CANADIAN ALCOHOL POLICY EVALUATION

CANADIAN ALCOHOL POLICY EVALUATION (CAPE) COMMUNITY OF PRACTICE

FASD prevention and public health policy

Event #24: May 8, 2024

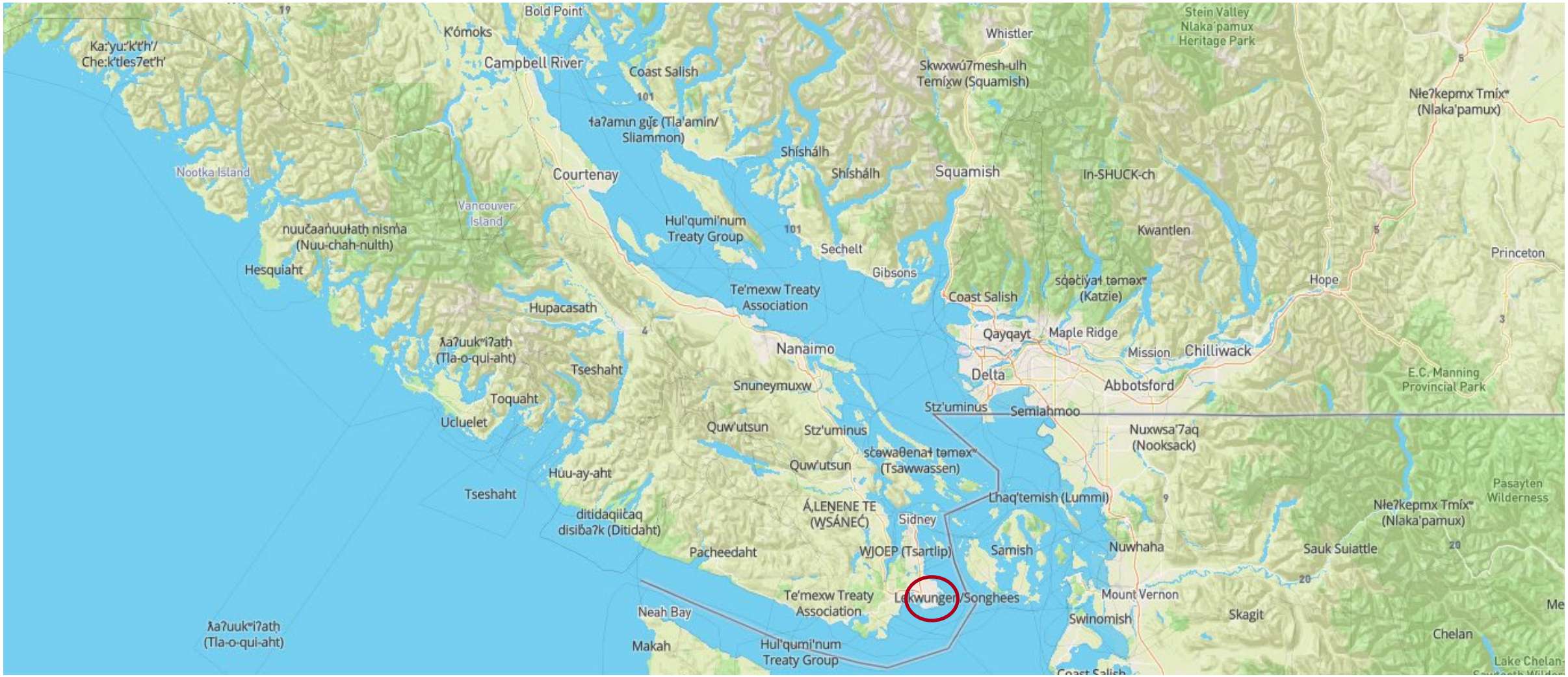
University of Victoria
Canadian Institute for Substance Use Research
Institut canadien de recherche sur l'usage de substances
camh
Centre for Addiction and Mental Health

INTERPRÉTATION SIMULTANÉE EN FRANÇAIS

CANADIAN ALCOHOL POLICY EVALUATION

Interprétation simultanée en français est disponible **sauf** pour la section Q&R

Simultaneous French interpretation is available **except** for the Q&A portion / (see Chat box for instructions)



We acknowledge and respect the Lək̓ʷəŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

HOUSEKEEPING

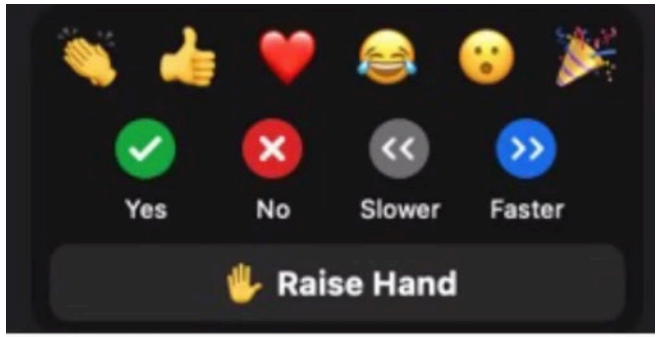
CANADIAN ALCOHOL POLICY EVALUATION

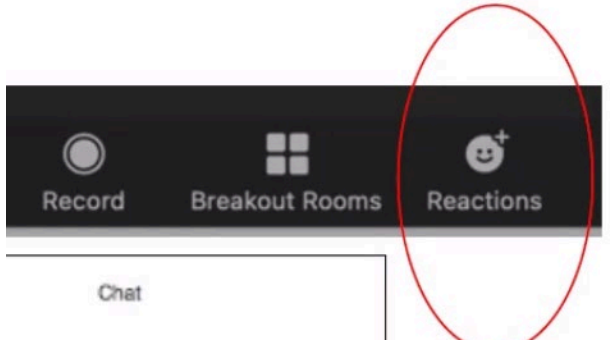
- Today's webinar includes a presentation and Q&A = 90mins
- The presentation segment will be recorded (not Q&A).
  Links to the recording and webinar slides will be emailed.
- We invite your feedback about today's session.
  A survey link will be shared in the Chat box and via email.
- For persons with lived/living experience stipends, email capecopcoord@uvic.ca

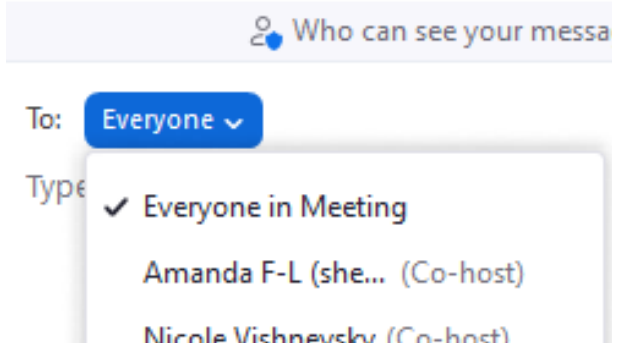
The views and opinions expressed as part of this event are those of the presenters alone and do not necessarily represent those of our funders or other organizations acknowledged

Q&A FORMAT

- Use chat box or Q&A tool to submit a question at any time.
- Use ‘raise hand’ during Q&A segment. The moderator will ask you to unmute to pose your question. Name the presenter to whom you are directing the question.
- The moderator may read aloud questions typed in the chat or Q&A tool.
- Technical difficulties? please message us in the chat.







FASD Prevention and Public Policy

Nancy Poole, Prevention Lead, CanFASD Research Network and Director of the Centre of Excellence for Women's Health

Audrey McFarlane, Executive Director, CanFASD Research Network

May 2024

Presenters

Audrey McFarlane, MBA

Executive Director,
CanFASD Research
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Nancy Poole, PhD, LLD. Hon.)

Director, Centre of
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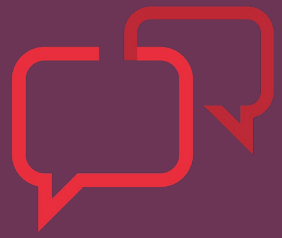
Women's Health

Prevention Lead,
CanFASD Research
Network

CanFASD
CANADA FASD RESEARCH NETWORK

centre of excellence
for women's health

Agenda



1. An update on FASD
2. FASD prevention as a public health issue
3. Canada's multi-level prevention model
4. Alcohol policy and FASD prevention

1. Update on FASD

CanFASD
CANADA FASD RESEARCH NETWORK

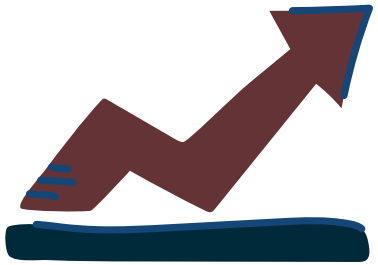
About CanFASD

In 2013, CanFASD became

- National Not For Profit Organization & Registered Charity
- Contractual relationship with the partnership as jurisdictional members

Purpose of CanFASD

Stimulate



Develop

Disseminate evidence in FASD to inform policy

Research Areas

FASD impacts 4% of Canadians

Prevalence

4%

of people in Canada

=

1.5 Million

people in Canada

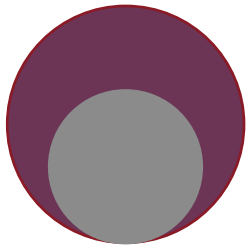
174k

people in Alberta

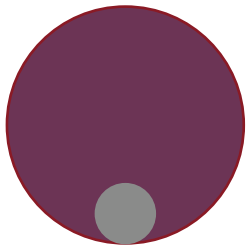
1 in 25

people in Canada

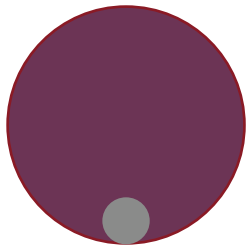
More Common than ASD



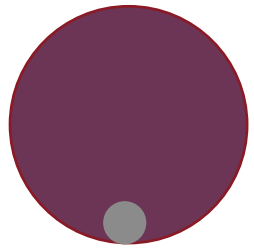
2.5X
more common than
Autism Spectrum Disorder (ASD)
(1.52%)



19X
more common than
Cerebral Palsy
(0.21%)



