL USE DURING PREGNANCY

The percentage of unplanned pregnancies in Canada (50%) is a major issue in the prevention of FASD. As 80% of Quebec women drink alcohol occasionally or frequently, we can estimate that a significant proportion of pregnancies may be unintentionally exposed to alcohol. Moreover, Quebec has the highest rate of mothers who say that they drank while they were pregnant (18%). The consumption of alcohol during pregnancy increases as the age of the future mother and the number of previous pregnancies.

Rates of alcohol consumption for young adults are constantly increasing in Quebec. This trend is worrying for the pregnancies of future generations.

The only safe way to prevent FASD is to avoid drinking alcohol during pregnancy. All women of childbearing age should be screened for the consumption of alcohol, regardless of her age, social class, education, income, or ethnicity.

As mentioned in Canada's Low-Risk Alcohol Drinking Guidelines, it is best to counsel abstinence during pregnancy. These guidelines also suggest that women should be encouraged to talk about their drinking with a health professional; health professionals are expected to listen carefully to the concerns of pregnant women.

Asking a woman about her use of alcohol is not simply a matter of finding out if she is drinking or not at the time of the meeting. It is important to dig deeper into the matter to find out her current and pre-pregnancy drinking habits. Many women report finding it difficult to stop drinking as soon as they learn that they are pregnant. Women may need support to help them abstain from drinking or, at least, to reduce their consumption during pregnancy and keep alcohol consumption at a safe level in line with recommendations while breastfeeding.

The amount and frequency of alcohol use and the types of alcohol consumed should be taken into account in an assessment questionnaire. Several myths minimizing the harm that can be caused by using alcohol during pregnancy and its effects on fetal development still persist. For ethical reasons, there are few studies that can provide guidelines regarding the amount of alcohol that can be safely consumed during pregnancy. To ensure safety, abstinence should be recommended.

PREVENTION OF FASD

To this day, health professionals working with families and future parents note a dichotomy of messages given to women and their families. Not all health professionals introduce the subject of alcohol consumption in the same way. It seems that some health professionals even avoid introducing the subject for fear of having to face the problem of alcohol use during pregnancy. These few health professionals feel that they are at a disadvantage and that they do not have the resources to intervene appropriately.

LEVELS OF PREVENTION

In 2008, Nancy Poole classified the different approaches to preventing FASD in Canada. She divided these prevention approaches into four levels; each level targets a specific population group and uses a different strategy:

- **First level of prevention:**
  improve people's knowledge through major public health promotion campaigns.
- **Second level of prevention:**
  discuss alcohol use with all women of childbearing age and the members of their support networks.
- **Third level of prevention:**
  provide holistic support for pregnant women with alcohol problems and other mental health problems.
- **Fourth level of prevention:**
  provide post-partum support to women who used alcohol during pregnancy and to their families.

COLLABORATIVE APPROACHES TO FASD PREVENTION

Collaborative approaches are a set of practices that enable health professionals to act in a coordinated, integrated manner in order to meet the pregnant woman's needs and to establish a real partnership with her to encourage lasting behavioural change. The health professional should:

- Keep the woman motivated
- Establish a partnership with the woman and her family to determine action objectives
- Support the woman throughout the change process
- Coordinate his/her actions with those of all the other health professionals involved in the woman's care

A holistic approach enables the health professional to consider the client in her own environment. The health professional should support the woman by meeting her short-term needs before taking action regarding her alcohol use —for example, a woman with a need for mental health services or a self-identified need for mother/child housing. Interventions must meet the woman's needs before she agrees to engage in a therapeutic process.

Collaborative approaches are thus rooted in a support-based approach with the common objective of reducing or stopping alcohol consumption. The health professional should show empathy as he/she works to increase the woman's motivation, letting her set the pace. These methods provide conclusive results in the prevention of FASD; they exist on an intervention continuum and integrate with each other according to the needs of the pregnant woman and her family.

THE HEALTH PROFESSIONAL'S ROLES

Health professionals should naturally scrutinize their own thoughts and feelings every day. They should take a step back and examine their emotions, values, and perceptions regarding the situation before interacting with a pregnant woman who has a drinking problem. Empathic, non-judgmental interventions are more effective when they are conducted by health professionals who are in touch with themselves and who keep abreast of the latest information on the subject.

2

Am I using the right approach?

When the health professional broaches the subject of the pregnant woman's alcohol consumption, the intervention should be structured as follows :

1. **Assess the level of change of behaviour, the motivation, and the level of commitment**

BASED ON THIS ANALYSIS:

2. **Provide relevant information regarding drinking alcohol during pregnancy**
3. **Guide towards change**

The ideal approach in these situations is to use the professional attitude and skills that the health professional has developed through experience. This section clarifies ideas about the health professional's roles, the knowledge and people skills that are mentioned in the checklist.

PEOPLE SKILLS

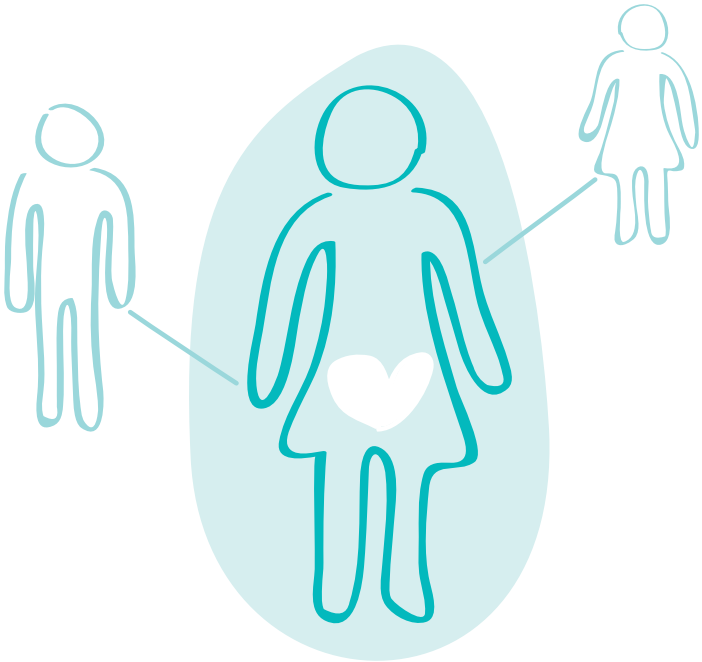
The health professional should adopt a warm, empathic, non-judgmental attitude when meeting with the woman. Right from the first meeting, the focus should be on discrediting myths about alcohol and pregnancy by adapting the information provided to the woman's level of knowledge. To do this, open questions can be used to learn more about the woman and to put her at ease. The health professional can use restating, summarizing, and validation to affirm his/her understanding of the woman's answers. That way, the woman will feel she is being listened to and understood.

GET TO KNOW THE WOMAN HOLISTICALLY

In the prevention of FASD, it is important to try to establish a partnership with the pregnant woman and her family. It is advisable to get to know the pregnant woman's background. A holistic approach can be useful to understand which factors can influence behaviours and motivation when committing to the change process.

WOMAN/FAMILY-CENTRED CARE

It is recognized that interventions that focus on the benefits to the woman's health and her ability to change can prevent relapses after pregnancy. When the woman's context is taken into consideration, interventions can be adapted to her unique situation. The holistic approach is characterized by an analysis of the pregnant woman's context. **There is a non-validated analysis template in Appendix 2** that can be used: *Analysis of the Pregnant Woman's Context*. This tool will give you an overview of the woman's degree of satisfaction with the various spheres of her life: physical and mental health, interpersonal relationships (support network), finances, home, responsibilities, lifestyle habits, etc.



