DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

The conversation matters: a qualitative study exploring the implementation of alcohol screening and brief interventions in antenatal care in Scotland.

Schölin L., Fitzgerald N.

Pregnancy and Childbirth: 2019, 19(316), p. 1–11.

A study spotlights antenatal care in Scotland – one of three priority settings in a national programme to deliver screening and brief interventions. Implementation leaders discussed midwives' roles in facilitating disclosures about drinking in pregnancy, and what happens when their professional opinions deviate from guidance.

SUMMARY Drinking alcohol during pregnancy can cause harm to the developing foetus, including increasing the risk of early labour, low birth weight, restricted child growth, and 'foetal alcohol spectrum disorders' (lifelong physical, behavioural, and cognitive disabilities caused solely by foetal exposure to alcohol) (1 2 3 4). Recent estimates suggest that 41% of women in the UK consume alcohol at some point during pregnancy – putting the UK rate among the highest in the World Health Organization European region. Identifying women who drink during pregnancy, and providing information and effective support, is therefore of public health importance.

International guidelines recommend that health professionals screen all pregnant women for drinking in pregnancy and deliver brief interventions aimed at motivating and facilitating reductions in drinking or abstinence to reduce the risk of harm.

In Scotland since 2003 clinical guidelines have highlighted antenatal care as an important setting for delivering screening and brief alcohol interventions. In 2008, this was formalised as a national programme with targets for delivery in three priority settings, including antenatal care, within which all midwives should be trained and should screen all pregnant women. Official drinking guidelines for pregnant women accompanied this national programme. Initially, the advice was not to "drink more than 1–2 units of alcohol once or twice per week" and not to "get drunk". However, this changed to an abstinence-focused message in 2010.

The aim of the featured study was to explore professionals' experiences of incorporating screening and brief interventions into antenatal care under the Scottish national programme.

Key points
From summary and commentary

The featured study aimed to explore the implementation of screening and brief interventions in antenatal settings in Scotland, an internationally recommended measure to prevent harm caused by alcohol exposure during pregnancy.

In several health boards where reported maternal alcohol use was lower than expected, implementation leaders discussed midwives' roles in facilitating disclosures, for example through having positive conversations, exploring pre-pregnancy drinking habits, and building a trusting relationship.

In contrast with current antenatal alcohol screening recommendations, a more flexible, conversational approach was advocated to enhance the accuracy and honesty of reporting.

Fourteen key people who worked as local implementation leaders were recruited. Participants came from areas in both high-performing and low-performing health boards, defined as above or below the mid-point number of screening and brief interventions delivered in antenatal care, and included specialist midwives/nurses, alcohol and drug partnership coordinators, and a senior public health doctor with both clinical and strategic experience. Telephone interviews were conducted between September and November 2013.

Main findings

Screening in the antenatal setting

There was no consensus on the best way to identify pregnant women who were drinking alcohol. In several areas, reported alcohol use was lower than was expected based on the local drinking culture, leading participants to conclude that reported drinking levels in pregnancy were inaccurate.

> *"When you look at the [local] culture of drinking and hazardous drinking among women and in the population in general, we don't think that less than 1% of women are drinking in pregnancy." (Health Board C)*

Implementation leaders considered ways that screening could be more flexible, in particular moving away from asking questions verbatim of each woman. Several health boards decided to limit change in their current practice by using

questions from existing forms rather than using the screening method advocated in the national programme.

In two areas experiences of implementation were documented as case studies. These revealed that additional prompts and questions, for example around pre-pregnancy drinking, were key to building trust and overcoming defensive responses.

