

Vital Signs Town Hall Teleconference
Partnering to Prevent Alcohol Use During Pregnancy: A Call to Action
February 9, 2016
1:00 pm CT

Coordinator: Welcome and thank you for standing by. I'd like to remind all participants they will be in a listen-only mode. Today's conference is being recorded. If you have any objections you may disconnect at this time. I'd like to turn the meeting over to Mr. Steve Reynolds. Sir, you may go ahead.

Steve Reynolds: Good afternoon everyone. I'm Steve Reynolds, the deputy director of CDC's Office for State, Tribal, Local and Territorial Support. I'm glad you could join us here today.

We'll be discussing the latest *Vital Signs* report on alcohol in pregnancy. Before we get started, let's go over some housekeeping details. You can go online and download today's PowerPoint presentation so you can follow along with the presenters.

The web address is www.cdc.gov/stltpublichealth. That's the CDC web site, with a forward slash, S-T-L-T Public Health. The *Vital Signs* teleconference link is on the far right side of the page or you can just simply Google CDC *Vital Signs* Town Hall and click on the top link. That should get you there.

On the same page, you can access bio's for today's presenters and the audio recording and transcript will be available sometime next week on the same web site.

Now, back to our topic for today, "Partnering to Prevent Alcohol Use During Pregnancy: A Call to Action." To begin today's call, we will hear from Dr.

Anne Schuchat, Principal Deputy Director for CDC. Dr. Schuchat will introduce this month's topic and CDC's recommendations. Dr. Schuchat.

Dr. Anne Schuchat: Thanks so much, Steve, and I'd like to thank everybody for joining us today for this town hall. The *Vital Signs* that we released last week addresses a very important topic, and I appreciate those on the call's ability to help participate today and to help respond to those calls to action.

Issues of health and pregnancy have been very much in the news recently and alcohol-related health effects have been a feature of our *Vital Signs* series since 2010.

Last week's *Vital Signs* got more attention than we expected potentially for some of the wrong reasons. We recognize that the communication about the *Vital Signs* report may not have been as clear as intended, and for some, that led to a degree of misinterpretation.

And so I hope that today's *Vital Signs* provides an opportunity for state and local health officers and partners to get the real story from the scientists and experts as well as clinicians managing this condition.

CDC's intention was to explain the risk of drinking during pregnancy, including before a woman knows she's pregnant, and to show that the harmful effects of alcohol on the developing baby are completely preventable.

Our intention was not to prescribe a lifestyle or suggest that women plan their entire lives around a hypothetical baby. There has been quite a bit of attention to our *Vital Signs* into CDC's communications and I really hope today we can help you learn what you need to know to improve health in your own community.

At CDC, our goal is to empower people including women to make good choices by giving them the best information we can so they can decide what they want to do themselves.

It's fairly clear now, with evolving science that gets stronger and stronger, that alcohol any time during pregnancy, in any amount, can be harmful to the developing baby.

Alcohol early in pregnancy can be particularly risky and we wanted to make sure that people were aware of that. What they decide to do with that information is, of course, up to them, but we hope that in today's call to action you'll learn about some tools and some strategies that can help you make sure that women get good information and are supported, as are healthcare providers, to make good choices.

Fetal Alcohol Spectrum Disorders are common. They can affect potentially 2% to 5% of children. We know that Fetal Alcohol Spectrum Disorders are 100% preventable if there's no exposure to alcohol during pregnancy.

So today's speakers are going to review a bit about the *Vital Signs* and Morbidity and Mortality Weekly Report we issued last week, talk a bit about interventions that can address alcohol use by clinicians and give you a sense of what partners and communities can do to support people in reducing their risk of harm from alcohol.

So I'd like to turn things back over to Steve and I'll be happy to address questions later in the session. Thank you.

Steve Reynolds: Thank you, Dr. Schuchat. Now, we'll hear from three more colleagues. First, Patricia Green, an epidemiologist in the Division of Congenital and Developmental Disorders at CDC's National Center on Birth Defects and Developmental Disabilities. She will talk about the findings of this month's *Vital Signs* report.