THE SETTING FOR WOMAN-CENTRED MEETINGS :

PROVIDE A WARM WELCOME
- Smile
- Give her a tour of the premises

SHOW INTEREST IN HER
- Talk about her before talking about the baby
- Talk about her emotional state, her stressors, her personal problems
- Ask questions about the pregnancy and parenting
- Ask about her well-being

DEVELOP A RELATIONSHIP OF TRUST
- Take the time needed to put her at her ease
- Follow up when she misses an appointment

TAKE TIME
Assure her that you are available

LISTEN ACTIVELY
Use reflecting and reformulation (put into words the emotions and feelings being expressed)

6 CRITERIA FOR THE WOMAN-CENTRED APPROACH

1. Consider the intervention holistically (overall environment)
2. Consider the needs and wishes of the pregnant woman and her family
3. Consider the right to privacy and dignity
4. Get her partner involved
5. Provide fast access
6. Establish a real partnership that will encourage the woman to commit

TRAUMA-INFORMED APPROACH

The Canadian public is not inclined to accept the use of alcohol during pregnancy. Women who drink are often judged by others and are afraid to disclose their use of alcohol to health professionals.

Nancy Poole of the British Columbia Centre for Women's Health works with women and has studied for many years the past experiences of women who abuse substances such as alcohol and drugs. She reports that a high proportion of women who use alcohol or drugs are or have been victims of physical or psychological violence. The problem of alcohol and drug use must therefore be considered holistically to support the woman through the process of behavioural change by considering these potential traumas.

The roles of the health professional are to create an environment that favours change and to listen. He/she must understand the woman's fears of talking about her alcohol use. The woman is the expert regarding her use of alcohol; she knows the most about it. Some authors also mention the partner's involvement in interventions to strengthen the parenting link during pregnancy and after birth.

3

Do I have the tools to promote change?

EXPERTISE: MOTIVATIONAL APPROACHES

To avoid rushing a pregnant woman with a drinking problem or making a pregnant woman feel needlessly guilty because she might have had a drink at the start of an unplanned pregnancy, the health professional should adopt an open approach in order to inform and guide the woman and her family.

The motivational interview (MI) is a style of intervention that allows health professionals to form relationships with their clients. Rather than educating the woman on the behaviours she should adopt, the health professional works with the woman to guide her toward behaviours that will foster openness to change. The MI can be used in both brief and more intensive interventions.

This section outlines MI and explains its effects on pregnant women without going into details about the techniques of MI. Training provided by accredited members of the *Motivational Interviewing Network Trainer* (MINT) is pertinent.

THE EFFECTS OF MI

MI is recommended for its effectiveness and the savings it yields. A decrease in intervention time has been observed when using these interview techniques. Meta-analyses report durable effects up to one year after the interventions.

MI PRACTICE

The MI spirit encompasses:

- EVOCATION — Help the woman to express herself
- COLLABORATION — The woman is considered to be a partner
- AUTONOMY — Respect for the wishes of the woman faced with potential change

Health professionals who employ MI techniques use five fundamental skills, the first four of which can be remembered by using the acronym **OARS**. The fifth is a directive specific to MI:

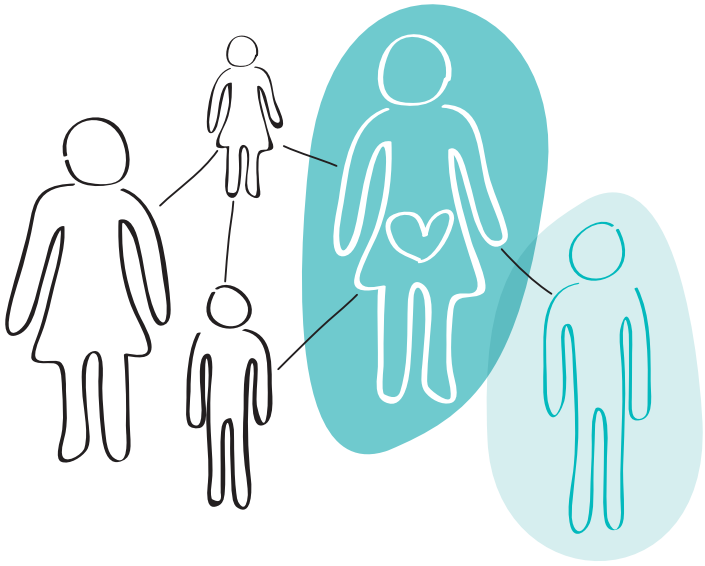
- Ask **O**pen questions
- **A**ffirm (validate, reinforce, affirm strengths)
- Practice **R**eflective listening
- **S**ummarize discussions
- Elicit change talk and share advice

Clients are more likely to overcome ambivalence to change and to commit to the process when they find the way to do it themselves. MI is characterized by open-ended questions that allow the woman to put into words what she knows. One technique consists in asking the woman what she knows about a subject, then providing information adapted to her knowledge and asking what she thinks about it (Elicit-Provide-Elicit approach). For example, the health professional addresses the issue of alcohol consumption with a question rather than with the prescribed information: "What do you know about drinking during pregnancy?"

The health professional should respond to discussions in an empathic manner (**EARS**):

- Ask the woman to **E**laborate: "How would you do it?" "What does that mean to you?"
- Practice **R**eflective listening
- **A**ffirm the woman's strengths
- **S**ummarize understanding

A health professional who is expert in MI techniques should speak less than 50% of the time, use twice as many open questions as closed questions, and use mirroring appropriately (interview technique).



SUGGESTED TOOLS

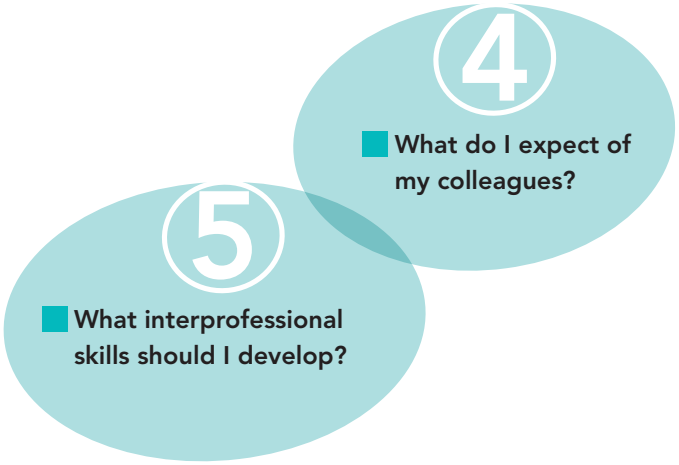
We advise you to learn about the MI tools suggested below. Examples of these tools can be found in Appendix 3. They will be useful in putting into practice the steps in the following section: *Intervention Using Collaborative Approaches*.

TOOLS	OBJECTIVES OF USE	CONTEXT OF USE	EXPECTED RESULTS
FRAMES Bien, Miller et Tonigan (1993); Miller et Rollnick (1991)	Raise awareness of drinking and potential consequences	In drinking and problematic drinking situations Not as effective in cases of addiction	Conduct a brief, effective intervention
Rollnick Scale or Motivation Scale Miller, William R. (1999)	Assess the pregnant woman's motivation Identify the strength of the desire to change Recognize her limits Recognize the appropriate moment to make changes Clarify the factors that contribute or not to mobilization to action: • importance given to change, • priority, • feeling of ability to change	During the interview, when the woman expresses a desire to change but seems unsure about taking action At the start of the process and throughout the follow-up	Determine the level of involvement in the change process Clarify the elements to work on, that would encourage greater commitment to the change process
Decisional balance Janis et Mann (1977)	Explore ambivalence Investigate the discrepancy between the current situation and the one the woman wants Specify the relative value of the various reasons for changing and for not changing	In the pre-contemplation and contemplation phases (see the section Adapting Intervention Strategies in the Guide) At the start of the process and throughout the follow-up	Bring out the positive aspects of change Recognize obstacles to change Present options Clarify and emphasize advantages to change Review perception of the drawbacks to change
Brainstorming Osborn (1953)	Give free rein to the imagination in order to explore the pregnant woman's change objectives and strategies	When developing objectives and strategies with the pregnant woman	Explore new avenues of intervention
Coping Lazarus et Folkman (1984) "All the processes that an individual interposes between himself/herself and the event perceived as menacing, to control, tolerate, or decrease the impact of the event on his/her well-being." (Lazarus, 1993)	Validate the woman's usual adaptation strategies: • The last time you were in this situation, what did you do to resolve it? • What usually helps you? • etc.	When facing commitment issues	Recognize the background associated with her lifestyle habits

INTERPROFESSIONAL COLLABORATIVE SKILLS

In the health and social services sector, good interprofessional collaboration (IPC) is associated with the ability of health professionals to meet the public's health and welfare needs in a more coordinated and consistent manner. There are many advantages to an IPC practice: improved access to care and services, as well as improved continuity and coordination, increased effectiveness, efficiency, and quality of these services. It is also associated with safer and more satisfying delivery of care and services, from the point of view of both the health professional and the patient. Furthermore, because services offered in a framework of interprofessional collaboration are so effective, the cost/benefit ratio is advantageous: various kinds of expertise are used in a coordinated manner thereby reducing the time spent on services.