> *"We had a lot of discussion about it being more important to ask about alcohol consumption before pregnancy, because pregnant women are less likely to disclose when they are drinking in pregnancy because they know they are not supposed to." (Health Board H)*

In one case study area, there was an increase in reported pre-pregnancy abstinence over time. However, this was presumed to be due to women's reporting becoming *less* accurate and honest, rather than reflecting a genuine fall in consumption. One interpretation was that women were 'coming prepared' to answer the questions. Another was that a recent focus by midwives on asking about parental capacity and home circumstances may have made women fearful about disclosing heavy drinking. As a result, midwives were encouraged to probe further if women reported no alcohol use pre-pregnancy, which translated to higher levels of disclosure.

Integration into routine practice

Participants stressed the importance of support from senior management, which was not always forthcoming. In one local health board there was "no buy-in from senior people in antenatal" for the delivery of a screening and brief intervention programme, whereas in other health boards there was strong support from heads of midwifery, which was perceived to be instrumental in progressing the programme.

Due to the obligation to report to Scottish Government, there was a strong focus on recording, integrating screening questions into existing electronic patient record systems, or (in one case) developing a new paper-based system.

At a local level, there were discussions about how to implement the programme – specifically, *who* to deliver brief interventions to following screening. While midwives were in agreement about total abstinence during pregnancy, the national guidance and training materials did not initially include a clear abstinence message.

Several participants noted that a focus on alcohol fitted with broader national efforts around early interventions for child health and wellbeing. However, sometimes midwives were being asked to implement multiple lifestyle and health agendas in different ways, leading to different types of training. The number of health behaviours midwives had to cover in 'booking appointments' (usually lasting one hour, and scheduled before the 10th week of pregnancy) was also seen as increasing midwives' workload and increasing the burden for pregnant women. This appeared to create some resistance.

Perceived outcomes

While participants believed that introducing screening and brief interventions had a positive impact – for example through pregnant women being asked more consistently about their drinking and having a greater awareness of foetal alcohol spectrum disorders – screening rates were low in many health boards, meaning midwives delivered few brief interventions.

In areas where there were higher rates of screening, the reported prevalence of drinking in pregnancy was often low. Several participants reported that midwives believed they would already know if a woman had a drinking problem, arguably negating the need for formal screening. Interviews revealed that implementing the screening and brief intervention programme failed to overcome this assumption.

The authors' conclusions

The featured study was the first to explore the implementation of a large-scale primary prevention programme to prevent harm caused by drinking during pregnancy in the UK, adding to understanding of the detailed practical and ethical dilemmas involved in establishing screening and brief alcohol interventions in the antenatal setting.

While nationally and internationally the recommendation is to use a validated screening tool, the study showed that in antenatal care, a flexible, conversational approach was perceived to be important for enhancing the accuracy and honesty of disclosure among pregnant women.

The drinking guidelines for pregnant women that existed at the time of implementation caused discomfort amongst midwives, who believed they should advise total abstinence. Several health boards therefore decided to offer brief interventions to any woman drinking in pregnancy rather than setting cut-off points for current drinking – an approach that was later reflected in the national programme.

FINDINGS **COMMENTARY** Due to the severity of problems that children can develop when exposed to alcohol before birth, official guidelines have moved away from advising women not to drink to excess, to advising abstinence both before and during pregnancy:

> *The British Medical Association's recommendation for women who are pregnant, or considering a pregnancy, is that "the safest option is not to consume any alcohol".*

> *The Royal College of Obstetricians and Gynaecologists advises that "The safest approach is not to drink alcohol at all if you are pregnant, if you think you could become pregnant or if you are breastfeeding".*

Guidelines from the Chief Medical Officer state that "If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum". However, "The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy".

Research has established a relationship between heavy drinking and high risks to pregnancies. However, there is no evidence about the level at which drinking becomes significant. The above examples of guidance are derived from a lack of evidence about "exactly how much alcohol is linked to increased risk", rather than evidence that any alcohol poses a risk. The safest option is therefore assumed to be for pregnant women not to drink at all.