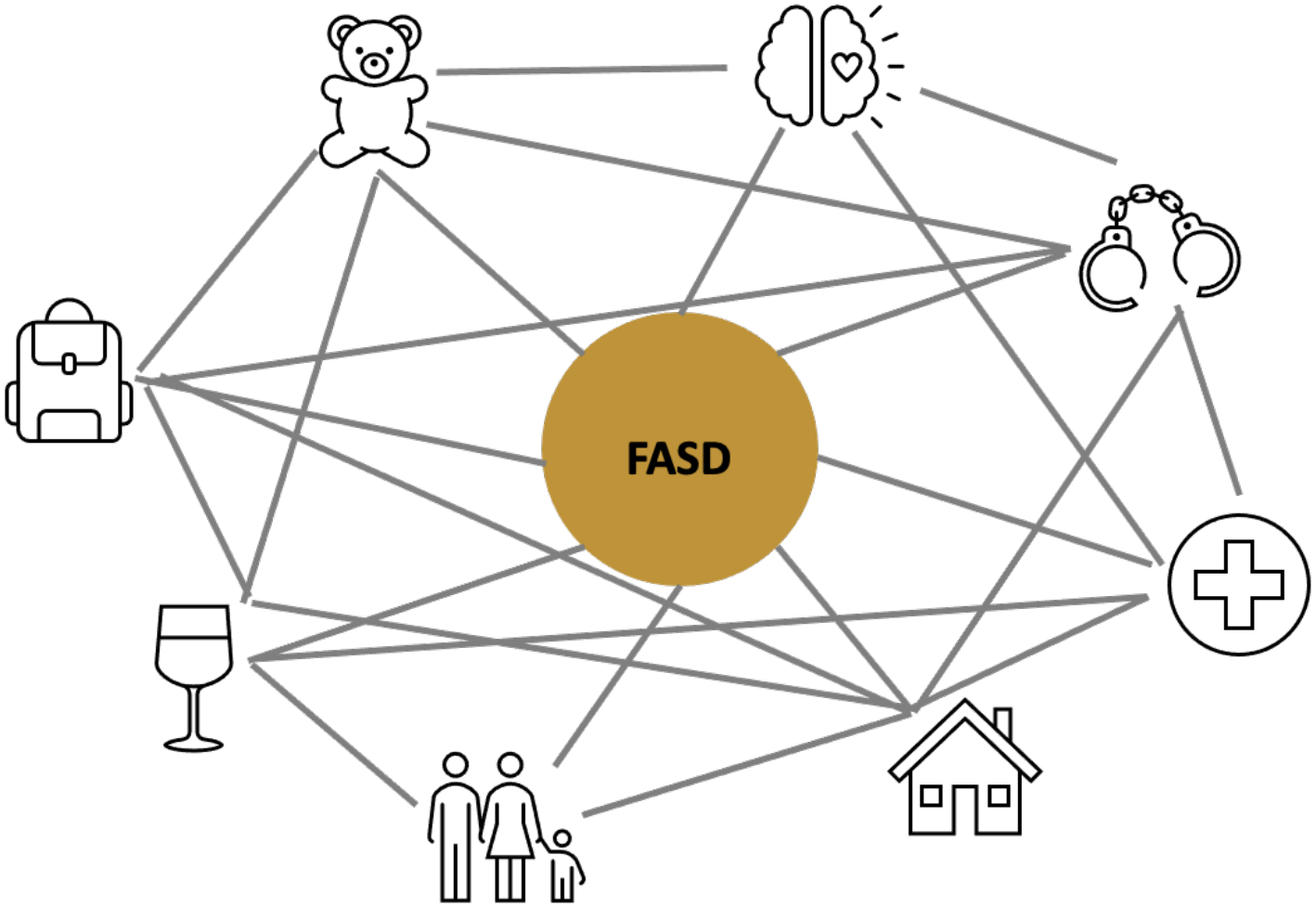
28X
more common than
Down Syndrome
(0.14%)



40X
more common than
Tourette's Syndrome
(0.10%)

This means that FASD is more common than Autism, Cerebral Palsy, Down Syndrome and Tourette's Syndrome *all combined*.

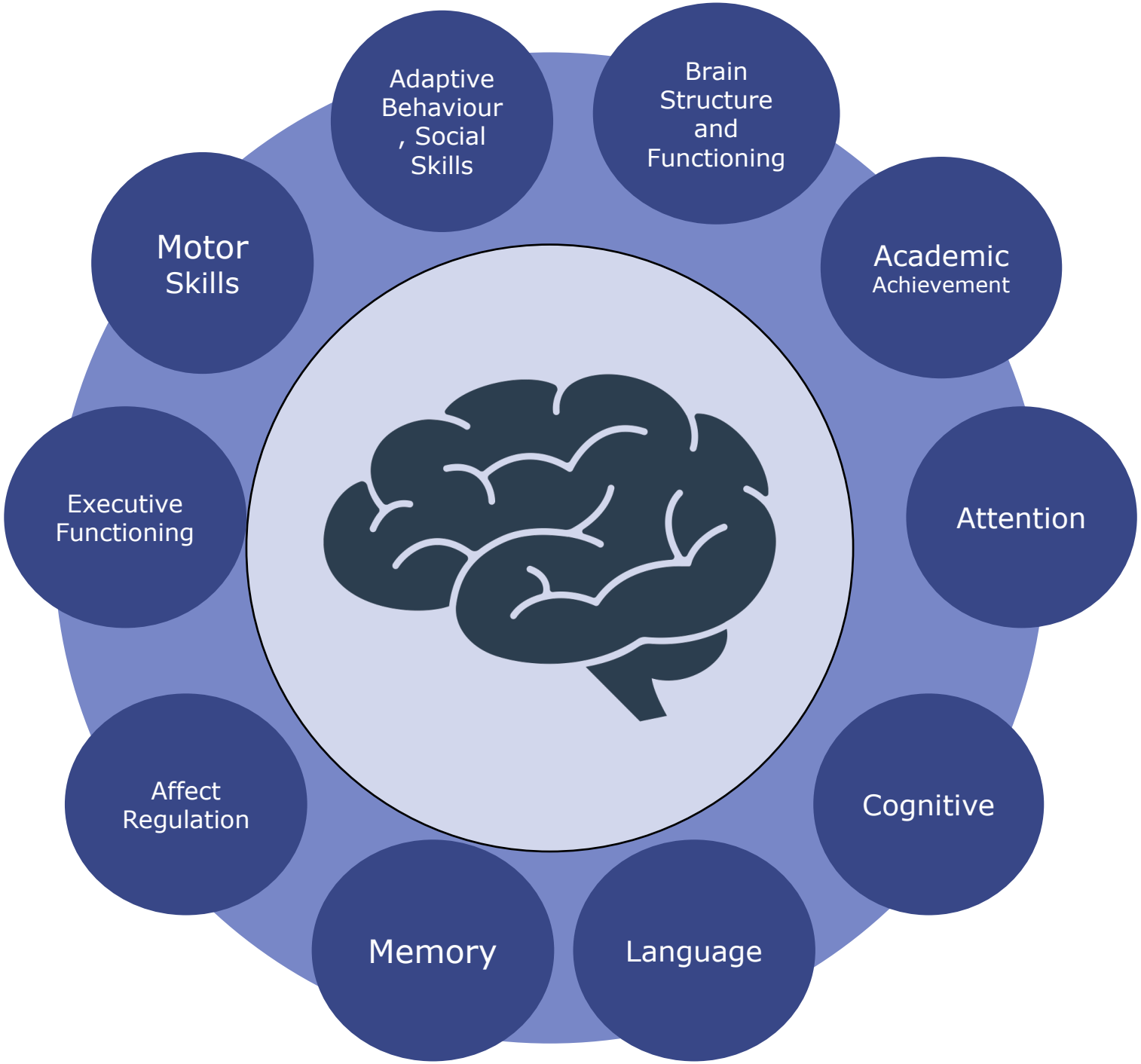
FASD is Uniquely Complex



Challenges

The challenges associated with FASD are often grouped into

Primary Disabilities



ADVERSE CHILDHOOD EXPERIENCES

Average of 3.4 (range 0-9)

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Characterizing adverse childhood experiences among children and adolescents with prenatal alcohol exposure and Fetal Alcohol Spectrum Disorder

Katherine Flannigan [a,*], Aamena Kapasi [b], Jacqueline Pei [a,b], Isabel Murdoch [b], Gail Andrew [c], Carmen Rasmussen [b]

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ARTICLE INFO

Keywords:
Fetal Alcohol Spectrum Disorder
Prenatal alcohol exposure
Adverse childhood experiences
Trauma
Neglect

ABSTRACT

Background: Individuals with Fetal Alcohol Spectrum Disorder (FASD) and prenatal alcohol exposure (PAE) face elevated rates of postnatal environmental adversity across the lifespan.
Objective: We explored early adversity among children and adolescents with PAE.
Participants and setting: Our sample included 333 children and adolescents with PAE assessed at a Canadian FASD diagnostic clinic, 66% of whom were diagnosed with FASD.
Methods: Data were collected retrospectively via record review, and adversity was measured using the Adverse Childhood Experiences Questionnaire (ACE-Q).
Results: Participants experienced high levels of adversity (mean ACE score of 3.4), which increased with age, mental health comorbidityes, and number of living placements. Common ACEs included: not being raised by both biological parents (97.3%), caregiver disruption (88.5%), and exposure to household substance use (69.7%). Females had significantly higher rates of sexual abuse than males ($p < .001$, $\phi = -0.18$). There was no difference in total ACE scores be-

Table 2
Prevalence of ACEs Across the Study Sample.

	% (n)
Total ACE score	
Low (0–1)	18.3 (61)
Medium (2–3)	35.7 (119)
High (4–5)	32.7 (109)
Extreme (6–9)	13.2 (44)
Abuse	
Emotional	8.4 (28)
Physical	18.9 (63)
Sexual	7.8 (26)
Neglect	
Physical	44.7 (149)
Emotional	12.3 (41)
Household Dysfunction	
Substance use	69.7 (232)
Violence	33.3 (111)
Incarceration	3.3 (11)
Mental health	45.9 (153)
Not raised by both biological parents	97.3 (324)
Caregiver disruption (n = 331)[a]	88.5 (293)

[a] Not included in total ACE scores.