In addition to ensuring that organizational structures and care paths are formalized in order to encourage interprofessional collaboration, it is necessary for health professionals to expand their collaborative skills. The level of complexity of the care and services situation will determine to what extent the members of the team are involved. Just the fact of meeting together does not necessarily bring added value to the exercise. The interprofessional work team must be aware of the ways they interact in order to optimize their actions and achieve the objectives the team has set. Several competencies are defined in the literature to support the idea that it is possible to become an exemplary collaborator through personal and professional experience. Six key competencies are illustrated in the Guide.



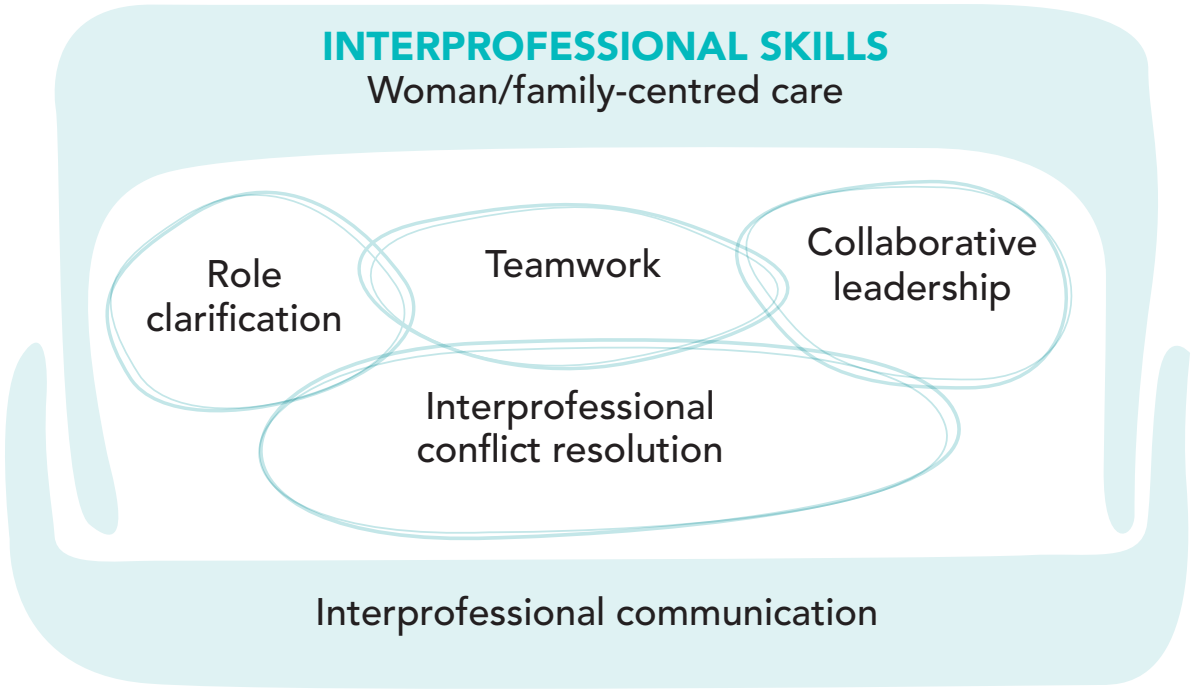


Figure 1

SIX COMPETENCIES*

All health professionals have their own strengths and limitations. The following Table and the one in Appendix 4 can be used to evaluate a health professional's interprofessional skills. The first objective is to learn about himself/herself; the next is to target the skills that must be worked on individually or as a team. Personal development objectives can then be set by adopting the attitudes listed. The strength of a team lies in its ability to combine the strengths of its members so that all their skills are used.

1. INTERPROFESSIONAL COMMUNICATION	
COMPETENCIES Develop effective interprofessional communication Establish communication methods adapted to teamwork: • protocols • questionnaires • statutory and/or individual meetings • interprofessional training The manager must ensure that all team members have the same theoretical knowledge bases for the intervention: knowledge of reference frameworks, codes of ethics, etc.	**SKILLS TO ACQUIRE** • Apply active listening principles • Communicate in an understandable manner: avoid professional jargon and use clear language (popularization) • Develop relationships of trust with team members, the woman, her family • Observe team members' nonverbal language and be as transparent as possible • Interprofessional communication involves: - negotiation - consultation - interaction - discussion - debate
ATTITUDES TO ADOPT Be a responsible communicator with a spirit of openness and collaboration	**ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN** • Save time • Make yourself understood • Consider individual points of view

2. WOMAN/FAMILY/COMMUNITY-CENTRED CARE	
COMPETENCIES The health professionals must develop a relationship of trust with the pregnant woman to enable her to be open and express her needs.	**SKILLS TO ACQUIRE** • Support participation and commitment • Use clear, understandable language to share information • Listen to the needs expressed by the parties involved • Be attentive to the nonverbal • Demonstrate advocacy
ATTITUDES TO ADOPT • Value the contribution and participation of the woman and her family • Share the care plan objectives with the team • Facilitate access to resources	**ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN** • The woman makes informed decisions • Services are more effective • Collective actions are oriented towards the woman's needs, expectations, and priorities and are not a reflection of various professional needs

*Canadian Interprofessional health collaborative. A national interprofessional competency framework, 2010, Canadian Interprofessional health collaborative

3. ROLE AND RESPONSIBILITY CLARIFICATION	
COMPETENCIES Learn about the other professions and show how your profession adds to the team.	**SKILLS TO ACQUIRE** • Understand your role and that of others • Have good listening skills • Express yourself clearly • Ask questions to target the professional who will best meet the woman's needs • Share your expertise
ATTITUDES TO ADOPT In each clinical situation, question your intervention role: • Which professional is best placed to intervene? • Is this a simple, complicated, or complex need? • Do we need to involve several health professionals and what types of relationships will they have? • With which professional has the woman developed a relationship?	**ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN** • Prevent conflicts • Ensure coordinated, complementary service • Ensure efficiency through optimal use of each person's expertise • Ensure greater collegiality between team members • Prevent duplication

4. TEAM FUNCTIONING	
COMPETENCIES The interprofessional team consists of members from two or more professions.	**SKILLS TO ACQUIRE** • Develop effective working relationships • Understand the principles of group dynamics • Participate to optimum effect during meetings: effective discussions and interactions • Set out working principles based on the team's values and mandates
ATTITUDES TO ADOPT • Reflect on the interaction between the professionals: - Who is best equipped to intervene based on the situation? - Which modality is most suitable for interaction? • Be available • Show respect, openness, trust, willingness to listen	**ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN** • Be effective and efficient • Establish consensual objectives

5. COLLABORATIVE LEADERSHIP

COMPETENCIES

Process through which each person affirms his/her expertise and recognizes others' expertise. Leadership is thus shared between team members depending on situations and contexts.

SKILLS TO ACQUIRE

- Understand your environment
- Establish common objectives
- Build relationships of trust through listening, openness, and transparency
- Share power
- Encourage those around you to develop their talents
- Support the involvement of team members
- Be innovative

ATTITUDES TO ADOPT

- Be open and inclusive
- Be honest and transparent
- Be genuine and innovative
- Ask for feedback
- Develop talents
- Think systematically
- Trust
- Anticipate and act responsibly
- Have common objectives

ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN

- Contribute to individual and collective commitment around a common vision, values, and a field of expression
- Encourage professional, individual, and collective responsibility
- Help establish consensual objectives
- Promote:
- collaboration
- effective teamwork methods
- decision-making
- the development of a collaborative work environment and climate
- ongoing improvement

6. INTERPROFESSIONAL CONFLICT RESOLUTION

COMPETENCIES

Interprofessional conflicts jeopardize the establishment of harmonious interactions that contribute to cohesion and interdependence. This affects the ability of health professionals to collaborate effectively and thereby affects the quality of services offered to parents. It is possible to prevent conflicts and to manage them effectively. All team members are encouraged to develop their competencies in this direction.