Then, Dr. Alicia Kowalchuk will present. She's an assistant professor in the Department of Family and Community Medicine at Baylor College of Medicine. She will address the role of healthcare providers in preventing alcohol exposed pregnancies.

And then hand the call over to Dr. Mary DeJoseph, an adjunct instructor and program facilitator for the New York Northeast FASD Education and Research Center at the Rutgers Centers for Alcohol Studies.

She will talk about the importance of parting with families living with Fetal Alcohol Spectrum Disorders. And now, I'll turn the call over to Patricia Green.

Patricia Green: Good afternoon. Today I will provide highlights from the *Vital Signs* Morbidity and Mortality Weekly Report on alcohol exposed pregnancies in the United States, 2011 to 2013.

Next slide. What is drinking too much? The 2015 to 2020 dietary guidelines for Americans recommends that adults who choose to drink should do so in moderation.

That is, up to one drink per day for women and up to two drinks per day for men. Excessive drinking or drinking above moderation, sometimes called alcohol misuse, according to these guidelines, is defined as eight or more drinks per week or four or more drinks within about two hours for women, 15

or more drinks per week or five or more drinks within about two hours for men.

At any amount of alcohol - any amount of drinking is considered excessive for pregnant women and for persons under the legal drinking age of 21. And there are a number of other groups that should not consume alcohol such as individuals taking certain medications and those recovering from alcoholism, for example.

Excessive alcohol use is associated with a number of health and social problems in both men and women and alcohol use during pregnancy is associated with a range of complications and poorly suggested outcomes such as increased risk for miscarriage, stillbirths, prematurity, Sudden Infant Death Syndrome and Fetal Alcohol Spectrum Disorders.

Slide six. Fetal Alcohol Spectrum Disorders are characterized by lifelong physical, behavioral and intellectual disabilities. The estimated prevalence of FASDs based on a community study of first grade students in the United States was reported to range between 2% and 5%.

In 2010, the cost of excessive alcohol use in the United States was \$249 billion including \$5.5 billion and pregnancy related costs which included increased healthcare needs and lost productivity as well as subsequent costs such a special education for children with an FASD.

Lifetime costs for an infant with Fetal Alcohol Syndrome, a single disorder within the FASD continuum, has been estimated at \$2 million. Alcohol exposed pregnancies are completely preventable if a woman does not drink alcohol during pregnancy.

Slide seven. The *Vital Signs* on alcohol exposed pregnancy aimed to estimate the national prevalence of alcohol exposed pregnancy risk among non-pregnant, non-sterile women in the United States and to identify characteristics of women at risk for an alcohol exposed pregnancy.

Slide eight. For this *Vital Signs* report, we analyzed data from the National Survey of Family Growth (NSFG) collected from September 2011 to September 2013. NSFG uses some multistage probability-based nationally representative samples of the household population of the males and females aged 15 to 44 years.

Our study included female respondents to the NSFG. A woman was considered at risk of alcohol exposed pregnancy risk if she met the following criteria - had vaginal sex with a male in the past four weeks, drank alcohol in any amount during the past 30 days and did not - and her partner did not, with her, use contraception during the month before the interview and is not sterile and she did not have a partner or partners known to be sterile.

Prevalent estimates of risk for alcohol exposed pregnancies were calculated for 4,303 non-pregnant, non-sterile women aged 15 to 44 years by selected demographics and behavioral factors.

An additional weighted analysis, both conducted to determine whether alcohol consumption different on the basis of pregnancy desire, sexual activity and contraception status.

The woman was considered to desire pregnancy if she was having sex without using contraception in the month of the interview and reported that the reason for not using contraception was that either she or her partner wanted to become pregnant as soon as possible.

Pregnancy desire was assessed by the following questions - is the reason you're not using a method of birth control now because you, yourself, want to become pregnant as soon as possible, and your partner, does he want you to become pregnant as soon as possible?

