FASD in Primary Care:

Exploring Systematic, Attitudinal, and Expert Knowledge Barriers to Best Practices

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This research is supported in part by funding from the Centre for Health Services and Policy Research, Queen's University

Objectives

1. Review the current state of knowledge regarding FASD epidemiology, screening, and intervention in the Canadian primary care environment;
2. Understand the emerging role of the Canadian primary care practitioner in FASD diagnosis, screening, and service provision; and
3. Present and discuss the implications of systematic, attitudinal, and expert knowledge barriers to best practice for FASD in the Ontario primary care environment.

FASD in Canada

- Epidemiology:
  - Leading cause of developmental disability (PHAC, 2005; Stade et al. 2009)
    - Canadian (2005) incidence: 1% (PHAC, 2005)
    - US (2009) prevalence: 2-5% (May et al. 2009; Stade et al. 2009)
      - Canadian and US alcohol consumption patterns similar (Chudley et al 2005; Sharpe et al., 2005)
- Screening & Intervention
  - Few Canadian initiatives (Stade et al 2009)
  - Policy focus on primary prevention (Legge et al 2001)
  - West more advanced than East (Burgoyne, 2007; Environics 2006).
  - Primary care key to prevention, screening & intervention (Health Canada 2001).

Primary Care: FASD Best Practices

- Consistent guidelines established in 2005 with Canadian Guidelines for Diagnosis of FASD (Chudley et al. 2005)
- Canadian medical association journal: ***Identifying fetal alcohol spectrum disorder in primary care*** (Loock et al. 2005)
- 3 main roles for primary care:
  1. Screening for alcohol use in pregnant women
  2. Referral for diagnosis based in Canadian Diagnosis Guidelines (Chudley et al. 2005)
  3. Follow-up and linking to community resources

Systematic Barriers in Ontario

- Busy primary care environment (Clarren et al. 2011)
- No health insurance billing code (Burns & Temple 2009)
- Multidisciplinary diagnostic team (Chudley et al. 2005)
- Proximity of diagnostic centres (Guilfoyle 2006)
- Lack of community services (FASD ONE 2010)
- Lack of a provincial strategy for FASD (FASD ONE 2010)
- Awareness of screening tools (Clarren et al. 2011)
- Lack of position statements from regulatory bodies (CMA 2012)

Attitudinal Barriers

- Cultural beliefs (May et al. 2009; Tough et al. 2007)
- Socioeconomic status and alcohol use (Health Canada 2003)
- Social stigma associated with alcohol abuse (Rutman 2011)
- Personal comfort with alcohol use (Tough et al. 2007)
- Don't feel it is their role to address it (Tough et al 2008)
- Feel a diagnosis of FASD is not helpful (Elliott et al., 2006)
- Reluctance to refer because patients may resist (Benz, Rasmussen & andrew, 2006).

Expert Knowledge Barriers

- Motivational interviewing techniques (Davis et al. 2008)
- Medical education (Diekman et al. 2000)
- Uncertainty over safety of alcohol (Davis et al. 2008)
- Awareness of roles (Tough et al. 2008)
- Emerging data re. FASD (Aliyu & Hayes 2001)
- Media influences (Yu et al. 2010)
- Uncertainty over how to intervene (Tough et al. 2008)

Conclusion:

- 8 years since Canadian diagnostic guidelines, but minimal impact
- Primary care providers need more knowledge on FASD in order to fulfill roles
- Barriers in the healthcare system, attitudes/perspectives of providers, and knowledge of physicians
- **Need a knowledge translation (KT) approach to address these barriers**

Questions?

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