SKILLS TO ACQUIRE

- Recognize the potential for conflict and take constructive actions
- Know and understand strategies to deal with conflict
- Analyze the causes of conflicts
- Set guidelines to deal with conflict
- Establish a safe environment in which to express diverse opinions

ATTITUDES TO ADOPT

- Have a proactive attitude
- Participate in a positive, constructive manner
- Aim for consensus

ADVANTAGES FOR THE INTERPROFESSIONAL TEAM AND THE WOMAN

- Encourage the creation of closer ties between team members
- Open the way for better collaboration

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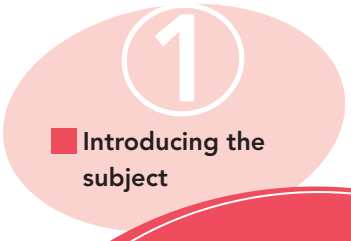
INTERVENTIONS

Collaborative approaches are rooted in a support-based approach with the common objective of reducing or stopping alcohol consumption. The health professional should show empathy as he/she works to increase the woman's motivation, letting her set the pace. These methods provide conclusive results in the prevention of FASD.

FIRST CONTACT



All women of childbearing age and pregnant women should be asked about their current and previous alcohol consumption

All women of childbearing age and pregnant women should be asked about their alcohol consumption. It is important to ask questions about the quantity and frequency of alcohol consumption to ensure that potential at-risk drinkers are identified. Some health professionals introduce the question of drinking in an informal conversation. In the checklist, we suggest some open-ended questions that will enable the woman to express her perceptions about her drinking. These sentences and questions are also designed to put her at ease. The health professional should be open-minded and acknowledge the woman's knowledge and experience. The woman will then be more receptive to the information given her.

Other health professionals prefer to use a validated questionnaire for more structured identification and screening. Identification and screening questionnaires are presented in Appendix 1, including a questionnaire specifically for adolescents.

SUGGESTIONS FOR INTRODUCING THE SUBJECT IN AN INFORMAL MANNER:

"WHEN DID YOU HAVE YOUR LAST DRINK?"

"BEFORE YOU BECAME PREGNANT, HOW MANY GLASSES OF ALCOHOL DID YOU DRINK EACH DAY? EACH WEEK?"

"HOW MANY GLASSES OF ALCOHOL HAVE YOU HAD DURING THE LAST MONTH?"

"WHAT DO YOU KNOW ABOUT DRINKING DURING PREGNANCY?"

"MANY WOMEN HAVE TOLD ME THAT THEY FIND IT HARD TO STOP DRINKING DURING PREGNANCY"

As previously mentioned, it is important to know the pregnant woman's background before intervening in her specific situation. The analysis of her current and previous alcohol consumption should be followed by the analysis of her context suggested in Appendix 2.

BRIEF INTERVENTIONS

Brief interventions (BI) make it possible to intervene quickly to identify and screen for the pregnant woman's level of alcohol consumption and to help her reduce her consumption, if necessary. Motivational interview techniques can be useful to the health professional during these interventions. Validated screening questions can be easily integrated into BIs.

APPLICATIONS

On average, BIs last between five and thirty minutes. Frequency will depend on the woman's needs and the capacity of the practice setting.

According to the Society of Obstetricians and Gynaecologists of Canada (SOGC), brief interventions with pregnant women are both efficient and cost effective. The authors cite three components of brief interventions:

1. Assessment and feedback aimed at increasing awareness
2. Advice including provision of pamphlets and discussion
3. Assistance using motivational interview techniques. Set realistic goals targeting harm reduction (explanation to follow) or abstinence. The intervention should focus on positive reinforcement and conclude with a referral, if necessary.

A screening tool has been developed by the Canadian Centre on Substance Abuse and the College of Family Physicians of Canada: *SBIR-DIBA*. This tool makes it possible to target individuals with an alcohol or drug use disorder or dependency and to effectively steer the interview towards services and care according to the person's objectives. This model is also relevant when it is important to know the individual's stage of change. We suggest an adaptation for pregnant women in the Checklist, that appears in Intervention—*Select the appropriate intervention section*.

Better results have been reported when a partner chosen by the pregnant woman (spouse or someone close to her) is involved. Other factors that contribute to success are a relationship of trust and the creation of a feeling of security with the health professional. The woman's stage of change should be considered when establishing change objectives (Prochaska, DiClemente, 1984).

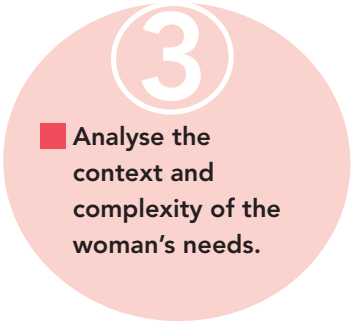
RESULTS

BIs based on behavioural changes can be effective if these elements are considered:

- Women who set their own abstinence goals right from the start have a tendency to adhere to them throughout the pregnancy and to decrease their subsequent consumption
- There was a greater decrease in alcohol consumption among women whose target was a decreased risk of Fetal Alcohol Syndrome Disorder
- Support from a partner (spouse, family, friend) improved the effectiveness of the interventions

BIs are more effective with high-risk drinkers (high consumption or addiction).

ANALYSIS OF THE PREGNANT WOMAN'S CONTEXT



As explained in the section Get to Know the Woman holistically, it is important to consider the woman's environment to put her drinking into context. In Appendix 2, we propose a template that divides the analysis into four sections:

1. The woman
2. Her family and social environment
3. Her physical environment
4. The political environment

Some analysis indicators are suggested but each health professional is free to ask questions on subjects that seem relevant to the context. The objective is to better understand the woman's life, the context of consumption, the scope of her support network, as well as barriers and openness to change. The analysis will give you information about other problems experienced and perceived by the woman.

HARM REDUCTION

When a woman is observed to have several problems, a more holistic approach is required to support her. By dealing with short-term issues, the health professional establishes a relationship of trust with the client to support her in addressing the needs she is aware of.

APPLICATIONS

Harm reduction refers to a set of practices aimed at reducing the negative consequences of substance abuse on health, society, and the economy. This concept maintains that the consequences of alcohol consumption are a societal problem and does not target the alcohol itself. The objective of harm reduction lies on a continuum between abstinence and reduction of consumption, and is adapted according to the person's stage of change. Thus, all women who drink alcohol during pregnancy are considered, and realistic objectives based on their personal experience are established.

Services should be offered by a team of health and social services specialists using a non-traditional approach to follow-up. In short, the interventions should resemble the following:

- A single service point
- Non-judgmental approach
- Consideration of the woman's stage of change
- Pragmatic: priority given to short-term objectives (housing, finances, marital relationship, job, other concerns) and taking into consideration the costs/benefits of behaviours (advantages and consequences of drinking)
- Establish a relationship of trust and a feeling of security that will lead to discussions

Nancy Poole mentions the importance of organizing services in community settings to improve access to services. In Quebec, Marielle Venne and her team developed the program Main dans la main and Rond-point in the 2000s. Rond-Point mobilizes the experiences of a number of health, social services, and addiction professionals in the same setting for the benefit of families and future parents struggling with alcohol and drug problems. The principles of harm reduction, the woman-centred focus to care, and interprofessional approaches guided the parents during the interventions.

THE SOGC QUOTES MOTZ AND LESLI TO EXPLAIN THE PRINCIPLE OF HARM REDUCTION IN THE CONTEXT OF PREGNANCY:

Implicit in this approach is a shift away from stigma, guilt, confrontation and shame, towards an empowering and strengths-based approach. A respectful, non-judgmental approach accommodates goals of reduced use rather than immediate abstinence.