Slide nine. Main findings from the *Vital Signs* report are that 7.3% of US women, aged 15 to 44 years, who were not pregnant and not sterile were at risk for an alcohol exposed pregnancy.

The reason for women who reported that they wanted to get pregnant as soon as possible also reported drinking alcohol. This study also found the prevalence of alcohol use was similar among three subgroups of sexually active, non-pregnant, non-sterile women ranging from 65.9% to 74.3% and did not differ by pregnancy desire.

Women who reported not having sex with a male during the preceding four weeks had the lowest presence of alcohol use at (50.7%). This study reinforces the importance of routinely screening all people for alcohol misuse including women of reproductive age.

Slide ten. So what is alcohol screening and brief counseling? Alcohol screening and brief counseling involves screening for alcohol misuse using a recommended and valid instrument or an approved screening question and then conducting a brief intervention or counseling session if a person screens positive.

A brief counseling intervention ascertains whether the patient wants to reduce their drinking and places their behavior in the context of their overall health.

Finally, the small percentage of patients with indications of alcohol dependence are referred for more specialized treatment.

Slide eleven. Although alcohol screening and brief counseling is routinely recommended in primary care and is effective in reducing excessive alcohol use, a previous CDC study reported that only one in six US adults reported ever talking to a health professional about alcohol.

Alcohol screening and brief counseling was ranked as one of the five most effective and cost efficient and underutilized clinical preventive services by the National Commission on Prevention Priorities.

It was also recommended by the US Preventive Services Taskforce in 2004 and also in 2013 for all adults in primary care, including pregnant women, based upon the evidence of effectiveness. It is also covered without co-pay by the Affordable Care Act for new insurance plans.

Slide 12. So what can be done to help reduce the risk of alcohol exposed pregnancies? Well, women can talk to their healthcare provider about any pregnancy plans, alcohol use and, if appropriate, way to prevent pregnancy if not immediately planning pregnancy.

For women who are not - who are pregnant or might be pregnant, avoid drinking alcohol. For women who are not pregnant, just be informed of the risks of alcohol misuse including during pregnancy. Therefore, women and men who are unable to stop drinking on their own, talk with the healthcare provider or friend about resources that might help.

Slide 13. Providers can help, too, by screening all adults for alcohol misuse, at least annually. (They can) discuss range of contraceptive methods available, if

needed, including the use of condoms to protect against sexually transmitted infections.

They can also advise women not to drink if they are pregnant or might be pregnant. They can counsel, refer and follow-up with all patients who need help to stop drinking and they can use correct billing codes as alcohol screening and counseling is reimbursable.

Slide 14. State and local governments can work with their Medicaid program to make sure alcohol screening and counseling services are reimbursable. They can encourage health plans and provider organizations to support alcohol screening and counseling.

They can monitor how many adults receiving the services in their communities and they can support proven policies and programs that work to prevent drinking too much. Thank you. Now I will turn the call over to Dr. Alicia Kowalchuk.

Dr. Alicia Kowalchuk: Thank you, Patricia. So I was asked to speak today for in depth about alcohol exposed pregnancy prevention. And we can think about three different levels of prevention for preventing alcohol exposed pregnancy.

One primary prevention, and this is really working with women ages 14 to 44, assessing their pregnancy risk and discussing effective contraception when that's appropriate.

And also screening all of our adult patients yearly for alcohol problems and providing brief intervention services as needed. The secondary prevention, we're doing alcohol screening and brief intervention with all pregnant women and incorporating that into routine care of pregnant women, but also

counseling pregnant women that we know of no known safe time or safe type of alcohol to use while pregnant.

In tertiary prevention, we're really focused on screening women with children who may have had a prior alcohol exposed pregnancy and providing the counseling and referrals that those women and children and families need.

How do we incorporate particularly primary prevention into pre-conceptive care? And one way to think about this, as a primary care provider, is to think about what we already do in terms of teratogen screening.