FASD is a Whole Body Disorder

100X

more likely to have health problems than the general population

Unrecognized & Unsupported

Inconsistency across the country

- 73 FASD Dx clinics in Canada
- 98% of people have not been diagnosed in Canada

Unsupported

- Lack of recognition
- Lack of service supports
- Lack of research to determine effective supports
- Leads to increases in unhealthy situations

90% experience **mental health challenges**

Rates of **suicide** are 5.5 times greater

35% experience **substance use challenges**

As well as

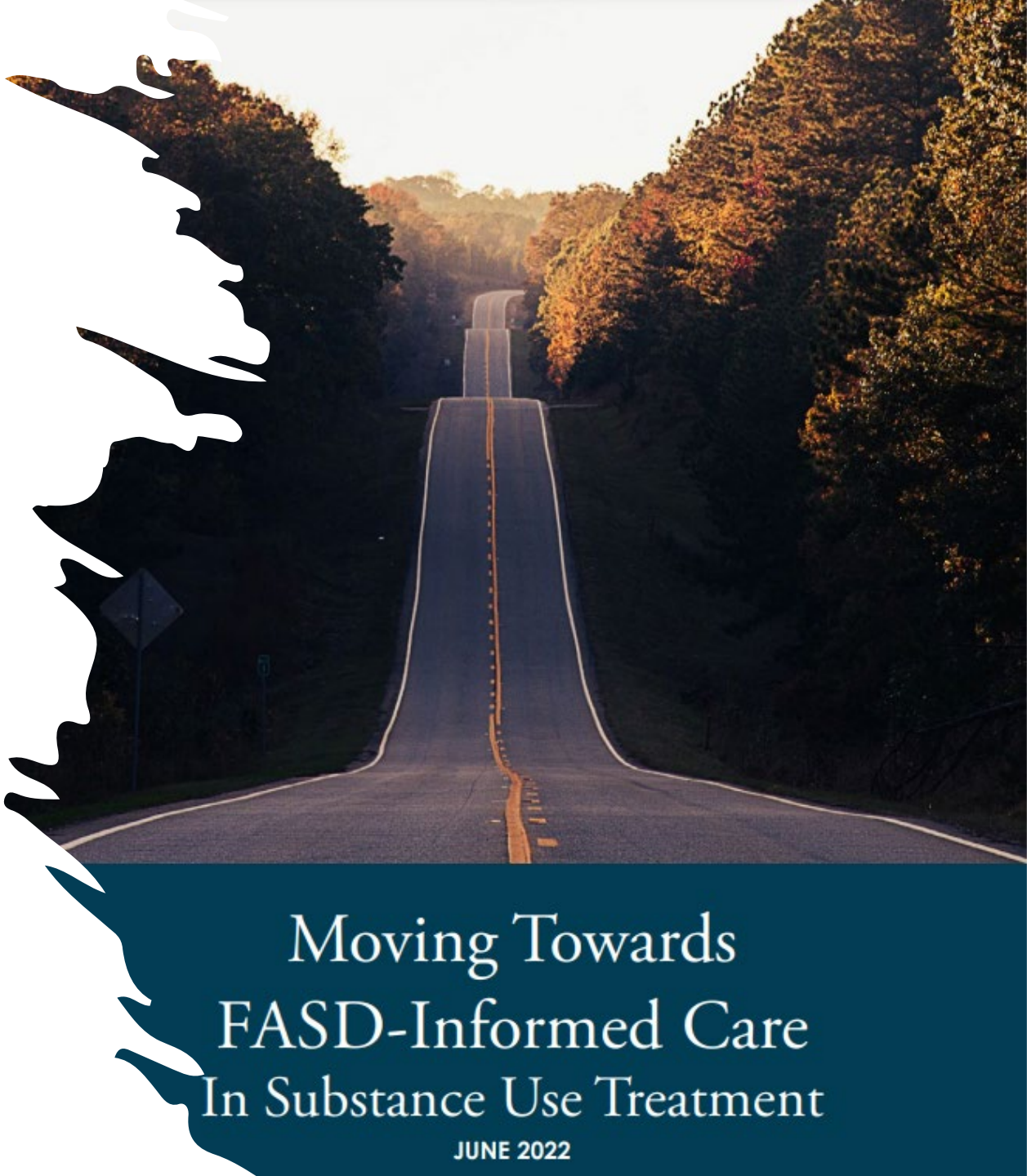
- 30% experience homelessness
- Approx 30% involved in the criminal justice system
- Many have children they struggle to raise
- Significant involvement in the Child welfare systems

Final thought…

In address Substance Use

- Developed evidence based resources for SU tmt programs to have better outcomes with this population
- Developed mental health toolkits

In dealing with the ongoing opioid crisis perhaps we need to consider the number of intersections individuals with FASD have with this situation, to build solutions with this in mind.



Reminder to help reduce stigma

CanFASD
CANADA FASD RESEARCH NETWORK

Common Messages

Guidelines for talking and writing about FASD

2022

canfasd.ca


How much longer
do we have to wait?
it's time for a
NATIONAL FASD STRATEGY

Alcohol policy

Senate Bill S253 will address a national framework for FASD

- Will include a robust alcohol policy to address prevention of FASD
- Diagnosis/assessment capacity
- Access to interventions
- Research
- Considerations from a number of stakeholders

2. FASD Prevention as a public health issue

Understanding factors and influences associated with alcohol use in pregnancy

- We prepare an annotated bibliography of articles published in English globally each year
- Nearly 1 in 3 articles on FASD prevention focus on the prevalence of alcohol use in pregnancy and factors and influences associated with alcohol use in pregnancy. Some factors associated with alcohol use in pregnancy include:

- Pregnancy recognition
- Knowledge of FASD/impacts of alcohol during pregnancy
- Tobacco and polysubstance use
- Preconception substance use
- ACEs
- Colonization
- Mental health status
- External stressors
- Education (as both risk and protective factor)
- Maternal age (as both risk and protective factor)
- Partner's alcohol use
- Poor social support
- Experiences of violence
- Employment

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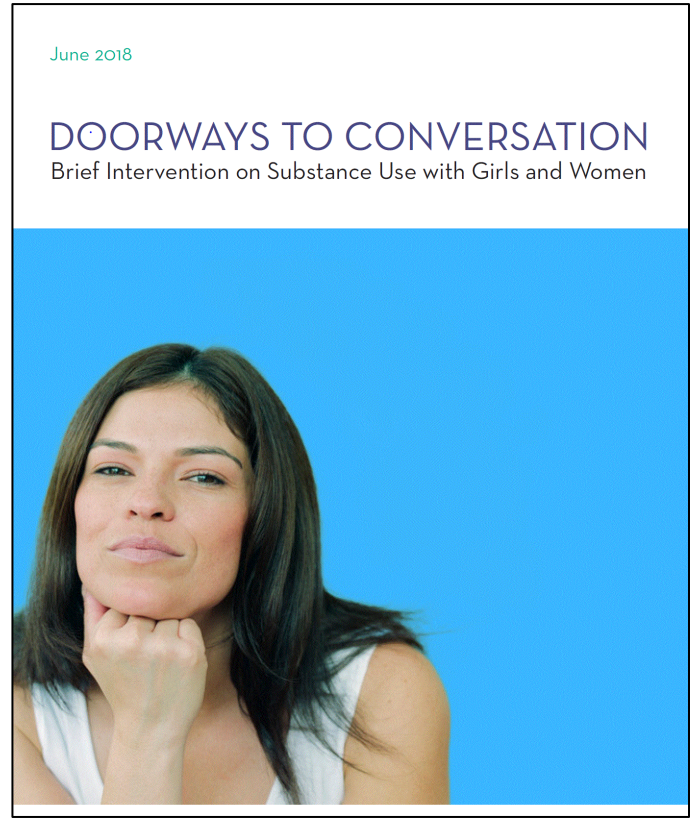
Challenges to knowing about the level of alcohol use in pregnancy

- Stigma, fear of judgement from health care providers and fear of child apprehension by child welfare authorities deters **women** from discussing their alcohol use with health and social care providers.
- Stigma, lack of time, lack of comfort with discussing alcohol, need for training in non-judgemental, compassionate, empowering brief intervention and screening approaches means that **care providers** often do not discuss alcohol with women in the preconception, pregnancy or postpartum period, or do not do so in effective ways.



Addressing stigma directed to women with alcohol problems and women who use alcohol in pregnancy

Received: 10 September 2020 | Revised: 16 January 2021 | Accepted: 17 February 2021
DOI: 10.1111/hsc.13335

REVIEW ARTICLE

Health and Social Care in the community | WILEY

Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework

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Funding information
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Abstract

Pregnant women and mothers who use substances often face significant barriers to accessing and engaging with substance use services. A scoping review was conducted in 2019 to understand how stigma impacts access to, retention in and outcomes of harm reduction and child welfare services for pregnant women and mothers who use substances. The forty-two ($n = 42$) articles were analysed using the *Action Framework for Building an Inclusive Health System* developed by Canada's Chief Public Health Officer to articulate the ways in which stigma and related health system barriers are experienced at the individual, interpersonal, institutional and population levels. Many articles highlighted barriers across multiple levels, 19 of which cited barriers at the individual level (i.e., fear and mistrust of child welfare services), 18 at the interpersonal level (i.e., familial and relational influence on accessing substance use treatment), 30 at the institutional level (i.e., high organisational expectations on women) and 17 at the population level (i.e., negative stereotypes and racism). Our findings highlight the interconnectedness of stigma and related barriers and the ways in which stigma at the institutional and population levels pervasively influence individual and interpersonal experiences of stigma. Despite a wealth of literature on barriers to treatment and support for pregnant women and mothers who use substances, there has been minimal focus on how systems can address these formidable barriers. This review highlights the ways in which the barriers are connected and identifies opportunities for service providers and policymakers to better support pregnant women and mothers who use substances.

KEYWORDS
harm reduction, parenting, pregnancy, stigma, substance use, women

What is known about this topic?

- Pregnant women and mothers who use substances face unique stigma and formidable barriers to support, for both reducing harms associated with their substance use and enhancing their capacity to parent.

ADDRESSING STIGMA: TOWARDS A MORE INCLUSIVE HEALTH SYSTEM
The Chief Public Health Officer's Report on the State of Public Health in Canada 2019

Action Framework for Building an Inclusive Health System

HOW STIGMA OPERATES	INTERVENTIONS TO ADDRESS STIGMA	POTENTIAL OUTCOMES
Individual		
Level of Stigma: person who experiences stigma		
• Enacted stigma (i.e., unfair treatment) (e.g., psychological stress) • Internalized stigma (e.g., low self-esteem and feelings of shame) • Anticipated stigma (e.g.,does not access support)	• Group-based supports to change stigmatizing beliefs, improve coping skills, support empowerment, and build social support	• Reduction in internalized stigma • Improved psychological well-being and mental health
Interpersonal (person-to-person)		
Level of Stigma: family, friends, social and work networks, healthcare and service providers		
• Language (e.g., using derogatory terms or dehumanizing labels; refusing to use preferred name and/or pronoun) • Intrusive attention and questions • Hate crimes and assault	• Education interventions to target myths and lack of knowledge. Include components that encourage examining personal values, biases, and beliefs • Contact interventions, including sharing personal stories, to target stigmatizing beliefs and attitudes	• Better understanding of the facts about stigmatized health conditions • Increased understanding of diverse perspectives and experiences of stigma • Growing social acceptance • Reduction in stereotyping
Institutional		
Level of Stigma: health system organizations, medical and health training schools, community sector organizations, social service organizations		
• Being made to feel "less than" (e.g., having to wait longer than others to be seen; lack of empathy from staff) • Physical environment is not inclusive (e.g., washrooms are single-sex; undersized chairs in public areas) • Institutional policies that cause harm (e.g., unnecessary drug tests; low investment of services)	• Ongoing and continued training targeting conscious and implicit bias • Implementation of cultural safety and cultural humility models • Safe and inclusive physical environments • Workforce diversity initiatives • Institutional collaboration with community; policies that support and fund meaningful engagement with people with lived experience of stigma • Implement trauma- and violence-informed care models • Accountability and monitoring frameworks that include stigma reduction indicators	• Institutional environment is inclusive, welcoming and diverse • Organizations are able to meet the needs of all populations • Reduction in stigmatizing beliefs and attitudes among staff • Improved patient/client ratings of care, satisfaction and trust • Patient/client outcomes improve
Population		
Level of Stigma: mass media, policies, and law		
• Widely held stereotypes • Negative portrayals in film and television (e.g., people with mental illness portrayed as violent) • Discriminatory policies and laws • Inadequate legal protections, or lack of enforcement of these protections	• Mass media campaigns to challenge stereotypes and prejudice • Guidelines to reduce stigma in media reports • Protective laws and policies • Addressing discrimination within existing laws and policies	• Reduction in stigmatizing beliefs, attitudes, and intended behaviour among the public • Reduction in discrimination practices

ons and potential outcomes taken from relevant literature. These examples are not exhaustive.