RESULTS

Harm reduction focuses on the harm caused by the context surrounding the consumption of alcohol rather than the alcohol itself. The woman and her family are involved in decision-making and an attempt is made to identify the overall problem by adopting a holistic view (considering the environment, as in the woman-centred approach).

CONTINUUM OF INTERPROFESSIONAL COLLABORATIVE PRACTICE

4

DETERMINE the need to have several professionals intervene

The Continuum is used to analyze the need to involve colleagues to meet the needs of the woman and her family.

Health professionals who work in a more multidisciplinary (consultation, reference, coordination of actions) or interdisciplinary (joint case management) model must develop effective collaborative methods adapted to the complexity of the situation, and ensure good communication and suitable shared leadership according to each person's expertise.

However, not every situation will require the involvement of several professionals and not every situation will require the same intensity of collaboration. *The Continuum of Interprofessional Collaborative Practice* from *the Réseau de collaboration sur les pratiques interprofessionnelles en santé et services sociaux* (RCPI) provides a simple model to determine whether or not to involve colleagues.

According to the Guide that accompanies this figure, the collaborative practices chart is "made up of four distinct components: *situation, intention, interactions, and disciplinary knowledge* (figure 2). These components are closely linked in a logical, coherent manner. Thus, apart from the establishment of a partnership with the client(s), which transcends the continuum, the degree of complexity of the biopsychosocial needs of clients and their families or the community (situation component) will influence the other three components (*intention, interactions, and disciplinary knowledge*). The intention underlying collaboration and the need to combine disciplinary knowledge to meet the needs of clients, their families, and community in an adapted manner depends on the complexity of the situation. The degree of interdependence required to respond to the situation is what should guide the choice of interactions."

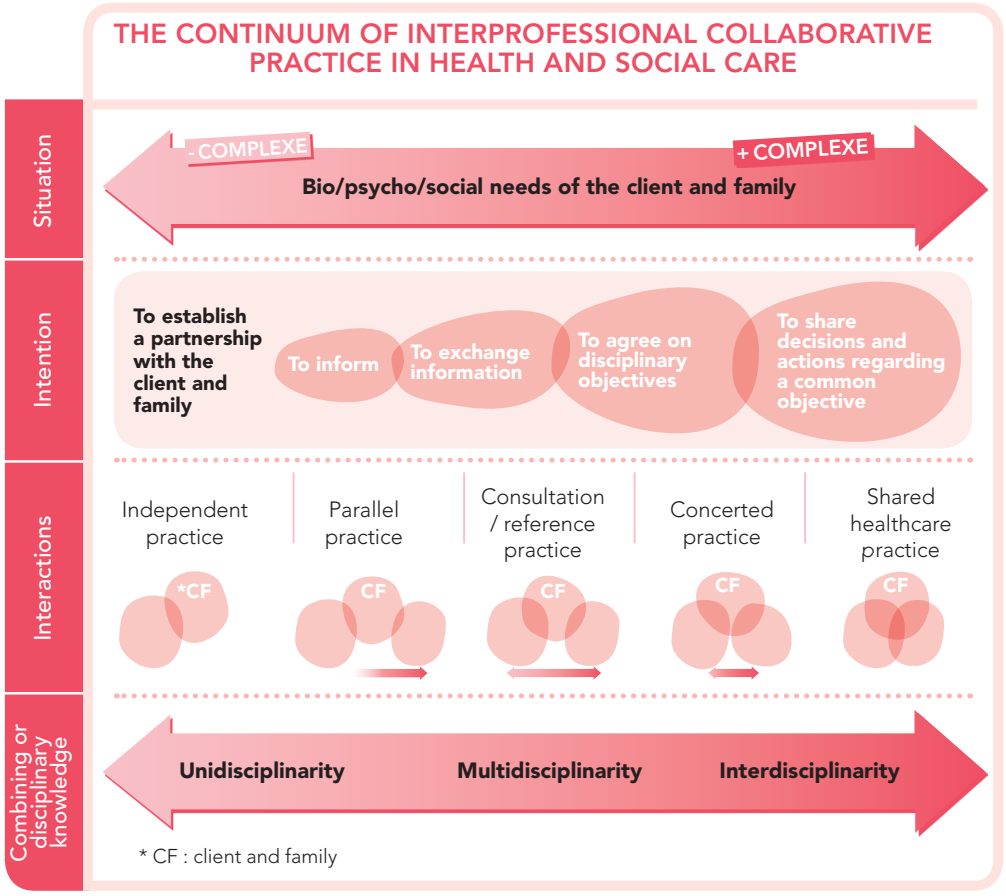


Figure 2
Continuum of Interprofessional Collaborative Practice in Health and Social Care developed by the RCPI

Careau, E., et al. (2014) *The continuum of interprofessional collaborative practice in health and social care.* Réseau de collaboration sur les pratiques interprofessionnelles en santé et services sociaux (RCPI)

RECOMMANDATIONS
→ FOR THE INITIAL APPROACH

5

PROVIDE INFORMATION about the risks of drinking.

Identify drinkers and screen for a problem, analyze the context, and use motivational interviewing or cognitive behavioural techniques

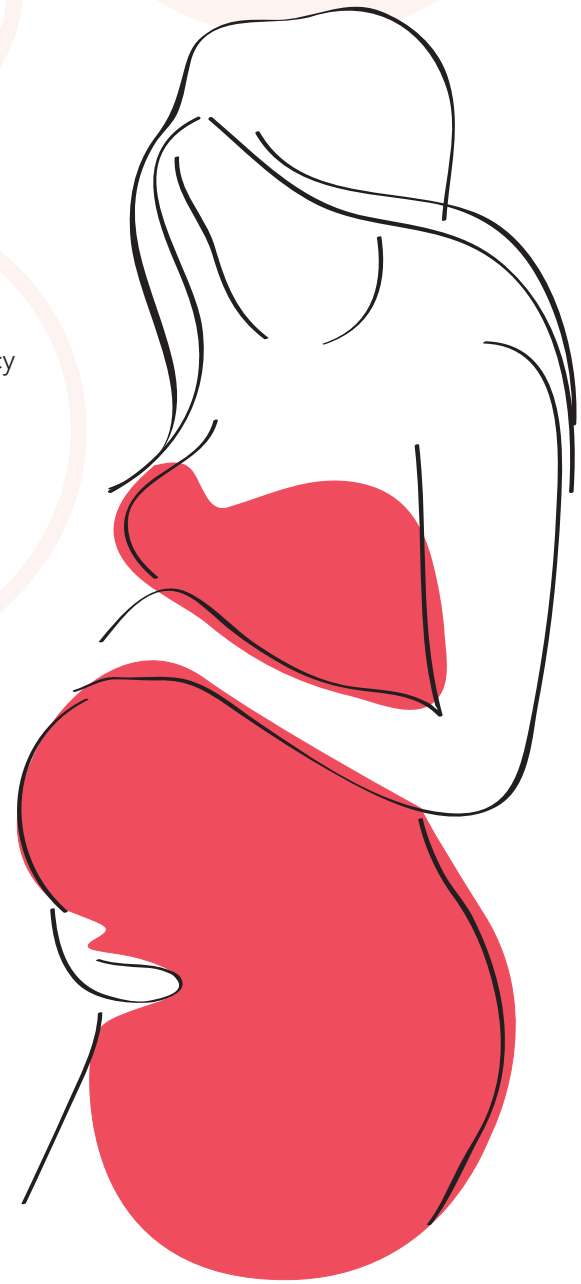
Create a relationship of trust and a feeling of security

Involve the woman's partner and family

Inform the woman about the risks of alcohol consumption during pregnancy in accordance with her level of knowledge and valid information on the subject (consult Appendix 6 and the Introduction of this document)

Consider the woman's stage of change when establishing objectives (Prochaska, DiClemente) and prioritize them realistically

Show a human face: encourage involvement and respect for the woman's rights and freedoms in the change process, including through self-organization and self-support



ADAPTING INTERVENTION STRATEGIES

The health professional can guide the woman towards pragmatic objectives that are adapted to her reality by first assessing her level of commitment to the process, her motivation, and her stage of change. The assessment tools in Appendix 3 will help you to determine where the woman is in her stage of change. There is no standardized, validated tool available to evaluate the woman's commitment and motivation. As they practice over the course of time, health professionals will develop tactics and methods to detect signs of motivation and commitment. The stage of change and the techniques proposed are clearly identified in the Checklist and refer to the tools in the section Health Professional's Roles in this Guide.

