Briefing note

Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder – Questions on Notice

Purpose

To provide a response from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to Questions on Notice from the Senate Standing Committee on Community Affairs on the Inquiry into effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder (the Inquiry).

Questions on Notice

1. **What is the degree of knowledge about FASD among your members?**

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and is responsible for training, educating and representing psychiatrists on policy issues.

There are 435 RANZCP members with a registered interest in the Section of Perinatal and Infant Psychiatry, 315 with an interest in the Section of Psychiatry of Intellectual and Developmental Disabilities and 444 with interest in the Faculty of Addiction Psychiatry.

Please note, that members have expressed interest in these areas through their registration as members of these groups and actual knowledge about FASD amongst these members may vary.

2. **Does the College provide or facilitate any ongoing professional development or educational material to members that covers FASD, including its manifestation and co-morbidities in children and adults? If not, will the College consider doing so?**

There is a reference to FASD within a professional development course titled, Australasian Psychiatry – February 2018 - Addiction Psychiatry. The RANZCP currently does not provide or facilitate any specific professional development or educational material to members on FASD.

The RANZCP's Fellowship Training Program does contain a requirement for understanding of 'Substance use on pregnancy/puerperium' in the Stage 2 syllabus (though not specifically FASD). The RANZCP's Child and Adolescent Advanced Training Certificate does have specific reference to FASD which is copied below:

Clinical syndromes Trainees are expected to acquire an in-depth knowledge of the following aspects of FASD: Definition, assessment, diagnostic criteria, clinical symptomatology and associated features, family, age, gender and culture-related features, epidemiology, aetiology (biopsychosocial, cultural), course, complications, outcome, differential diagnosis, prevention, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities.

Providing or facilitating providing any additional professional or educational material to members which covers important topics, such as FASD, is always under ongoing consideration.

3. **Your submission mentions there are currently very few evidence-based mental health interventions or treatments available for people with FASD. What is available and what is lacking?**

The RANZCP has several points in relation to Question 3 including:

- Psychiatrists largely treat symptoms of mental health conditions once an issue has been identified. While better screening at a primary level is required to help identify substance use, prevention is still the best cure for FASD. .

- Specialist mental health services are urgently required to address service gaps for people with complex and challenging behaviours including many people with FASD. This includes addressing the needs of people with intellectual disability in specialist inpatient and community mental health services by developing services and projects which aim to address their mental health needs.
- There are a number of neurodevelopmental conditions in childhood which may initially present with signs and symptoms that should be investigated, and early intervention implemented. In child and adolescent psychiatry, the diagnosis, assessment and treatment of the children usually occurs in close collaboration with treatment partners such as paediatricians. As with other neurodevelopmental presentations in children, a multidisciplinary approach to assessment and treatment utilising a developmental strengths and vulnerabilities model, in addition to a diagnostic-specific approach, and a mental health approach, is appropriate with respect to FASD.
- The FASD Hub has several systematic reviews and meta-analyses on FASD interventions.
- Most pregnant women are not in contact with a psychiatrist, meaning interventions or treatments, such as screening, sit within primary care (GPs) or maternity services (Gynaecology/Obstetrics).

4. **The National Drug Research Institute's submission notes that anxiety is a risk factor for risky drinking in pregnancy. Is this something your practitioners are aware of and address in practice?**

The RANZCP is committed to promoting evidence-based psychiatric practice and encouraging members to be aware of recent research in their areas of practice. The RANZCP, however, is unable to quantify the specific level of awareness amongst members regarding anxiety as a risk factor for risky drinking in pregnancy.

5. **The National Drug Research Institute also mentions that "psycho-social risk factors" should be used to profile women at high-risk of alcohol consumption and that health professionals can use these to identify and support vulnerable women in pregnancy. Does this happen at the moment (besides the optional use of the Audit-C alcohol assessment)? Do practitioners have the tools and knowledge to do this?**

The RANZCP would advise that primary and maternity services support vulnerable pregnant women through many of the necessary interventions or treatments, such as screening, and should be made readily available, irrespective of geographical location.

Further consultation with primary health and maternity health professionals would be required to determine the current knowledge regarding the use of psycho-social risk factors.