International Journal of *Environmental Research and Public Health*

MDPI

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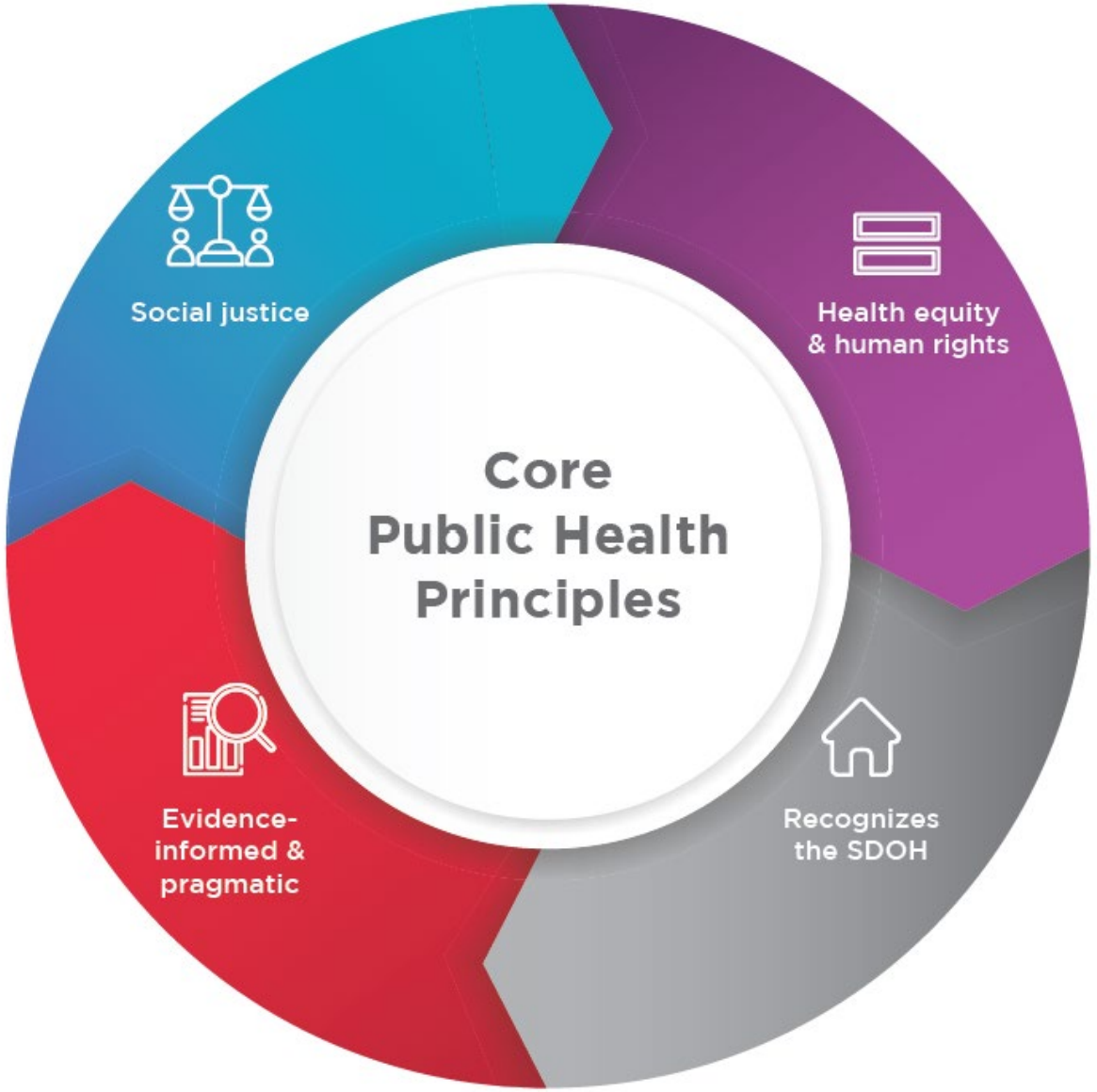
Using principles from A Public Health Approach to Substance Use

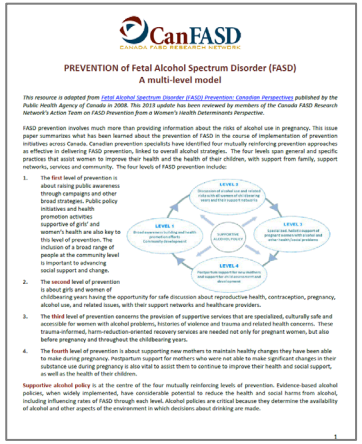
https://substanceuse.ca/ p6



- **social justice**
- **attention to human rights and equity**
- **evidence-informed policy, and practice**
- **addressing the underlying social determinants of health (SDOH)**

3. Canada’s multi-level prevention model

Building upon the 4 Level Model of FASD Prevention



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PREVENTION of Fetal Alcohol Spectrum Disorder (FASD)
A multi-level model

This resource is adapted from Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives published by the Public Health Agency of Canada in 2008. This 2019 update has been reviewed by members of the Canada FASD Research Network's Action Team on FASD Prevention from a Women's Health Determinants Perspective.

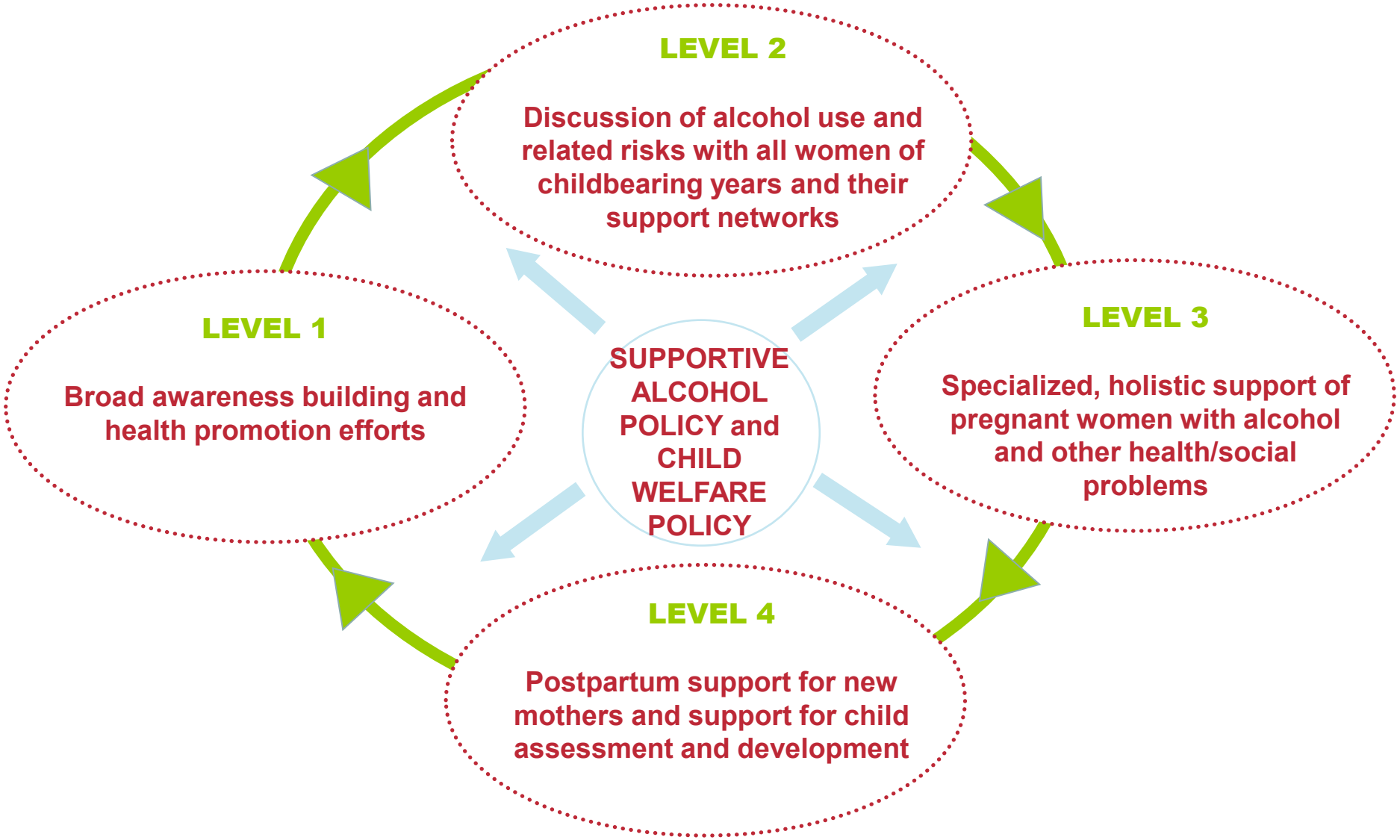
FASD prevention involves much more than providing information about the risks of alcohol use in pregnancy. This issue paper summarizes what has been learned about the prevention of FASD in the course of implementation of prevention initiatives across Canada. Canadian prevention specialists have identified four mutually reinforcing prevention approaches as effective in delivering FASD prevention, linked to overall alcohol strategies. The four levels span general and specific practices that assist women to improve their health and the health of their children, with support from family, support networks, services and community. The four levels of FASD prevention include:

1. The first level of prevention is about raising public awareness through campaigns and other broad strategies. Public policy initiatives and health promotion activities supportive of girls' and women's health are also key to this level of prevention. The inclusion of a broad range of people at the community level is important to advancing social support and change.
2. The second level of prevention is about girls and women of childbearing years having the opportunity for safe discussion about reproductive health, contraception, pregnancy, alcohol use, and related issues, with their support networks and healthcare providers.
3. The third level of prevention concerns the provision of supportive services that are specialized, culturally safe and accessible for women with alcohol problems, histories of violence and trauma and related health concerns. These trauma-informed, harm-reduction-oriented recovery services are needed not only for pregnant women, but also before pregnancy and throughout the childbearing years.
4. The fourth level of prevention is about supporting new mothers to maintain healthy changes they have been able to make during pregnancy. Postpartum support for mothers who were not able to make significant changes in their substance use during pregnancy is also vital to assist them to continue to improve their health and social support, as well as the health of their children.