ASSESS THE LEVEL OF MOTIVATION

6

Assess motivation and commitment to the process.

Motivation is a dynamic process influenced by both internal and external factors. Health professionals should adopt different approaches depending on the motivation of the patient. The pregnant woman's perceptions will influence her motivation to change:

- Perception of her competence to make a change in her behaviour
- Perception of the extent of the negative effects of the behaviour

Motivation will vary throughout the change process; it can be placed on a continuum going from the absence of motivation through various stages of extrinsic motivation to intrinsic motivation. Intrinsic motivation is guided by feelings of competence and autonomy and when the person's level of perception allows the person to describe it as "pleasant." When objectives are influenced by factors in our environment and our family, they are extrinsically motivated. For example, women who reduce their alcohol consumption solely for the well-being of the fetus and not for their own wellbeing or for deeper values.

Extrinsic motivation can become intrinsic motivation when a behaviour is internalized* . Thus, with the previous example, there may be information that will help the mother-to-be understand the importance of not drinking while she is pregnant. It will then be easier for her to continue with the behaviour and her motivation will eventually become intrinsic (the pleasure of creating a healthy environment for the development of the fetus and for her own health).

The principles of the motivational approach presented in the first section of the Guide (*Health Professional's Roles*) will help you to introduce the behavioural change.

→ DEALING WITH RESISTANCE ←

Resistance is created in situations where freedom of choice is compromised. Strategic responses and mirroring are helpful in avoiding confrontation. The health professional may also decide to change the subject voluntarily to avoid confrontation in a situation where there is resistance:

EXAMPLE OF MIRRORING

OBSTACLE: " I went to happy hour at the bar with my coworkers, as usual. It's the only chance I get to see people. "

MIRRORING: " Going out during happy hour with your coworkers is important to your social life. "

AMPLIFIED MIRRORING: " You enjoy spending some downtime with your coworkers. "

DOUBLE-SIDED MIRRORING: " You feel guilty for going out and enjoying happy hour at the bar, but at the same time you need a social life right now. "

Amotivation	Extrinsic Motivation				Intrinsic Motivation
	External Regulation	Introjection	Identification	Integration	

Figure 3
Motivation continuum (Deci and Ryan 1985)

*Internalisation: process through which a value or a rule is understood and then accepted for its importance.

	Precontemplation « You're exaggerating! »	Contemplation « Maybe, but I like it! »	Preparation « I want to change »	Action « I'm drinking less »	Maintenance « I've stopped but I need support. »
OBJECTIVES	Increase risk awareness without causing alarm Ensure that the woman wants to return.	Guide her towards preparation	Negotiate a plan for change	Guide and support her actions	Encourage action and prevent relapses
RECOMMANDED INTERVENTIONS	Establish a relationship with the pregnant woman	Explore ambivalence • Decisional balance	Offer several choices • Brainstorming • Coping	Positive reinforcement	Assist with other follow-ups
	Use mirroring	Explore the reasons behind her alcohol consumption and her relationship with drinking	Eliminate barriers to change • Decisional balance • Refer to other services	Practical assistance with other problems • Brainstorming • Coping	Confirm commitment
	Remain pragmatic	Do not give orders • Brainstorming • Coping	Support self-efficacy	Eliminate barriers to change • Decisional balance • Refer to other services	Emotional support
	Harm reduction • Do not aim for abstinence • Respect the woman's pace	Support self-efficacy	Establish a plan in collaboration with the woman		Pragmatic
		Harm reduction • Do not aim for abstinence • Respect the woman's pace	Harm reduction • Do not aim for abstinence • Respect the woman's pace		Accept relapses and help prevent them

Figure 4

ASSESS THE LEVEL OF COMMITMENT

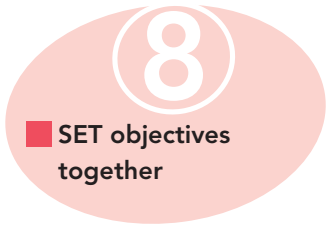
Commitment uses actions to confirm words. For example, the woman may want to cut down on her drinking, have the tools and the motivation to do so, but still not commit to change. The health professional can use simple techniques to encourage commitment during the period of preparation for change.

- Encourage the woman to speak publicly about her desire to change
- Use visualization techniques to get the woman to talk about her desire to change
- Ask questions in a way that gets the woman to describe the first realistic steps to the desired change, and have her specify how she is going to make it happen.

INTERVENTIONS BASED ON THE WOMAN'S STAGE OF CHANGE

Interventions will be different depending on the woman's levels of commitment and motivation for the change process. The model of behavioural change developed in the 1980s by Prochaska and Di Clemente consists of six stages: from pre-contemplation of behavioural change all the way to maintaining the desired behaviour. An individual can progress along the change continuum and have relapses. Progression towards change is rarely linear, which is why it is often depicted in the form of a circle because there are steps forward and steps backwards in the various stages. Ambivalence is normal and conveys that change is taking place. It can be maintained for a long time. Steps backward are often indicators that there are additional elements to be understood in order to move to the next stage. The fall is not as important as is helping the woman to quickly get back on the wheel of change. This model is now used in several fields and can be adapted to any clinical situation.

Margaret Leslie and Wendy Reynolds have written a detailed guide on the subject: *The SMART Guide: Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Alcohol*. **Figure 4** succinctly summarizes the stages set out in the guide. Consulting it is strongly recommended in order to understand the details of the suggested motivational approaches to interventions with pregnant women who consume alcohol.



SET OBJECTIVES TOGETHER

It is important to be pragmatic when defining intervention objectives. The consumption of alcohol may seem a priority to the health professional, but it is preferable to keep the focus on the woman's immediate needs. The health professional can thus develop a relationship of trust which will eventually allow the woman to feel comfortable about taking action regarding her drinking.

SMART objectives provide some useful indicators to the health professional to help clarify strategies for effecting change. The SMART objectives are:

SPECIFIC: Clarify and specify objectives. It is important that the woman talk about the behaviour she wishes to achieve. The health professional will guide her to find the right terms by using mirroring as needed.

MEASURABLE: Clarify how we will know that the objectives have been achieved.

ATTAINABLE: Determine how the woman will achieve these objectives.

REALISTIC: Make sure she has the resources to achieve the objectives.

TIMELY: Establish a flexible schedule for achieving the objectives.

The woman may express elements that modify the specific objectives depending on the various levels of her commitment:

DESIRE: I would like to stop drinking.

ABILITY: I am able to stop drinking

REASONS: Drinking can affect my health and that of the baby.

NEEDS: I have to stop drinking.

COMMITMENT: I am going to stop drinking.

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FASD

APPENDIX 1 VALIDATED IDENTIFICATION AND SCREENING TOOLS

T-ACE [1]

T – TOLERANCE How many drinks does it take to make you feel high?
Less than or equal to 2 drinks : 0 point. More than 2 drinks : 1 point

A – ANNOYANCE Have people annoyed you by criticizing yous drinking?
No : 0 point. Yes : 1 point

C – CUT DOWN Have you felt you ought to cut down on drinking?
No : 0 point. Yes : 1 point

E – EYE OPENER Have you ever had a drink first thing in the morning to steady you nerves or to get rid of a hangover? No : 0 point. Yes : 1 point

SCORE

A total of two points or greater indicate potential prenatal risk

TWEAK [2]

T – TOLERANCE How many drinks can you hold? Less than 5 : 0 point. More than five drinks without falling asleep or passing out : 2 points

W – WORRIED Have close friends or relatives Worried or complained about your drinking in the past year?
Non : 0 point. Oui : 2 points

E – EYE OPENER Do you sometimes take a drink in the morning when you first get up?
No : 0 point. Yes : 1 point

A – AMNESIA Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? No : 0 point. Yes : 1 point

K – (CUT) Do you sometimes feel the need to Cut Down on your drinking?
No : 0 point. Yes : 1 point

SCORE

A total score of 2 or more points indicates the woman is likely to be a risk drinker.