And so we have someone in our practice, a woman who is of childbearing age that we know has the potential for becoming pregnant and we see other medication list, for example, a known teratogen like a retinol or an ACE inhibitor prescribed for her.

We already know, and most primary care physicians, are fairly - primary care providers are fairly comfortable in having those discussions which are around, is there way to eliminate or reduce the use of a teratogen - a known teratogen, so for another medication to handle the medical condition. Is that medication still needed, et cetera?

And/or helping that woman to choose and effectively use a birth control methods to avoid pregnancy while they're on that known teratogen. We're also routinely comfortable and used to screening for occupational exposures in the same vein.

And so it's really about us adding alcohol to that list and having that dialogue with our patients around their alcohol use and being able to have those discussions.

And all of this is really about empowering women to make healthy choices for their lives. And one of the ways to do this in a way that is empowering and giving control to women over the information that they want to receive and how they want to use that information is called elicit provide elicit.

And so it's really talking with our patients and asking them, first of all, what they may already know about a particular topic or what they would like information about.

So, for example, what do you already know about alcohol use and your health? What birth control methods would you like more information about? And then providing the specific information that that woman says that she wants and needs to make an informed choice.

“So it sounds like you already know quite a bit about how alcohol affects your health. What we also know about alcohol use is” - and providing information that fills in those gaps for her.

“To avoid an alcohol exposed pregnancy, you can choose to use effective birth control methods, stop drinking or both.” So again, providing that information. “Or other women who I've talked with who share your concerns about that particular birth control method have found” - and giving some information to the woman about a particular birth control method that she's interested in exploring further.

And then going back to eliciting, so what does the new information provided to that woman, what does that mean to her, what does that mean in terms of her wanting to move forward and make a choice or a change in her behavior or not?

“So what you think about that? What do you see fitting best with your life right now? Or what else would you like to know about that?” And then, in concluding that conversation, providing that summary, so the woman knows that you’ve heard what she’s been saying and you’re helping her formulate a plan and move forward.

“Today we talked about pregnancy prevention and alcohol use. You learned about these things. Let’s talk about the plan that you’ve made and what questions you might have moving forward.”

So that’s a simple, brief intervention around alcohol exposed pregnancy prevention in the pre-conceptive period. And a more general intervention would be around alcohol screening and brief intervention and this is really targeted to all adult patients, both men and women in practice.

And as Patricia shared with us earlier, it’s a very effective intervention that is unfortunately underutilized in the primary care setting. And one of the things that providers need to work with patients about understanding and making sure that they have that understanding, is what is a standard drink?

So we have drinking limits and what’s considered moderate drinking or risky drinking or misuse of drinking - drinking levels, but that all depends on us defining a standard drink and talking about the same quantity of alcohol.

And so on Slide 21, could see that all of these are standard units of the particular alcohol. So a 12 ounce beer, a 5 ounce glass of wine, a mixed drink made with a single shot or 1.5 ounces of 80 proof spirits.

And the point of this graphic is that all of the standard units of alcohol contained the same gram amount of alcohol, so one beer, 12 ounce beer, has the same amount of alcohol as a mixed drink made with a single shot as a 5 ounce pour table wine.

And for a lot of patients, that's new information. And it also helps when we're trying to talk with their patients about how much they're drinking to really figure out the quantity.

So some of its having one or two beers a night, if they're a man and they're having two beers a night and they're 12 ounces, that would be considered not to be at a risky for misuse level.

If they're 40 ounce beers, and that would be at a risky level because that would be actually much more than two standard drinks. In Slide 22, you can actually see the drinking too much limits.

And, again, Patricia covered this information as well, but for men - men's drinking is considered five or more drinks on one occasion and for women, four or more drinks on one occasion.

And risky drinking for men is 15 or more drinks in a week and for women, it's eight or more drinks in a week. And for pregnant women or anyone under the age of 21, really, the drinking - healthy drinking limit would be considered zero.