Supportive alcohol policy is at the centre of the four mutually reinforcing levels of prevention. Evidence-based alcohol policies, when widely implemented, have considerable potential to reduce the health and social harms from alcohol, including influencing rates of FASD through each level. Alcohol policies are critical because they determine the availability of alcohol and other aspects of the environment in which decisions about drinking are made.

1

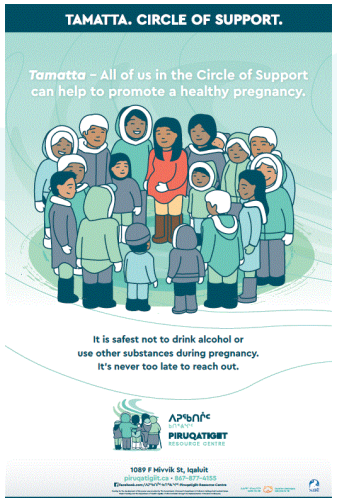
https://canfasd.ca/wp-content/uploads/2016/09/PREVENTION-of-Fetal-Alcohol-Spectrum-Disorder-FASD-A-multi-level-model.pdf



Public health work at each level of FASD prevention

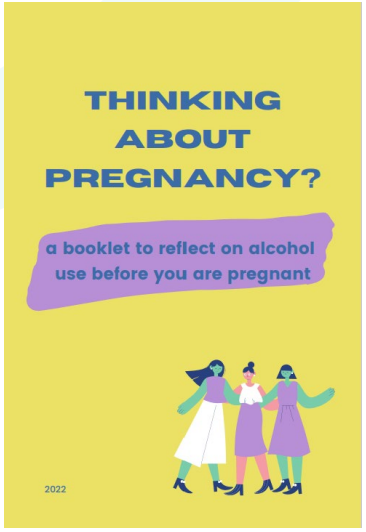
Level 1:

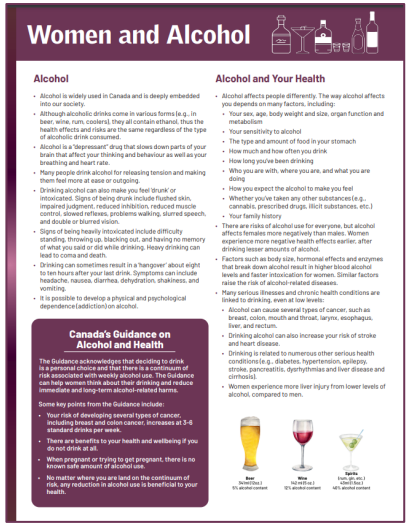
- Development of health education materials (pamphlets, posters) continues in many jurisdictions
- Community-wide health promotion strategies



Level 2:

- We continue to create resources to support health and social service providers in their role to discuss alcohol and other substance use.





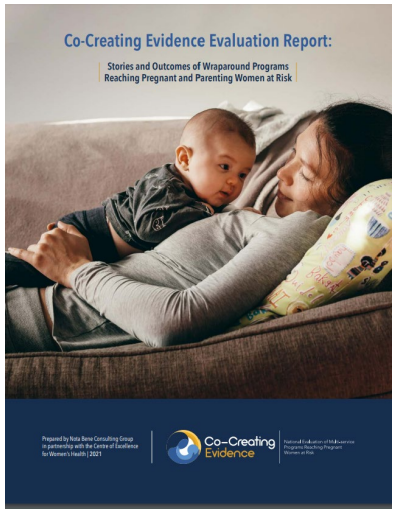
Levels 3 and 4 involves:

- Includes outreach to treatment
- Practical support
- Integrated support
- Mother **and** children
- Trauma-informed
- Harm reducing
- Culturally grounded
- Relational
- Supporting women's self determination
- Respectful and kind

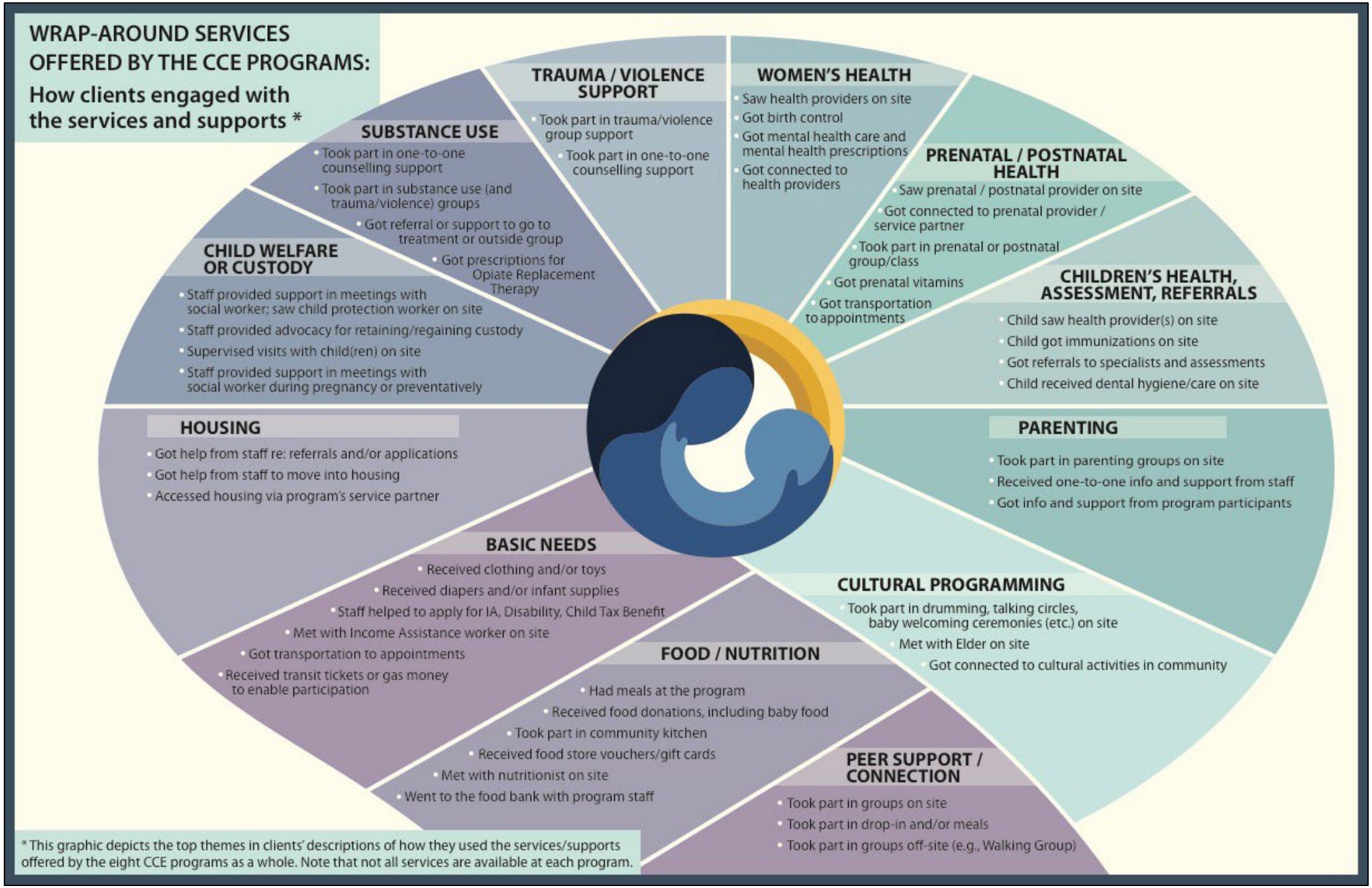
We conducted evaluative research to evidence level 3 and 4 prevention

Offering services

- that address the underlying (SDOH)
- are social justice oriented

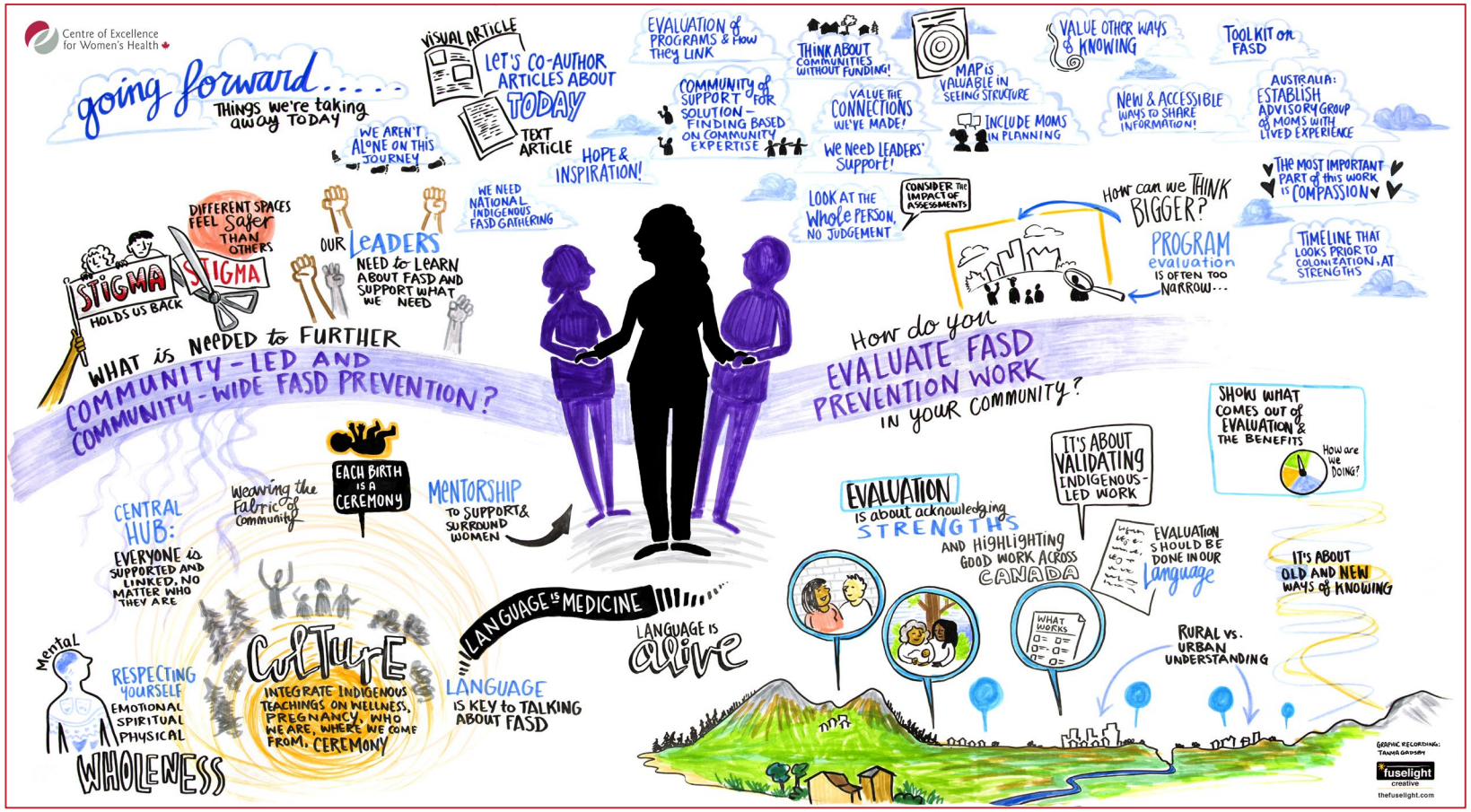


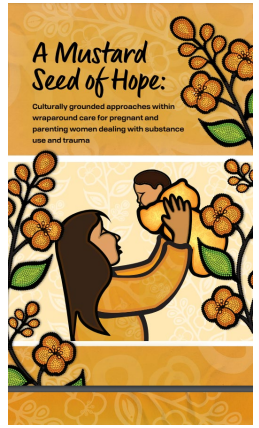
https://bccewh.bc.ca/featured-projects/women-alcohol-and-fasd-prevention/the-co-creating-evidence-evaluation-project/

