DRUG & ALCOHOL FINDINGS *Review analysis*

This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review 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 review. Below is a commentary from Drug and Alcohol Findings.

▶ Screening, brief intervention, and referral to treatment for opioid and other substance use during infertility treatment.

Wright T.E.

Fertility and Sterility: 2017, 108(2), p. 214–221.

Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Wright at tewright@hawaii.edu.

How can infertility specialists integrate screening, brief intervention, and referral to treatment into their everyday practice?

SUMMARY The featured paper frames it as an ethical and medical duty for reproductive specialists to screen for drug and alcohol problems (which are more common than many conditions routinely screened for), provide initial advice, and refer to substance use treatment when needed. It provides an overview of screening, brief intervention, and referral to treatment – a public health approach shown to be effective in ameliorating the harms of substance use.

Screening

Given that, by definition, pregnancies conceived with infertility treatments are *planned*, pre-conception counselling should include screening for substance use. Universal screening for tobacco use, at-risk drinking, illicit drug use, and prescription drug misuse should occur at the initial consultation visit as well as periodically during the course of infertility treatment (and especially after unsuccessful courses of treatment). An example is the '4Ps' for substance use in pregnancy:

1. Have you ever used drugs or alcohol during **pregnancy**?
2. Have you had a problem with drugs or alcohol in the **past?**
3. Does your **partner** have a problem with drugs or alcohol?
4. Do you consider one of your **parents** to be an "addict" or "alcoholic"?

Key points
From summary and commentary

Drug and alcohol problems are more common than many conditions routinely screened for in infertility treatment.

A review describes in practical terms how screening, brief intervention, and referral to treatment could be integrated into the routine practice of reproductive specialists.

For women who fall into the higher-risk category, a referral to treatment for substance use disorders should be made before any infertility treatment is initiated – the same as for other mental health or medical conditions.

Regardless of which method is used or how the screening is delivered, it is essential that conversations around substance use be non-judgmental. Substance use should be discussed in the same manner as all lifestyle issues that can affect fertility, such as diet and exercise. Prefacing screening with statements such as, "I ask all my patients about substance use", can help normalise the enquiry and increase the patient's comfort with disclosure, as can questions that link substance use to the treatment context, for example, "How have infertility treatments affected your drinking behaviour?"

The overarching purpose of screening for substance use is to stratify patients into zones of risk given their pattern of use:
• Low risk (no past or current use, or a low level of use that stops prior to or immediately upon knowing about pregnancy) – the majority of women will fall into this category, and will need only brief advice and/or a written pamphlet.
• Moderate risk (high use in the past, use which stopped late in pregnancy, or continued low level use) – recommended brief intervention, motivational interviewing, and frequent follow-up visits with provider.
• High risk (current use meets diagnostic criteria for substance use disorder) – requires referral to specialised treatment and frequent follow-up visits with provider.

Brief intervention

Effective brief interventions consist of the following:
• providing feedback about personal responsibility (eg, "As your doctor, I recommend you stop smoking cigarettes for your health and to improve your chances of getting pregnant, but it's your decision on what you want to do");
• listening to and understanding a patient's motivation for using one or more substances (eg, "I hear that you use pills to deal with the pain of your pregnancy losses");
• exploring other options to address patient's motivation for substance use (eg, "Are there other ways you deal with stress in a more healthy way?").

Given that brief interventions are for patients with moderate-risk substance use, closer follow-up (generally every two weeks) is recommended. These follow-up visits can be incorporated into fertility assessment and treatment, as would any other medical condition. Patients who are unable to make any behavioural change or whose use increases during the course of treatment should be referred for specialised addiction treatment.

Referral to treatment

The process of screening is only the first step in a conversation with the patient that may lead to treatment referral or provision of other resources.

Only a minority of patients will screen in the high-risk category and require specialised substance use treatment. These women are likely to meet criteria for having a substance use disorder. It is not the responsibility of the infertility provider to deliver specialised treatment, but his or her knowledge of appropriate referral resources is essential. Many infertility clinics work closely with mental health providers, and those providers should be familiar with signs of substance use disorders and treatment resources. The referral should be made via a "warm handoff" – that is, via direct communication between the infertility or mental health provider and the substance use treatment provider.

FINDINGS **COMMENTARY** The paper demonstrated the importance of infertility specialists identifying women who may need treatment, support, or advice relating to their drinking and/or drug use, and described in practical terms how screening, brief intervention, and referral to treatment could be integrated into their practice. In this context, the impetus is not only to improve the health and wellbeing of women, but to help prevent alcohol- and drug-exposed pregnancies.

From their origins in research in the 1970s and 1980s, screening and brief intervention have come to form major planks in national public health and alcohol strategies, and their implementation has been promoted through national programmes backed by funding, training and implementation targets, now in the UK transitioning to the embedding of this work in routine medical practice. But just as their policy and practice significance has reached a peak, doubts have been building over whether their initial promise will be realised. Whatever the efficacy of brief interventions – and this answer seems clearer for drinking problems than problems with illicit drug use – they can only directly have an impact if experienced by the patient. An Effectiveness Bank hot topic unpacks the obstacles and incentives involved in the struggle for widespread implementation of brief interventions.

Advice for women who are pregnant or planning to become pregnant

A critical issue for the British Medical Association is building capacity to prevent and manage 'foetal alcohol spectrum disorders' – lifelong physical, behavioural, and cognitive disabilities caused by alcohol consumption during pregnancy. In the UK, their recommendation for women who are pregnant, or considering a pregnancy, is that "the safest option is not to consume any alcohol". Similarly, 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".

A report commissioned by Alcohol Concern (which merged with Alcohol Research UK in 2017, and launched as 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 during/before pregnancy to be inconsistent with "the informed-choice approach that underpins alcohol advice for the general population". Some stakeholders concluded for themselves (ie, it was not explicit in the guidelines) that guidance was intended to "provide an extra layer of protection to the foetus", and others that "it is intended to protect more vulnerable and less educated women who lack the capacity to interpret the evidence wisely". There was also a perception that this was "an example of over-reach, legitimising social surveillance of pregnant women" and "congruent with a normalised directive approach to communicating with women in pregnancy".

There are many reasons why women may continue to drink during pregnancy – for example, not

knowing they are pregnant, not being aware of the risks of drinking during pregnancy, and having problems with alcohol dependence. 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".

In the featured paper, the term 'pre-conception' was used to describe interventions delivered *before* pregnancy, as opposed to *during* pregnancy. This vernacular comes from a life-course view of alcohol harm prevention that reflects a primary focus on mitigating the harms to the *foetus/child*, but involves interventions delivered to the *mother* – 'pre-conception' is followed by 'pregnancy', which is followed by 'childhood' (when the children are aged 0–18 years), and finally 'adulthood' (over 18 years). According to official guidance (▶ text), the 'safest' option for women considering or planning a pregnancy is not to drink at all. For women who are hoping to become pregnant but are having problems conceiving, treating them as if they are in a perpetual state of 'pre-pregnancy' may be prudent but problematic. Advice such as, 'avoid drinking if you are trying to conceive', may not be sustainable or desirable for women who are trying to conceive for many years at the same time as continuing with life as normal.

UK guidance published in 2013 details the effects that drugs and alcohol can have on conception and pregnancy in the context of assessing and treating people with fertility problems.

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