However, communicating to women about alcohol and pregnancy in this way is not without its problems. A report commissioned by Alcohol Concern (which merged with Alcohol Research UK in 2017, and launched as the new charity Alcohol Change UK in 2018) found that key stakeholder groups including policymakers, health service practitioners, antenatal educators, and parents perceived the precautionary principle underpinning advice about drinking before/during pregnancy to be *inconsistent with* "the informed-choice approach that underpins alcohol advice for the general population". It was felt to be "an example of over-reach, legitimising social surveillance of pregnant women" and "congruent with a normalised directive approach to communicating with women in pregnancy". Some stakeholders concluded for themselves (ie, it was not explicit in the guidelines) that guidance was intended to "protect more vulnerable and less educated women who lack the capacity to interpret the evidence wisely" and to "provide an extra layer of protection to the foetus".

There are many reasons why women may continue to drink during pregnancy, including not knowing they are pregnant, not being aware of the risks of drinking during pregnancy, and having pre-existing problems with drinking. They may also, in the absence of evidence that light drinking can cause serious lasting effects, want to continue to have 'a glass every now and again' for the same reasons why people who are not pregnant enjoy doing the same.

Emphasising the importance of removing the stigma from women who drink during pregnancy, or who enter pregnancy with existing drinking problems, the British Medical Association have advised that:

- Healthcare professionals should reassure pregnant patients that, while there is no definitive evidence, the risks associated with drinking small quantities of alcohol are likely to be low.
- Healthcare professionals should be given sufficient time and resources to ensure that any woman who is pregnant, or who is planning a pregnancy, and who is identified as drinking at low-to-moderate levels, is offered brief intervention counselling. This should occur at the earliest possible stage and be considered part of routine antenatal care.
- Where high levels of consumption are identified, and with this a high-risk of prenatal alcohol exposure, pregnant women should be offered referral to specialist alcohol services for appropriate treatment.
- Healthcare professionals should avoid blame, and create an environment where patients can disclose their drinking without feeling threatened or judged.
- There should be a deeper understanding of the many reasons why women may drink during pregnancy, and a deeper appreciation for the fact that "alcohol consumption during pregnancy does not occur in isolation [and…] must be viewed in the context of society's relationship with alcohol".

Screening and brief advice in antenatal care

The featured study aimed to explore the implementation of a national screening and brief intervention programme in antenatal settings in Scotland, an internationally recommended measure to prevent harm caused by alcohol exposure during pregnancy.

In contrast to treatment, screening and brief interventions are usually seen as *public health* measures. Rather than narrowing in on dependent individuals or just those seeking help, the aim is to reduce alcohol-related harm across a whole population, including those unaware of or unconcerned about their risky drinking.

Brief alcohol interventions are typically targeted at risky or heavy drinkers, and seek to nudge those people towards moderating their drinking or abstaining from alcohol altogether in order to reduce their risk of harm. Brief interventions delivered to pregnant women have the same end-goal of preventing harm, but as the featured study illustrated, there is seemingly only one acceptable behavioural change a woman can make (ie, to stop drinking). Standing out among the general run of brief interventions, those delivered in antenatal settings are built on the presumption that *all* drinking during pregnancy is risky and therefore *any* drinking during pregnancy could be a cue for a brief intervention.

One of the most important findings was that in antenatal care, a flexible, conversational approach was perceived to be important for enhancing the accuracy and honesty of disclosure among pregnant women, which in practice meant a departure from the validated screening tool. Unless they are implemented, there is no chance that screening and brief interventions can work. However, adaptations risk compromising the effectiveness of research-validated screening and intervention

packages.

Other UK studies (1 2) have testified to this conundrum. To get addressing alcohol into the service mix requires departing from the research script, meaning the 'intervention' that's left has at best not yet been shown to be effective, and at worst, may be ineffective or counterproductive. In settings outside primary care – for example, in housing, probation, social work, antenatal care, and sexual health clinics – what looks like a simple set of questions followed by brief advice becomes far more complicated.

Last revised 20 November 2019. First uploaded 22 October 2019