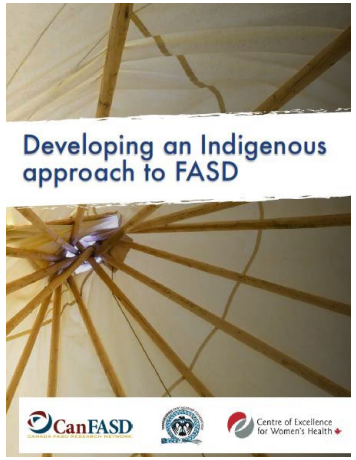


Working in collaboration with Indigenous organizations towards FASD prevention that is community and culture led

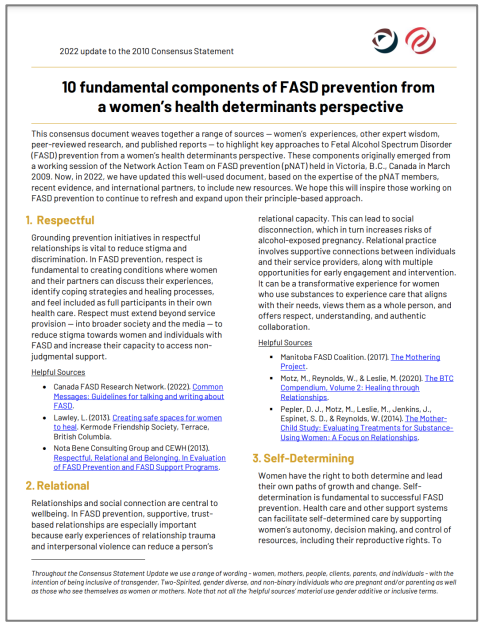
We work in collaboration with Indigenous organizations to achieve the TRC's Call to Action 33 about preventative programs that are community and culture led







https://canfasd.ca/topics/prevention/



2022 update to the 2010 Consensus Statement

10 fundamental components of FASD prevention from a women's health determinants perspective

This consensus document weaves together a range of sources — women's experiences, other expert wisdom, peer-reviewed research, and published reports — to highlight key approaches to Fetal Alcohol Spectrum Disorder (FASD) prevention from a women's health determinants perspective. These components originally emerged from a working session of the Network Action Team on FASD prevention (pNAT) held in Victoria, B.C., Canada in March 2009. Now, in 2022, we have updated this well-used document, based on the expertise of the pNAT members, recent evidence, and international partners, to include new resources. We hope this will inspire those working on FASD prevention to continue to refresh and expand upon their principle-based approach.

1. Respectful

Grounding prevention initiatives in respectful relationships is vital to reduce stigma and discrimination. In FASD prevention, respect is fundamental to creating conditions where women and their partners can discuss their experiences, identify coping strategies and healing processes, and feel included as full participants in their own health care. Respect must extend beyond service provision — into broader society and the media — to reduce stigma towards women and individuals with FASD and increase their capacity to access non-judgmental support.

Helpful Sources

- Canada FASD Research Network. (2022). Common Messages: Guidelines for talking and writing about FASD.
- Lawley, L. (2013). Creating safe spaces for women to heal. Kermode Friendship Society. Terrace, British Columbia.
- Nota Bene Consulting Group and CEWH (2013). Respectful, Relational and Belonging. In Evaluation of FASD Prevention and FASD Support Programs.

2. Relational

Relationships and social connection are central to wellbeing. In FASD prevention, supportive, trust-based relationships are especially important because early experiences of relationship trauma and interpersonal violence can reduce a person's relational capacity. This can lead to social disconnection, which in turn increases risks of alcohol-exposed pregnancy. Relational practice involves supportive connections between individuals and their service providers, along with multiple opportunities for early engagement and intervention. It can be a transformative experience for women who use substances to experience care that aligns with their needs, views them as a whole person, and offers respect, understanding, and authentic collaboration.

Helpful Sources

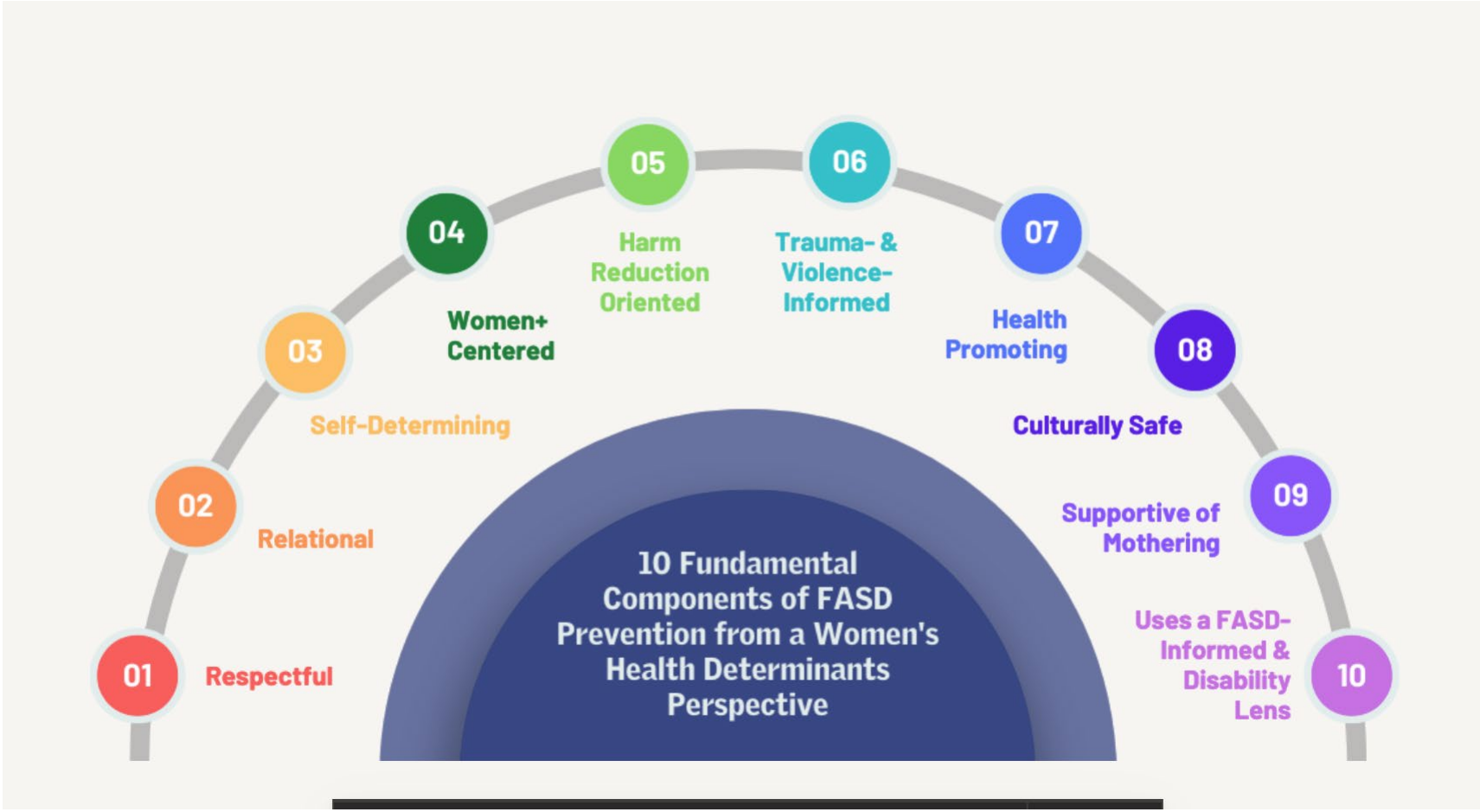
- Manitoba FASD Coalition. (2017). The Mothering Project.
- Motz, M., Reynolds, W., & Leslie, M. (2020). The BTC Compendium, Volume 2: Healing through Relationships.
- Pepler, D. J., Motz, M., Leslie, M., Jenkins, J., Espinet, S. D., & Reynolds, W. (2014). The Mother-Child Study: Evaluating Treatments for Substance-Using Women: A Focus on Relationships.

3. Self-Determining

Women have the right to both determine and lead their own paths of growth and change. Self-determination is fundamental to successful FASD prevention. Health care and other support systems can facilitate self-determined care by supporting women's autonomy, decision making, and control of resources, including their reproductive rights. To

Throughout the Consensus Statement Update we use a range of wording - women, mothers, people, clients, parents, and individuals - with the intention of being inclusive of transgender, Two-Spirited, gender diverse, and non-binary individuals who are pregnant and/or parenting as well as those who see themselves as women or mothers. Note that not all the 'helpful sources' material use gender additive or inclusive terms.

