The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

Submission

Inquiry into Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder (FASD)

Thank you for inviting the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to make a submission to the Senate Community Affairs References Committee on the Inquiry into Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder.

RANZCOG is the lead standards body in women's health in Australia and New Zealand, with responsibility for postgraduate education, accreditation, recertification and the continuing professional development of practitioners in women's health, including both specialist obstetricians and gynaecologists, and GP obstetricians.

Background

Alcohol consumption in pregnancy can have differing effects upon the fetus, including lifelong problems such as the Fetal Alcohol Spectrum Disorder (FASD).[i] FASD is a diagnostic term for the range of physical, cognitive, behavioural and neurodevelopmental abnormalities which can result from maternal drinking during pregnancy.[ii]

According to Australian and International Guidelines, there is no 'safe level' of alcohol use during pregnancy and while breast feeding.[iii] Alcohol crosses the placenta and may irreparably damage the brain and other organs of the developing embryo and fetus.[iv] The timing and intensity of alcohol exposure can contribute to fetal harm, caused by prenatal exposure to alcohol. Alcohol may harm the fetal brain at any time during the pregnancy, although birth defects including facial anomalies result from first trimester exposure. The dose, pattern and timing of prenatal alcohol exposure all influence the type of resulting adverse fetal outcomes. Prenatal exposure at moderate (3-4 drinks per occasion) or higher levels increase the risk, type and severity of child behaviour problems, and the timing of exposure influences the type of behaviour problems exhibited. For example, for outcomes such as language delays, the risk to the fetus appears to be highest when moderate-to-heavy levels of alcohol were consumed in the third trimester.[v] Not all exposure to alcohol in utero will have an effect, or the same degree or type of effect on the fetus. A number of complex and interrelated factors can influence the effects of alcohol on the fetus which include socio-economic factors, nutrition, substance abuse and trauma, combined with genetics.[vi]

Specific Feedback

RANZCOG notes that the feedback provided to the below questions are supplementary to the written and verbal submission provided to the Senate Community Affairs References Committee's inquiry into Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder, in November 2019 and 16 September 2020, respectively.

Question 1

Does the College provide or facilitate any ongoing professional development or educational material that covers the risks of drinking in pregnancy, and specifically the risks of FASD? If not, why not, and will the College consider offering this in future?

As a member-based, not for profit organisation, RANZCOG is committed to the establishment of high standards of practice in obstetrics and gynaecology, in line with RANZCOG's vision to achieve excellence in women's health. To this end, RANZCOG is responsible for the development and dissemination of guidelines for provision of safe, evidence-based and woman centred care.

RANZCOG has developed a number of resources, including a very comprehensive RANZCOG statement on '*Substance use in Pregnancy'*(the statement).[vii] This statement is designed to provide advice on the management of substance use in pregnancy and encompasses implications of using alcohol as well as a number of other harmful substances including recreational drugs and tobacco. The statement is comparable to the contemporary international best practices of both World Health Organisation (WHO) as well as the Society of Obstetricians and Gynaecologists of Canada (SOGC) and is to be used by health professionals providing maternity care, as well as patients. In summary, the statement broadly covers a myriad of attendant issues including but not limited to, incidence, economic costs, diagnosis as well as advice relating to co-existing mental health disorders.

RANZCOG recommends that the safest option in pregnancy is to avoid any alcohol consumption.[viii] This recommendation is in line with the National Health and Medical Research Council (NHMRC) *Australian guidelines to reduce health risks from drinking alcohol (2009).*[ix] The statement summarises that alcohol use in pregnancy is associated with increased risks of miscarriage, premature birth and low birth weight as well as stillbirth and Fetal Alcohol Spectrum Disorder (FASD).[x]

In addition, RANZCOG also states that heavy alcohol consumption in pregnancy can lead to the development of the Fetal Alcohol Syndrome (FAS), which can result in varying degrees of neurodevelopmental and intellectual impairment and can include facial dysmorphic changes.[xi]

RANZCOG is of the view that a verbal screen should be undertaken to identify substance use. It is recommended that, if substance use is identified, sensitive counselling and referral to an appropriate multidisciplinary drug and alcohol management program should be undertaken.[xii] RANZCOG further recommends that, if potentially harmful alcohol use is suspected, the T-ace screening tool may be used.[xiii] Where there is evidence of pathological drinking behaviour, involvement of a drug and alcohol specialist in counselling and care is deemed appropriate.

In addition to the RANZCOG statement which outlines the contemporary, evidence-based recommendations to health care providers, free access is also available to all health professionals to the *RANZCOG Women Want to Know course*.[xiv] This Department of Health initiative aims to upskill health professionals to facilitate discussion on alcohol and pregnancy with women. The online course also ensures that the message about alcohol consumption during preconception, pregnancy and breastfeeding remains uniform among all clinicians.