CRAFFT [3]

IDENTIFICATION OF HARMFUL USE OF PSYCHOACTIVE SUBSTANCES IN ADOLESCENTS

SCORE

Score one point for each " yes " answer. The higher the score, the higher the risk of a substance use disorder

C (CAR) 1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ☐ Yes ☐ No

R (RELAX) 2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? ☐ Yes ☐ No

A (ALONE) 3. Do you ever use alcohol/drugs while you are by yourself, ALONE? ☐ Yes ☐ No

F (FORGET) 4. Do you ever FORGET things you did while using alcohol or drugs? ☐ Yes ☐ No

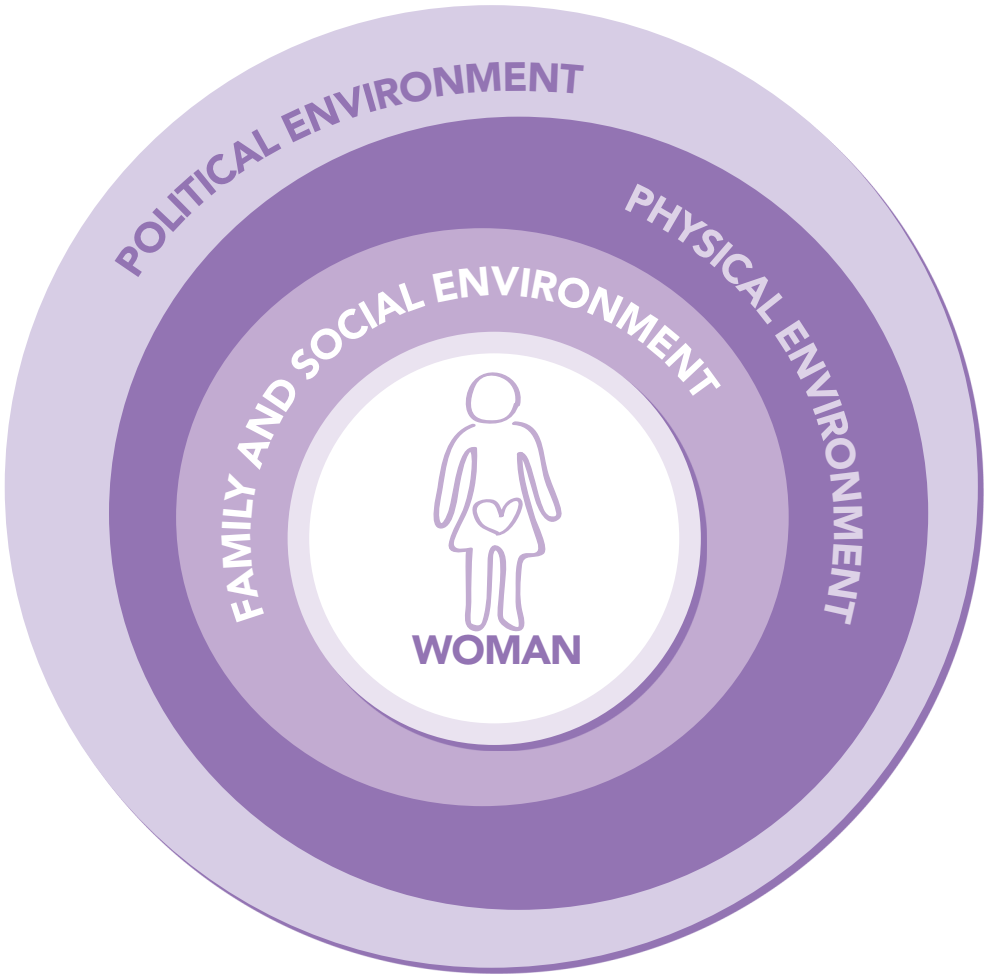
F (FAMILY/FRIENDS) 5. Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No

T (TROUBLE) 6. Have you ever gotten into TROUBLE while you were using alcohol or other drugs? ☐ Yes ☐ No

APPENDIX 2 CONTEXT ASSESSMENT TOOLS

→ OBJECTIVES :

1. Give you information about other problems experienced and perceived by the woman
2. To better understand the woman's life, the context of consumption, the scope of her support network, as well as barriers and openness to change.



WOMAN	FAMILY AND SOCIAL ENVIRONMENT	PHYSICAL ENVIRONMENT	POLITICAL ENVIRONMENT
Lifestyle habits	Parenting	Housing	Finances
Physical and psychological health	Conjugal life	Employment	Access to services
Previous pregnancies	Family relationships		

APPENDIX 3 MOTIVATIONAL INTERVIEW INTERVENTION TECHNIQUES

FRAMES [4]

SIX ELEMENTS OF A BRIEF INTERVIEW USING MOTIVATIONAL INTERVIEW:

FEEDBACKS ON CURRENT STATUS OF ALCOHOL USE
(EMPHASIS ON CLIENT) **R**ESPONSABILITY
(CLEAR) **A**DVICE TO CHANGE
(A)**MENU** OF OPTIONS
EMPATHY
SUPPORT TOWARD SELF-EFFICACY

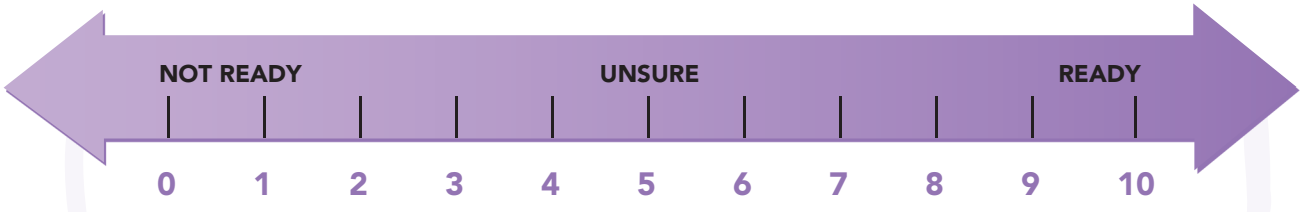
ROLLNICK SCALE [5]

OBJECTIVES

- To assess the level of commitment and motivation
- To explore the limits of change

PROCEDURE

- Ask what the level of motivation and commitment is (from 1 to 10)
- Explore why it is not higher



REPLACEMENT SOLUTIONS [6]

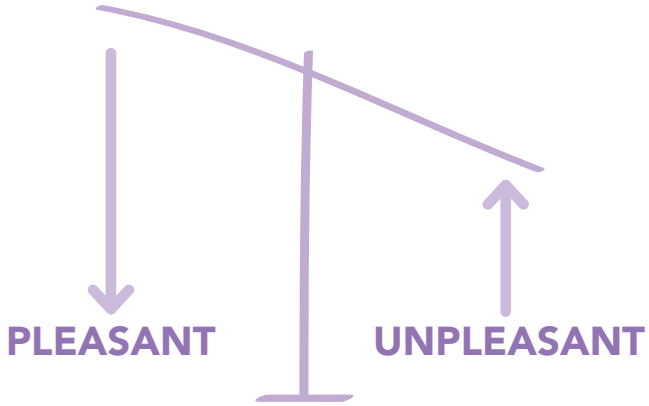
PROCEDURE

- Make a list of the situations, places, and people that trigger a desire to use alcohol/drugs
- Find replacement solutions

DECISIONAL BALANCE [7]

PROCEDURE

1. List the pleasant and unpleasant aspects of alcohol consumption
2. Ask the woman to draw a line on the scale, showing which aspects have more weight: the pleasant or unpleasant aspects?