People working on FASD prevention over the past decade agree on these 10 fundamental components as important for all programming and policy with the goal of preventing of FASD



https://cewh.ca/wp-content/uploads/2022/12/Consensus-Statement-10-Fundamental-Comonents-of-FASD-Prevention.pdf

4. Policy action needed

Substance Use and Pregnancy – Review

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Supportive alcohol policy as a key element of fetal alcohol spectrum disorder prevention

Lindsay Wolfson[1,2] and Nancy Poole[1,2]

Abstract

In Canada, a Four-Part Model of Fetal Alcohol Spectrum Disorder (FASD) Prevention has been developed that describes a continuum of multi-sectoral efforts, including broad awareness campaigns, safe and respectful conversations around pregnancy and alcohol use, and holistic and wraparound support services for pregnant and postpartum women with alcohol, and other health and social concerns. Supportive alcohol policy is at the centre of the four mutually reinforcing levels of prevention. The purpose of this narrative review is to describe alcohol policies related to specific levels of FASD prevention, and to consider the implications of alcohol policies on FASD prevention and women's and fetal health. The majority of the evidence focused on alcohol in pregnancy guidelines, alcohol warning labels, and knowledge and uptake of national or regional alcohol and pregnancy guidelines. Several US studies described shifts in alcohol and pregnancy policy over the 7-year period, including moves to punitive approaches that criminalize women's substance use or prompt child apprehension. This review indicates that more attention could be paid to the role of alcohol policy in FASD prevention and in promoting women's and fetal health, and that policy actions and advocacy could be important catalysts for both FASD prevention and women's health promotion. Moving forward, it is essential that alcohol policies are rooted in evidence; attend to and promote women's health including health during pregnancy; and are collaborative in order to prompt a higher standard of care, and more holistically respond to the factors that contribute to women's alcohol use during pregnancy.

Keywords

alcohol policy, fetal alcohol spectrum disorder, maternal health, pregnancy, women's health

Date received: 25 August 2022; revised: 9 December 2022; accepted: 3 January 2023

Introduction

Fetal alcohol spectrum disorder (FASD) describes a range of lifelong cognitive, behavioural, physical, and emotional disabilities that can result from alcohol use in pregnancy.[1] FASD is preventable, and efforts to prevent FASD are multi-sectoral and inextricably linked to alcohol regulatory policy, health, child welfare, mental health, substance use, housing, and social justice fields.

Internationally, attention to developing alcohol policy has increased. In 2017, the World Health Organization released *'Best Buys' And Other Recommended Interventions For The Prevention And Control Of Noncommunicable Disease*, which identified the need for multi-sectoral actions to address the harmful use of alcohol.[2] Further to its release, international alcohol policy best practices for improving public health and safety outcomes have been evaluated in 11 policy domains including Pricing and Taxation; Physical Availability; Impaired Driving Countermeasures; Marketing and Advertising Controls; Minimum Legal Drinking Age; Screening, Brief Intervention and Referral (SBIR); Liquor Law Enforcement; Alcohol

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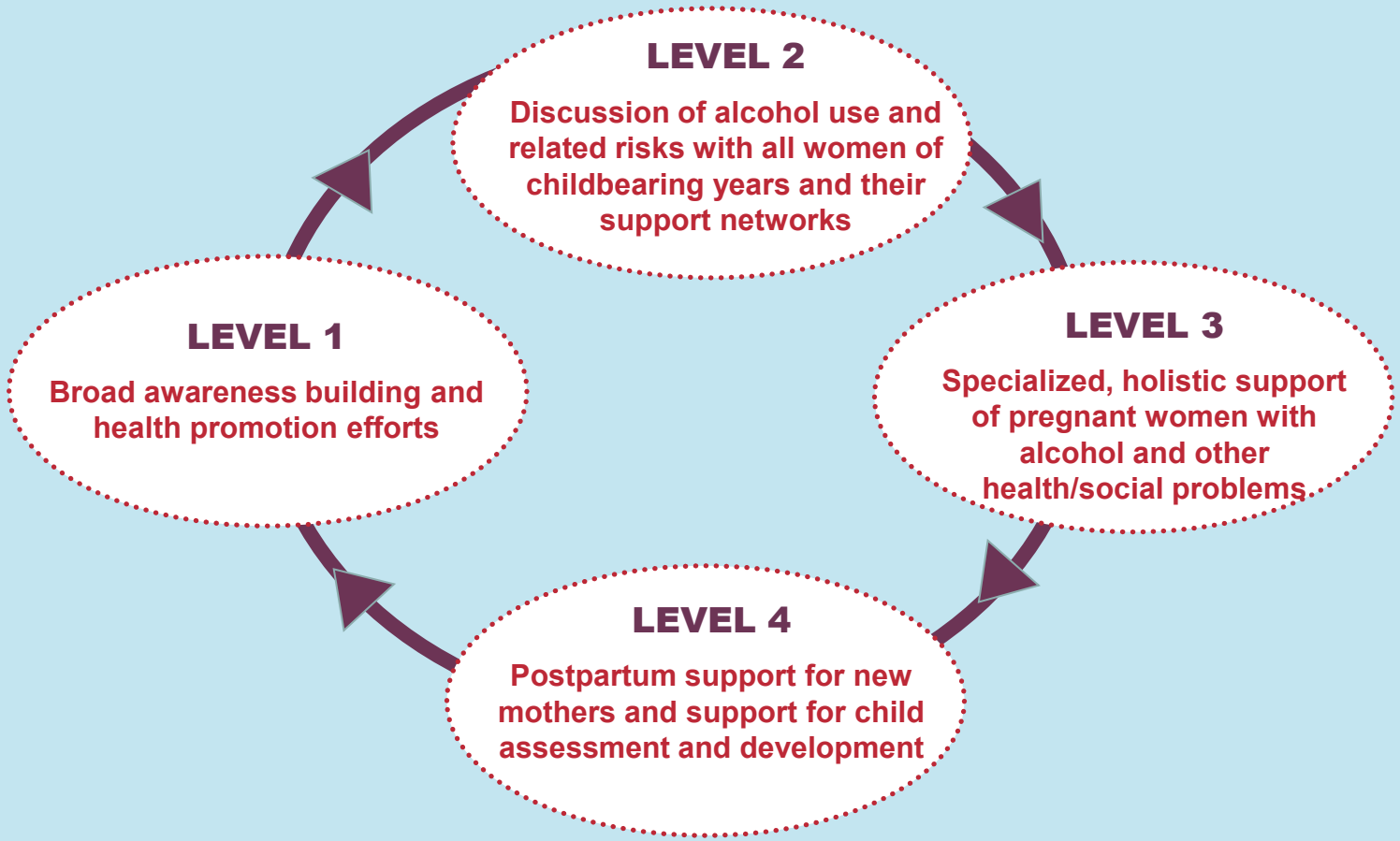
SUPPORTIVE ALCOHOL AND RELATED POLICIES FOR FASD PREVENTION

Need to be synchronized and mutually reinforcing

Guidance and training



Warning labels

Warning signage

Harm reduction service policy, including MAPS

Treatment policy

Child welfare policy

All alcohol policy is relevant – pricing, outlet distribution ...

Mother –child treatment policy
Child welfare policy

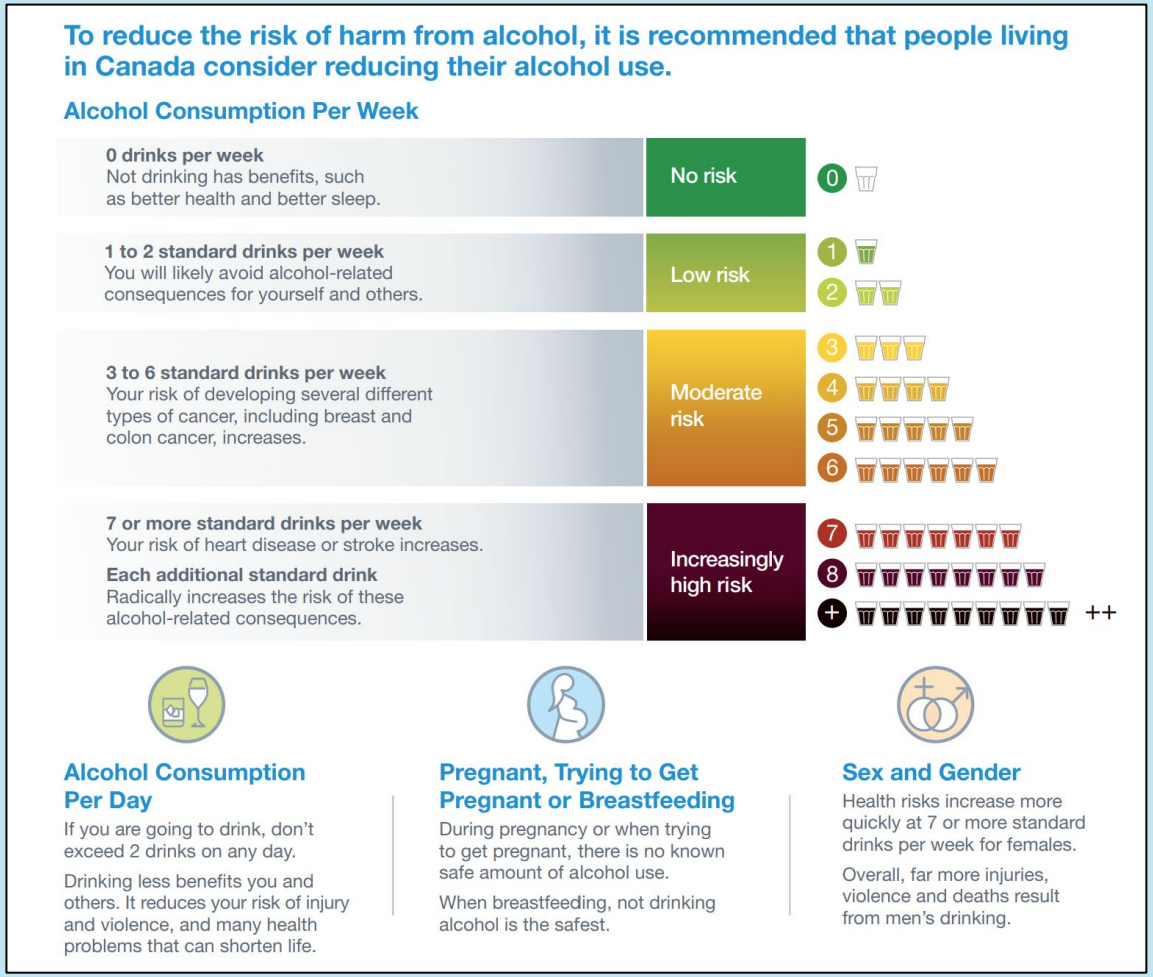
Level 1 Prevention - Warning labels and signage

- Mixed evidence on the efficacy of warning labels as FASD prevention strategy
  - One Canadian study found that alcohol sales decreased following a re-introduction of pregnancy warning labels (Zhao et al., 2020)
  - A US study found that mandatory warning signs were associated with lower odds of binge drinking (Roberts et al., 2019)
  - Research from Canada, Australia, and France have emphasized that warning labels are most effective as part of a multi-component FASD strategy (Bell et al., 2015; Dumas et al., 2018; Smith et al., 2020)

https://fare.org.au/labelling-campaign/

Level 2 Prevention – Guidance and guidelines

- Many countries have low-risk or dietary and lifestyle guidelines that offer recommendations about alcohol use in pregnancy
- However, not all health and social service providers know about the guidelines or use the most updated guidelines (Smith et al., 2021)
- In some places, screening for substance use is legislated for health care providers, data from the US shows that screening rates are higher where this is the case (Patel et al., 2021)
- Enablers to guidance include: specialized roles to help increase education and uptake; knowledge of the risks of alcohol use in pregnancy; and beliefs that women are motivated reduce alcohol use during pregnancy (Reid & McStay, 2018; Sword et al., 2020)