So screening and brief intervention involves - for alcohol screening involves three steps. And one is setting the stage, and this is really important to getting accurate information and creating a welcoming dialogue for a patient.

So for non-pregnant adults, it's about normalizing the conversation. Alcohol use can affect your health, so I ask all my patients yearly about the use of alcohol.

For pregnant adults, we really need to address the stigma up front. And one way to do that would be saying, "My pregnant patients often have questions or concerns about drinking alcohol during pregnancy or before realizing they were pregnant. How about you?"

And then using an evidence-based screening tool. So for non-pregnant adults, there's a variety of evidence-based screening tools including the single question alcohol screen AUDIT and the AUDIT-C for pregnant adults, we talk about an evidence-based screening tool called the TACE or T-A-C-E.

And then once we do that evidence-based screening with our patients, it's providing feedback. So for a non-drinker or someone at a low risk drinking, it's reinforcing their healthy choices.

"It sounds like you're making healthy decisions around or alcohol use." And if someone's at risk, it's really expressing concern, trying to link that risk to their current health and the healthy drinking limits in seeking their perspective and asking permission to continue the discussion.

Which leads us into the brief intervention - brief interventions are based on the principles of motivational interviewing and trans-theoretical model. They can be incorporated very quickly into routine primary care.

And so once a patient discloses that they are drinking at risky levels, it's really asking them about their drinking and getting them to reflect about where they

are with that in their lives and what choices they'd like to move forward and make going forward.

So one way to do this is to perform a decisional balance and that's asking your patients, "What you like about your drinking?" and letting them respond and then, "What are some not so good things about your drinking?" and reflecting that back.

So, on the one hand, you like drinking because it relaxes you and you enjoy going out with your friends. On the other hand, your drinking has led to some tension within your relationships and you blacked out one night and that was really scary for you.

So where does that leave you? So really assessing where the patient is that in terms of their readiness to make a change around their drinking. "On a scale of 0 to 10, 0, you're not at all ready to cut back or stop your drinking, and 10, you're ready to make a change today, where are you at with that?"

And then letting the patient respond and matching the rest of your conversation to where - their stage of readiness. So if they tell you they're a two, that means they are most likely not ready to make much of a change with their drinking at that moment.

And your job them, on Slide 25, is to really help them see any additional, negative consequences, express your concern over their drinking and offer to follow up with that.

So they're likely not to make significant change at that moment. They just told you that they're not ready. If they're contemplative, so they're really in that

unsure area, so maybe they tell you, “Well, I’m a five,” it’s really a great opportunity to explore that with your patient.

“So why are you a five and not a two?” And that really allows patients to express and reflect why they may want to make a change in their drinking, and then “What would it take for you to go from a five to, say, a seven?”

And that really lets them start to problem solve and think about maybe barriers to them wanting to change and how they would get around that, and again, offering that support and follow-up.

And then patients that respond that they’re really ready to go, so, “I’m a nine. I’m ready to make a change with my drinking” it’s about helping them develop a plan for how they’d like to cut back or stop, what resources do the hour to have available to them or maybe need your help to link to, to make those changes.

So just to summarize, the keys to alcohol exposed pregnancy prevention, is to really shift in focus the preconception care, remaining non-judgmental, to reduce the stigma, to allow patients to feel comfortable to talk about these very sensitive issues.

So we do know that women with prior alcohol exposed pregnancies are at the greatest risk for recurrent - or future alcohol exposed pregnancy, so paying close attention to that, and keep it simple.

We know that FASDs are 100% preventable and that there is no known safe amount of alcohol in pregnancy, no safe time in pregnancy to drink alcohol, and no safe type of alcohol to drink while you’re pregnant. Thank you so much and I’m going to turn it over now to Dr. Mary DeJoseph.