Considering all of the above, RANZCOG confirms that currently RANZCOG is facilitating access to all up to date, available information in the form of RANZCOG statements that covers the risks of drinking in pregnancy, and specifically the risks of FASD for the use of all health care professionals as well as the patients. Furthermore, free access is available to all clinicians to upskills themselves on providing specific advice regarding alcohol consumption during preconception, pregnancy and breastfeeding.

Question 2

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

In Australia, it's estimated that 45 per cent of people will experience a mental health condition in their lifetime.[xv] In any one year, around 1 million Australian adults have depression, and over 2 million have anxiety.[xvi] Mental health problems are common during pregnancy and after birth. Recognised risk factors do exist but mental health disorders can arise for the first time in the perinatal period.[xvii] Perinatal anxiety and depression is the result of biological, sociological and psychological factors occurring at this time and can affect mothers and fathers.[xviii]

Mental health problems affect the wellbeing of the woman, her baby, her partner and family, during a time that is critical to the future health and wellbeing of children. RANZCOG is of the view that early detection and intervention can improve outcomes for all and are the responsibility of all maternity care providers. RANZCOG also recognises that risk factors leading to depression and other mental health problems can include a history of drug or alcohol abuse, antecedent mental health problems, lack of support, previous trauma including physical, emotional or sexual abuse, isolation (physical, mental, cultural) or stressful life events.[xix]

RANZCOG has developed a statement on '*Mental Health Care in the Perinatal Period'*, which is consistent with the evidence review undertaken as part of the development of the evidence-based 2017 *Australian National guideline Mental Health Care in the Perinatal Period*.[xx] This statement aims at providing advice to all health professionals providing maternity and mental health care and patients, on perinatal anxiety and depression, serious mental illness and bipolar disorder.

RANZCOG acknowledges and recognises that anxiety and depression, bipolar disorder, schizophrenia or personality disorders may contribute to substance use in pregnancy, or may be the effect of substance use[xxi],[xxii],[xxiii]. RANZCOG recommends that, if a mental health disorder is suspected, referral to a mental health service,[xxiv] liaison psychiatrist, or community mental health service should be undertaken.[xxv]

In addition, RANZCOG recommends that all pregnant women should be routinely screened for depression and anxiety symptoms and the use the Edinburgh Postnatal Depression Scale (EPDS) for screening is recommended.[xxvi] Moreover, RANZCOG further recommends screening for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the ANRQ3[xxvii]. Screening for psychosocial risk factors can be undertaken at the same time as screening for depression and anxiety and should be considered part of routine antenatal and postpartum care.

To this end, RANZCOG acknowledges and agrees with the National Drug Research Institute's statement that anxiety is a risk factor for risky drinking in pregnancy. RANZCOG has addressed this issue and provided evidence-based guidance to the healthcare providers as well as the patients on early identification, treatment and management of the mental health disorders. Furthermore, RANZCOG has endorsed the Marcé International Society Position Statement on *'Psychosocial assessment and depression screening in perinatal women'* which provides guidance to assist decision-making by clinicians, policy makers and health services undertaking universal psychosocial assessment (including depression screening) of women during the 'perinatal period'.[xxviii]

Question 3

In his evidence, Prof Shelton said health practitioner education and early intervention on alcohol use is important, especially where the opportunity has been missed with a first pregnancy in order to avoid a further alcohol exposed pregnancy. He also said there are three questions a health practitioner can ask to engage a woman on the topic of alcohol use in pregnancy (which are available on the FASD Hub site). The three questions are, 'Was the pregnancy planned or unplanned? How many weeks were you when you realised you were pregnant? What lifestyle changes did you make at that point?'. Do practitioners routinely use these or similar questions to broach the issue of alcohol use? If not, is this something on which the college will provide guidance to members?

Less than 1% of women report alcohol use in pregnancy to maternity care givers, but population surveys show that one third drink some alcohol during pregnancy, commonly in the setting of an unplanned pregnancy.[xxix] A quarter of Australian women still consume alcohol after becoming aware of their pregnancy[xxx] and 60% of women consume alcohol between conception and recognising they are pregnant.[xxxi] Therefore, alcohol use in pregnancy is common and an important issue in maternity care as it involves adverse pregnancy outcomes and also a cascade of health, legal, social, and financial problems that adversely affect the welfare of the mother and child.

As stated under *Question 1 response* above, RANZCOG recommends verbal screening in the first instance to identify substance/alcohol use. This verbal screening would encompass all aspects relating to substance use including but not limited to the types of substances, dosage and also psychological and psychosocial considerations. RANZCOG also recommends that, if substance use is identified, sensitive counselling and referral to an appropriate multidisciplinary drug and alcohol management program should be undertaken.[xxxii] RANZCOG further recommends that, if potentially harmful alcohol use is suspected, the T-ace screening tool may be used. To this end, RANZCOG has provided advice to clinicians for the identification and management of alcohol use during pregnancy, that are in line with the international guidelines.