COPING [8]

UNHELPFUL OR UNPRODUCTIVE STRATEGIES

Doing nothing, worrying, using, taking risks, blaming oneself, reprimanding oneself, ignoring the problem, withdraw

HELPFUL OR PRODUCTIVE STRATEGIES

Making an effort to solve the problem, working hard in order to succeed, thinking positively, self affirmation, relaxing, having fun, talking to a trusted person, being physically active

APPENDIX 4 SUMMARY TABLE OF INTERPROFESSIONAL SKILLS

COMPETENCIES	KNOWLEDGE	SKILLS	ATTITUDE
Role clarification	I am able to describe my role and the roles of others.	I can count on the knowledge of other health professionals to meet the objectives of the person, the family and the community.	I assume my role and respect the roles of others. I listen to others in order to know them better.
Person, family and community-centred care	I understand the philosophy of person, family and community-centred care and services.	When providing information to the person, the family and the community, I communicate respectfully, using comprehensible language that encourages discussion and promotes informed decision-making.	I acknowledge the experience of the person, the family and the community. I respect the values and the needs of the person, the family and the community.
Teamwork	I know which attitudes to develop to create a climate of trust (respect, openness, listening).	I am able to establish a consensus regarding precise objectives at the beginning of a meeting.	I develop relationships of trust with others. I respect other people's points of view.
Collaborative leadership	I am aware of my strengths and my limitations in a team.	I express my point of view even if it differs from those of others.	I encourage the integration of the points of view and information provided by other professionals. I share my expertise as soon as the situation warrants it.
Interprofessional communication	I am able to give feedback.	I share my professional opinion using language that others will understand.	I am respectful toward the person, the family and the community. I am transparent in my communications with others.
Interprofessional conflict resolution	I am familiar with conflict resolution strategies.	I emphasize my complementarity with another health professional rather than our differences.	I do not seek to impose my point of view, but rather to understand those of others and ensure that mine is understood.

APPENDIX 5 OBSTACLES TO COLLABORATION [9]

A number of obstacles may arise when a collaborative approach is implemented. Each individual has a certain level of understanding of the collaborative approach as well as personal and professional experience that may influence their level of commitment.

LACK OF FAMILIARITY WITH PEERS' PROFESSIONAL VALUES. Some professionals take a more paternalistic approach while others work on patients' autonomy. Conflicting objectives can arise.

LACK OF RECOGNITION OF WORK METHODS. Professionals work within theoretical frameworks that have different requirements and approaches. It is essential to recall the principles of interprofessional education in order to rally the team around complementary or similar theoretical frameworks.

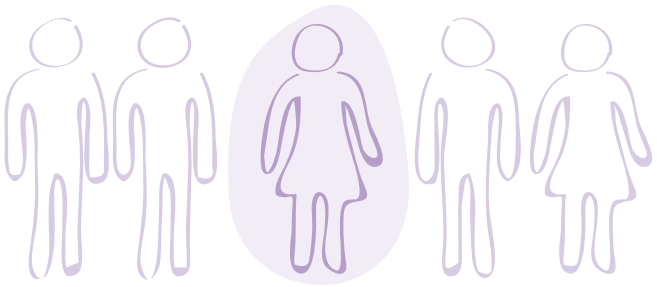
PREJUDICES, FALSE BELIEFS AND STEREOTYPES. Our own personal and professional experiences forge our perceptions of other professions. Whether these perceptions are true or false, it is important to be aware of them and to take stock of our views by becoming more open

LACK OF KNOWLEDGE OF FIELDS OF PRACTICE (LAWS AND RESERVED ACTIVITIES). The professions are regulated by a number of laws and policies. It is essential to be familiar with them and to be aware of the constraints they can place on everyday activities. The Office des professions du Québec's website provides a great deal of information on this subject. For example:

- Bill 90 (2002) regulates the fields of practice.
- Bill 21 (2013) redefines mental health practices, including psychotherapy.
- Bill 41 amended laws that apply to pharmacies.

But beyond theoretical knowledge about fields of practice, it is important that health professionals be familiar with the scope of their colleagues' activities, which may be carried out differently from one institution to another. Recognizing the particular details of each person's responsibilities also contributes to building cohesiveness.

NON-ADHERENCE BY HEALTH PROFESSIONALS AND MANAGERS TO THE VALUES OF A PERSON-CENTRED APPROACH. When conflicts arise, health professionals are often observed to become entrenched in professional considerations and objectives. Refocusing on the real needs and expectations of patients can help overcome obstacles



HIGH TURNOVER IN A WORK TEAM TENDS TO WEAKEN THE GROUP'S COHESIVENESS. In order to foster good collaboration, it is also important that partners get to know each other professionally and personally. It is therefore important to provide the space and time necessary for forging interpersonal bonds between health professionals.

HIERARCHICAL LEADERSHIP. To ensure successful collaboration, relationships between partners should be non-hierarchical and "power" should be shared according to the type of expertise required in a given situation. First-level managers have an important role to play in coordinating the efforts of those involved, but they should take on the role of mentor or supportive partner rather than employ a directive management style.

UPPER MANAGEMENT'S LACK OF VISION OF THE IMPORTANCE OF INTERPROFESSIONAL COLLABORATION. The entire organization must buy into the culture of collaboration. Time and space should be allocated to the effective communication and administrative processes it requires.

UNDERESTIMATING NETWORKING. Looser organizational structures promote interprofessional communication. Informal relationships play a powerful role in creating positive interactions. Individuals and organizations must adopt flexible methods of collaborating that take into account each person's reality.

APPENDIX 6 OTHER REFERENCES

INTERPROFESSIONAL COLLABORATION

Center for interdisciplinary research in rehabilitation and social integration

The RCPI is a centre of expertise for interprofessional collaboration and its associated human expertise. The centre of expertise is dedicated to developing best practices in interprofessional collaboration in order to meet the health and well-being needs of people and communities.

418-681-8787, extension 3805

Info-rcpi@cifss.ulaval.ca

FASD

FASD prevention brochures

dispensaire.ca

Breaking the cycle

mothercraft.ca

Alanna (documentary on FASD)

Rocher A-M, Turgeon J. 2009. NFB

Coalescing on women and substance use

www.coalescing-vc.org

Canadian Centre on Substance Abuse

www.ccsa.ca

CHOICES

cdc.gov/ncbddd/fasd/documents/choices_onepager_-april2013.pdf

Quebec Centre for Information on Addictions

CQDT

INTERVENTION USING COLLABORATIVE APPROACHES

Rond-Point

Centre d'expertise périnatal et familial de toxicomanie à Montréal

Centre Domrémy

Centre de réadaptation en dépendances de la Mauricie et du centre du Québec

Portail virtuel France-Québec sur les interventions en dépendances

parentalite-dependances.com

***SMART* Guide**

***PRIMA* Guide**

Guide de changement de ma consommation d'alcool et de drogues

Centre de réadaptation en dépendance Domrémy-de-la-Mauricie Centre-du-Québec

Alcohol Screening, Brief Intervention & Referral

sbir-diba.ca

Delivering an Alcohol Brief Intervention, Antenatal professional pack

NHS Scotland

Parentalité, alcool et drogues Un défi multidisciplinaire

Morissette P. and Venne M., Parentalité, alcool et drogues Un défi multidisciplinaire, 2009. CHU Ste-Justine Editions

PREGNANCY

Motherisk

A telephone helpline for Canadian health professionals and the general public.

In English and French.

1 877-327-4636

www.motherisk.org/FAR/

Centre IMAGe

Information on medication during pregnancy and while breastfeeding.

CHU Ste-Justine

514 345-2333

Drogue : aide et référence

Support, information and references throughout Quebec.

514 527-2626

1 800 265-2626

SOS Grossesse

Community organizations in Quebec that provide support to families during pregnancy.

Quebec City region

1 877 662-9666

(418) 682-6222

Eastern Townships (Estrie) region

(819) 822-1181

1 877 822-1181

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Founded in 1879, the Montreal Diet Dispensary is Quebec's leader in social nutrition for pregnant women in difficulty. Each year, the Dispensary helps on average 1,500 of these women in the Greater Montreal to give birth to healthy babies and to foster optimal development of their children. Our innovative interventions in nutrition counselling, perinatal and social support, and community development help families feel empowered.