Levels 3 & 4 Prevention – Priority treatment for pregnant women and mother-centered treatment

- Research in these areas is limited and only published in the US context
- Substance use treatment can help with safety and connection (Myra et al., 2016)
- One study found that criminalizing substance use during pregnancy resulted in a decline to substance use treatment whereas where multi-pronged approaches were adopted, there were increases in treatment admissions (Kozhimannil et al., 2019)

The Jean Tweed Centre
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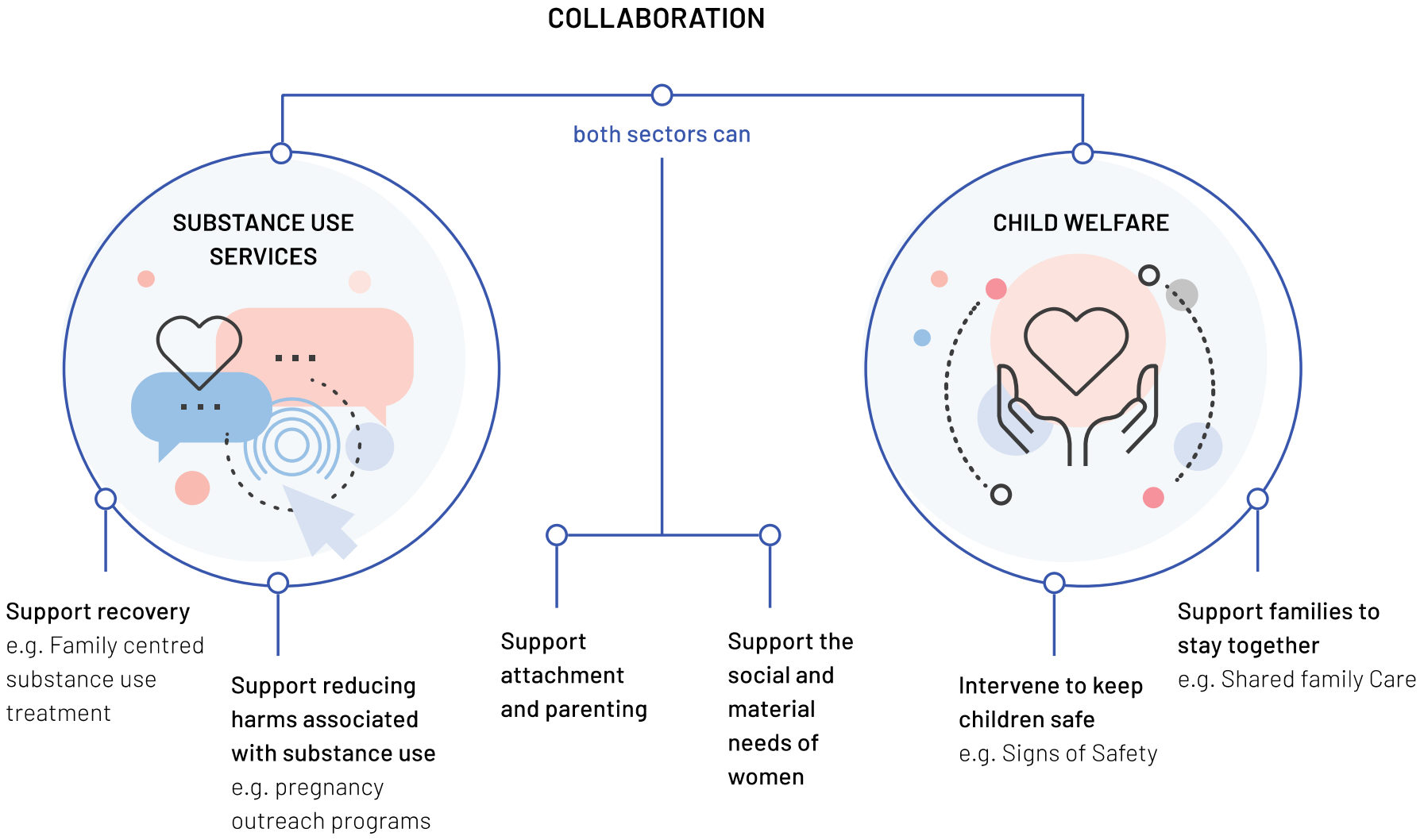
For Women & Their Families

Moms and Kids Too (Mk2)

- Less intensive time commitment
  7 weeks, 3 days per week, shorter days (10-3)
- Breakfast
- Play group – Mother Goose
- Healthy Parenting Program
- Women's Health
- Relapse Prevention
- Group Therapy

When supporting pregnant women who need substance use treatment – it is important that child welfare experts work closely with treatment providers to find areas for collaboration



The US *National Center on Substance Abuse and Child Welfare* promotes the Plans of Safe Care (POSCs) model of collaboration
https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care.aspx

https://cewh.ca/wp-content/uploads/2022/01/CEWH-03-MO-Toolkit_WEB_Update-F-1.pdf

Alcohol and Pregnancy Legislation

Punitive Policies

- Control and report women's behaviours
- Prompt child removal

Outcomes:

- Low birth weight, premature birth (Subbaraman, 2018)
- Lower odds of binge and heavy drinking (Roberts, 2019)
- Decreased & late entry to prenatal care (Subbaraman, 2018; Roberts, 2019)

Supportive Policies

- Improve women's health
- Support healthy pregnancies through education, early intervention, and treatment

Outcomes:

- Increased odds of alcohol use (Roberts, 2019)
- Prenatal care utilization (Roberts, 2019)

Mother-Child Centred Alcohol Policy

Stigma reduction

Gender-informed

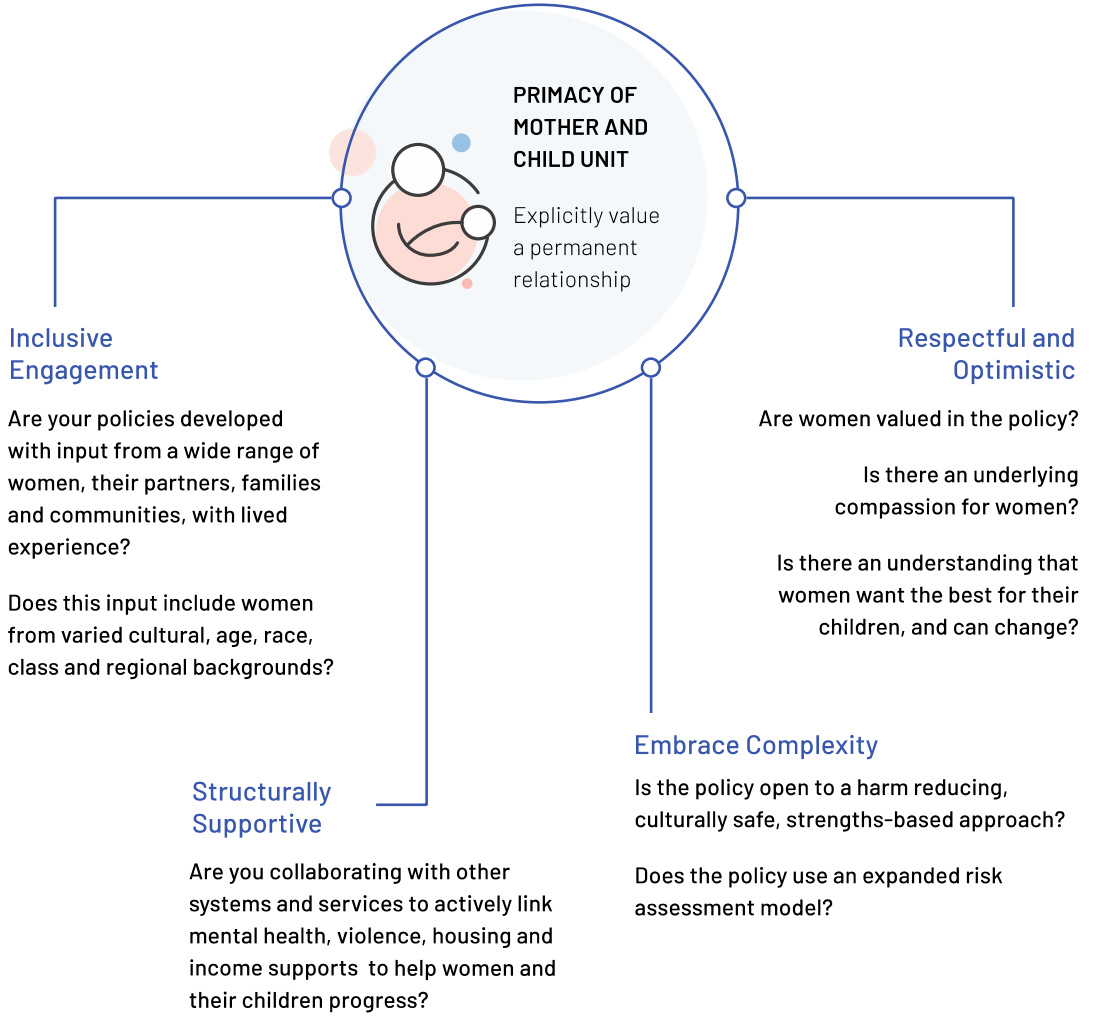
Health promotion oriented

Evidence-based

Attend to women's and fetal health

Promotes

- Treatment/appropriate referral pathways
- Multi-sectoral approaches
- Training of service providers
- Support for pregnant women and mothers
- Cultural diversity
- Collaboration
- Addresses the SDOH



https://cewh.ca/wp-content/uploads/2022/01/CEWH-03-MO-Toolkit_WEB_Update-F-1.pdf

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CAPE
CANADIAN ALCOHOL POLICY EVALUATION

Government of Canada / Gouvernement du Canada

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Substance Use and Addictions Program | Programme sur l'usage et les dépendances aux substances

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Public Health Agency of Canada / Agence de la santé publique du Canada

Public Health Agency of Canada | Agence de la santé publique du Canada

In-kind funding and support from co-investigator institutions, knowledge users, and government stakeholders

CANADIAN ALCOHOL POLICY EVALUATION

Thank you for attending this CAPE Community of Practice Event!

Complete our **3min** feedback survey!

English: https://www.surveymonkey.ca/r/CV657SK

French: https://www.surveymonkey.ca/r/CV657SK?lang=fr