Dr. Mary DeJoseph: Thanks, Dr. Kowalchuk and you can see on Slide 28 that I'm going to finish as a speaker with a few minutes about partnering with families and screening as a partnership and not just a one-way provision of care from the healthcare provider to the patient, and certainly not just a memorized evidence-based script, all right?

So if you go to Slide 29, you can see that, if I introduced myself, you already know that I'm Dr. Mary DeJoseph. I'm a primary care physician. What my bio doesn't say is that I'm also a recovering alcoholic and I was not in recovery for my first two pregnancies.

So I have two sons who are now adults who have been affected by my drinking, so I have sat on both sides of the screening relationship or partnership.

And what I'd like to do for a few minutes is just provide some of my personal experiences in being screened as a patient and providing education and messages that I've heard and how they impacted me and how they impacted my children and, perhaps, the next generation.

And our hope is that you can look at the messages that you provide and consider what their impact is in your language and values and beliefs around them.

So if we go to Slide 30, you can see one of the questions that I have gotten as both the birth parent and as an educator, if someone had screened you, would you have told the truth?

And during my first pregnancy with Steven, I would not have had to trust you at all to tell the truth. So I could have told you I was an American woman in her 20s. I considered myself a social drinker. I had no alcohol related consequences.

I was able to stop drinking when planned the pregnancy. I drank on a handful of occasions during the pregnancy. And we wouldn't know the impact of that drinking until much later.

The picture was different by the time I was pregnant for the second time, and this is Michael and I and the delivery room and we both had signs of alcohol withdrawal during that pregnancy.

In what I can tell you during this pregnancy, if you had screened me, all of my mental health and trauma and addiction issues would have interfered with my telling you the truth the first time.

So if you had done a cursory or judgmental or a one-time screening and then so that you are done with it, I wouldn't have been able to talk to you about my drinking at all.

So I would go with Dr. Kowalchuk's recommendations - screening frequently, take the time to do it right and start off the screening as a health related issue because that's much more neutral and less threatening.

It we go to Slide 31, that's my husband Paul and the two boys. And Paul is an example of a partner who would be 110% committed to my having an alcoholic exposed pregnancy and he didn't have that opportunity.

He had a much different message, a more difficult message that he had to give to me. But he developed that message with the help of a primary care provider. So I just - you know, while we're talking about including partners in this whole process, don't forget that if you include the partner it may not be a simple yes or no and be prepared for that.

And the other thing is, don't forget about safety first because many home test issues, mental health and domestic violence issues that we know nothing about, and the woman as always, always, in every case, our guide to who is - who she considers appropriate support for her pregnancy.

All right, but that - so that can certainly be an amazing support system for sure. Slide 32 is a picture of my daughter. She was a nationally ranked snowboarder a few years back and she's my third pregnancy.

And by the time I was pregnant with her, I had a very high risk pregnancy and I saw a high-risk obstetrician and this is what he said, "You have a very high risk pregnancy, but if you don't drink, the risk will be less. Why don't you take care of your sobriety and I'll take care of the pregnancy," and that worked.

That worked. He was clear and non-judgmental and give me something to do and we each did our jobs. And not only did keep my pregnancy healthy, Cristina was born and remains with no cognitive or intellectual or developmental disabilities.

And still be able to make great choices if she ever decides to get pregnant herself. So that one first meeting impacted possibly three generations of folks. So if we go to Slide 33, you know, we talk about doctors and other healthcare providers who are giving messages.

We have lots of - too many challenges to talk about, you know, in the space of a few minutes. We've already looked at the data about only one in six patients hearing the message. The CDC continues to address the barrier and provide us with clear diagnosis and information about prevalence and interventions and so on.

I just wanted to pass along a thought about the culture of medicine. And medicine, like every other culture, has values and beliefs and language that are under the deck that are not spoken.

So if you hear the questions, depending on how it's delivered, well, we have told the truth when you were screened. It may be a code for women who are drinking during pregnancy or using drugs during pregnancy never tell the truth.

