



Government of **Western Australia**  
Drug and Alcohol Office

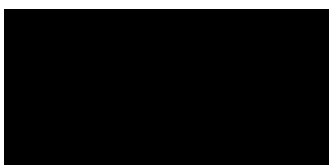
To Whom It May Concern

**SUBMISSION OF THE WESTERN AUSTRALIAN DRUG AND  
ALCOHOL OFFICE TO THE PARLIAMENT OF AUSTRALIA:  
HOUSE STANDING COMMITTEE ON SOCIAL POLICY AND  
LEGAL AFFAIRS INQUIRY INTO FOETAL ALCOHOL  
SPECTRUM DISORDER**

Please find attached a submission prepared by the Western Australian Government Drug and Alcohol Office for the House Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder.

The Drug and Alcohol Office will be pleased to provide further information to the Committee if required.

Yours sincerely



**Neil Guard**  
**EXECUTIVE DIRECTOR**

12 December 2011

**The Western Australian Drug and Alcohol Office  
Submission to the Parliament of Australia: House  
Standing Committee on Social Policy and Legal  
Affairs Inquiry into Foetal Alcohol Spectrum Disorder**

December 2011

# Parliament of Australia: House Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder

This document responds to the Terms of Reference for *prevention strategies*.

## Background

The drinking culture in Australia is one that condones and tolerates short-term and long-term harmful alcohol use, which causes significant social and economic burden to the Australian community. It is estimated that in Australia, the social cost of harmful alcohol use is \$15.3 billion per year (Collins and Lapsley 2008). Given the widespread acceptance and normalisation of alcohol in the general community, it is understandable that women experience difficulty abstaining from alcohol use when pregnant, planning a pregnancy or breastfeeding.

FASD is a term used to describe the range of effects that can occur for a child exposed to alcohol in their mother's womb. Alcohol use during pregnancy can disturb fetal development, causing irreparable damage and resulting in life-long health and developmental problems. The effects of alcohol on the developing fetus can include damage to the brain, major organs, facial structures and central nervous system. People who are affected by alcohol in-utero can also experience a range of secondary disabilities including unemployment, dependant living and mental health problems (Streissguth, Barr et al. 1997). FASD is the main cause of "preventable non-genetic intellectual handicap in developed countries" (Russell 2002, p. 16).

Diagnosis of FASD is a complex process and requires a range of specially trained health professionals. Currently, there is no national co-ordinated approach to measuring the prevalence of FASD in Australia (Pyett, with Loughron et al. 2007). FASD incorporates a range of diagnoses including Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (pFAS), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopmental Disorders (ARND). Conservative estimates of FAS, the most visible form of FASD, in Western Australia (WA) are 2.76 per 1000

Aboriginal children compared to 0.02 per 1000 for non-Aboriginal births (O'Leary 2002).

Without an agreed diagnostic tool and appropriately trained multidisciplinary health professionals it is difficult to establish prevalence of FASD. Additionally, the establishment of effective prevention strategies requires an understanding of the extent of the issue. Experts agree that the prevalence of FASD is largely underestimated in Australia.

## **Prevention**

### ***Why:***

The 2009 National Health and Medical Research Council Australian Guidelines to reduce health risks from drinking alcohol recommend that no alcohol is the safest option for women who are pregnant, planning a pregnancy or breastfeeding. As FASD is caused by pre-natal alcohol exposure, the simplest strategy for the prevention of FASD is for women not to use alcohol during pregnancy (Murphy-Brennan and Oei 1999). FASD prevention is a complex task because the reasons behind alcohol use during pregnancy are not simple. As with other prevention strategies, any activity must be contextualised in order to create effective strategies that are relevant to the target population.

### ***How:***

Understanding alcohol use in pregnancy is essential for the development of effective prevention strategies. The Alcohol and Pregnancy Project (2009, p. 14) reported that women who drink alcohol during pregnancy do so for a range of reasons including:

- Not knowing they are pregnant
- A lack of knowledge around the consequences of using alcohol while pregnant
- As a strategy to cope with life problems
- Normalisation of drinking during pregnancy in their social circle.