In conclusion, RANZCOG suggests that more strategies are required to raise awareness of the risks associated with alcohol consumption in pregnancy. RANZCOG is of the view that all women of child-bearing age need to be made aware of the potential risks of harm of drinking alcohol, before they consider pregnancy. This will enable them to make informed decisions about drinking in pregnancy. As the pioneering standards setting body in obstetrics and gynaecology, RANZCOG has proactively developed a number of evidence based, resourceful statements, in line with the international best practices on both substance use and mental health in pregnancy. RANZCOG believes that these resources provide adequate information and guidance to inform the health care providers as well as the patients on these important and topical issues.

Yours sincerely,

Dr Vijay Roach
President

References

[i] RANZCOG. Substance use in pregnancy (C-Obs- 55) 2018. Available at: https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Substance-use-in-pregnancy-(C-Obs-55)-March-2018.pdf?ext=.pdf

[ii] The Department of Health. National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028. 2018. Available at: https://www.health.gov.au/sites/default/files/national-fasd-strategic-action-plan-2018-2028.pdf

[iii] National Health and Medical Research Council (NHMRC). Australian Guidelines to Reduce Health Risks from Drinking Alcohol.2009. Available at: https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol

[iv] Elliott E. Fetal alcohol spectrum disorders in Australia – the future is prevention. 2015. Public Health Res Pract. 25(2)

[v] O'Leary C, Zubrick S, Taylor C, Dixon G, Bower C. Prenatal Alcohol Exposure and Language Delay in 2-year Old Children: The Importance of Dose and Timing on Risk. 2009. Pediatrics; 123(2): 547-54.

[vi] May P, Gossage J. Maternal risk factors for fetal alcohol spectrum disorder. 2011. Alcohol Research and Health, 34(1);15-26

[vii] Ibid i.

[viii] Ibid i, p.6.

[ix] Ibid iii.

[x] Ibid viii.

[xi] Ibid.

[xii] Ibid I ,p 3.

[xiii] T-ACE Screening Tool. 2018. Available from: https://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf.

[xiv] Department of Health. Women Want To Know initiative. 2020. Available at: https://www.health.gov.au/initiatives-and-programs/women-want-to-know-initiative

[xv] Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results, 2007 (2008), p 41. Available at: https://www.abs.gov.au/statistics/health/mental-health/national-survey-mental-health-and-wellbeing-summary-results/latest-release

[xvi] Ibid.

[xvii] Austin M-P. Highet N. and the Expert Working Group. Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Centre of Perinatal Excellence. Melbourne: 2017.

[xviii] RANZCOG. Mental Health Care in the Perinatal Period (C-Obs 48). July 2018. Available at: https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-

MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Mental-health-care-in-the-perinatal-period-(C-Obs-48).pdf?ext=.pdf

[xix] Ibid. xviii, p 5.

[xx] National Health and Medical Research Council. Mental health care in the perinatal period: Australian clinical practice guideline. 2017. Available at: https://www.clinicalguidelines.gov.au/portal/2586/mental-health-care-perinatal-period-australian-clinical-practice-guideline

[xxi] Witt WPD, T. Hagen, E.W. Wichmann, M.A. Wisk, L.E. Spear, H.A. Cheng, E.R. Maddox, T. Hampton, J. The prevalence and determinants of antepartum mental health problems among women in the USA: a nationally representative population-based study. Archives of Women's Mental Health. 2010;13(5):425-37.

[xxii] Breckenridge JS, M. and Shaw, E. Use and abuse: Understanding the intersections of child abuse, drug use and mental health. Adults Surviving Child Abuse and the Centre for Gender Related Violence Studies. 2010.

[xxiii] American Psychiatric Association. Diagnostic and statistical manual of mental health disorders. 2018. Available at: http://www.psych.org/mainmenu/research/dsmiv/dsmivtr.aspx.

[xxiv] HEALTH Insite. A healthdirect Australia health information service. Mental Health and Wellbeing. 2018. Available from: : https://www.healthdirect.gov.au/mental- health-and-wellbeing

[xxv] Ibid xviii.

[xxvi] Ibid xviii, p 4.

[xxvii] Ibid.

[xxviii] RANZCOG. Marcé International Society Position Statement. Psychosocial assessment and depression screening in perinatal women. 2013. Available at: https://ranzcog.edu.au/getattachment/Statements-Guidelines/Obstetrics/Psychosocial-Assessment-and-Depression-Screening-i/Marce-Statement-Psychosocial-assessment-and-depression-screening-in-perinatal-women.pdf?lang=en-AU&ext=.pdf

[xxix] Finer LB ZM. Unintended pregnancy in the United States: incidence and disparities 2006. Contraception. 2011;84(5):478-85.

[xxx] AIHW 2017 National Drug Strategy Household Survey 2016. 2017. Available at: https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/contents/table-of-contents

[xxxi] McCormack C et al. Prenatal Alcohol Consumption between a conception and recognition of pregnancy. Alcohol Clin Exp Res. 2017;41(2):369-378

[xxxii] Ibid i, p.3.