If you hear, "Oh, alcohol screening, I don't have anyone like that in my practice," it may be code for, "I think that only end-stage alcoholics and drug addicts are the ones who do the damage and I can spot them a mile away."

Consider the culture of medicine as we work on teams, you know, and promoting screening and brief interventions. Lots of folks went into healthcare to help people and screening seems like, in some cases, it can be irritating and inflammatory and upsetting.

So, you know, we have to address unspoken as well as spoken barriers that are expressed, right. One more barrier in the short time that I have is I don't have enough time to do alcohol screening.

And I remember talking to an obstetrician and her frustration, she was every visit, you know, addressing a media firestorm about heavy metals in tuna fish and not getting things like alcohol and smoking, you know.

And I had to tell her, “You know, there’s always an emergency and there’re so many different priorities and patients can be so worried and sometimes you just have to bargain with them to take turns expressing a concern.”

You express a concern and then we do one of mine and then one of yours until you run out of time or energy. And that way, I mean, alcohol screening in intervention may not seem like an emergency on any given visit.

But the risk accumulates and that way we can make sure that you can prioritize your other screening issues that you need to get with, all right. And Slide 35, the next - yes, the next slide, 35, it’s just to address that visit that you have, you’ve done and alcohol screening, maybe a brief intervention.

You think it’s successful. You follow Dr. Kowalchuk’s three steps and it’s been a good visit. And the woman comes that the next visit and you’re star- you feel like you’re starting off exactly where you were at the last visit, you know, and people have said to me, like, “What’s up with that?”

And I don’t think we can underestimate, if you’ve heard before, the power of stigma and shaming messages that women will get from all different folks. I’ve heard it from legislators, you know, you’re running around pregnant and drinking is code for you don’t care enough to have a healthy pregnancy. You should be in jail.

You know, it doesn't need any coding. Drinking during pregnancy is unforgivable. And those of you who know our family story in more depth know that forgiveness was the missing piece for all of us to get into recovery.

So stigma is a powerful force. It doesn't mean that you've wasted time with your screening in intervention. It's just - it means that we still have work to do. The other reason that women may come back the next visit and it's as if you never made any progress in the first place, is unidentified and untreated mental health issues, developmental disabilities and the woman who is - was alcohol exposed during pregnancy herself.

Let's go to Slide 36, my last content slide, and just spend a minute with that population. Women and men, because we're looking at partnerships, and have been prenatally exposed to alcohol, you know, as we listen to those adults in they're coming into their voice and they're telling us their story and their experience.

They can look and act that sound very typical. To me, if some of you - this is my son Steven in this slide - if you've heard him present, you know, he has higher verbal IQ than I do.

And it is very difficult for them to be identified by looking at them or by one conversation. And, you know, if you think of their risk, they may have the genes for alcohol use disorder.

They may have grown up in alcoholic families with all the challenges and traumas. They have impairments that interfere with their planning and carrying out good planning for alcohol use and birth control and pregnancy and asking for help.

These are - this is a generation of people that are of reproductive age who are at higher risk than their parents for alcohol exposed pregnancy. And they are in desperate need of your conviction and your belief in your hope that they can and will have an alcohol-free pregnancy and break that cycle of alcohol exposed pregnancy that, you know, that they're trapped in this lifetime.

You know, they have to be identified. It's going to take a higher level of services and support but I believe that, you know, the folks are interested enough to be on this call and to carry this message forward are capable of providing some of those services and support.

I know you can do it because you did it for me. So thank you so much for listening to that. The last slide, 37, is my contact information and I will do everything I can to reply in a timely manner if you contact me.

If you lose that contact information, I have to extend my thanks to my family for giving me permission to talk about them and to NOFAS and to Kathy Mitchell for the Circle of Hope and the Birthmother's Network.

You can just be in contact with them and they'll connect you with a birthmother in your area if you need a resource, and a thanks - a shout-out also to NOFAS New Jersey for their support and empowerment of the birthmothers here in New Jersey. And I believe I turned back- this back over to our facilitator, Steve.