Aboriginal women are overrepresented in experiencing social determinants of poor health such as housing instability, poverty and unemployment, and they have higher

birth rates of children with FASD (Saggers and Gray 2007, p. 7). Poverty (in addition to maternal alcohol consumption) is considered to have a significant impact on rates of FASD, rather than ethnicity, culture and race (Pyett, with Loughron et al. 2007).

Given the role of social determinants of health on a child being affected by FASD it seems prudent that funding and resources be invested in holistic approaches for FASD prevention (Poole 2008). Improved knowledge and awareness of the risks need to be underpinned by broader strategies addressing alcohol use in the wider community among women of childbearing age. Policies, programs and messages should aim to reduce levels of risky drinking, prevent women's use of alcohol during pregnancy and encourage early engagement in antenatal care.

***What:***

In order to bring about behaviour change, key prevention strategies should include coordinated activities such as public awareness campaigns using social marketing principles, alcohol control measures, pre-natal and post-partum support and workforce development. Target groups for public awareness campaigns should include all women of childbearing age including young people, women who are pregnant, planning a pregnancy or breastfeeding, women's partners, families and communities.

***Social marketing***

Public education or social marketing campaigns offer population-wide methods to raise awareness in the prevention of FASD. Social marketing campaigns are vital to increase community demand for, and acceptance of, evidence-based population-wide policy strategies that are effective in changing behaviour. However, when carried out in isolation, public awareness campaigns are limited in their ability to shift behaviour (Dell and Roberts 2005). Evidence suggests that FASD awareness strategies should be a component of a holistic approach to address prenatal exposure to alcohol (Burgoyne 2006). Awareness raising strategies such as labels warning about alcohol use during pregnancy were found to be effective among young people in the United States (Foundation of Alcohol Research and Education

2011). Campaign messages designed to facilitate norms such as, “if you are pregnant, planning a pregnancy or breast feeding, no alcohol is the best option for growing strong and healthy babies”, are more likely to be effective when undertaken in conjunction with other strategies.

It is also important to consider alcohol and pregnancy social marketing campaigns as one component of broader population-wide social marketing campaigns that aim to change short-term and long-term harmful alcohol use.

#### *Alcohol control measures*

The House of Lords Science and Technology Select Committee Report into Behaviour Change (2011) observed that it is important to create environments that make it easier for people to make the healthier choice. The literature about reducing alcohol-related harm further supports this view, stating repeatedly that certain policies have been associated with reductions in harmful alcohol use. For example, at a policy level increasing alcohol prices through taxation is considered the most cost effective strategy in reducing alcohol-related harm (Stockwell 2010). Policies that limit high-risk consumption would also be effective in reducing prenatal exposure and FASD (Dell and Roberts 2005, p. 37). Research has shown that women reduce their alcohol consumption due to price increases more than men. This may suggest that increasing the price of alcohol may be an effective measure for reducing drinking by pregnant women (Dell and Roberts 2005, p. 37).

It is important to consider alcohol control strategies that make a difference in changing harmful drinking at a population level to support a low-risk drinking culture. The literature has shown that other policy initiatives that can reduce alcohol-related harm and harmful consumption include limiting the availability of alcohol (trading hours and outlet density), limiting the promotion of alcohol (alcohol advertising and promotions) and those that decrease the normalisation of alcohol as a necessary part of everyday life.

### *Pre-natal and Post-partum support*

Pre-natal support is essential for a healthy pregnancy. Unfortunately, at-risk women are less likely to access pre-natal care early in their pregnancy, which reduces opportunities for support and information regarding healthy pregnancies. There are limited specialist services in Western Australia which respond to alcohol and other drug use during pregnancy. For example, WANDAS (Women and Newborn Drug and Alcohol Service) based at King Edward Memorial Hospital in Perth, provides a specialist service to women who experience alcohol and other drug-related problems during their pregnancy. In order for women from rural or remote areas to use this service they must leave their community, family and social supports. Workforce development initiatives can respond to these service gaps by building the capacity of workers who provide pre-natal care to identify and respond to alcohol and other drug use.

Post partum support is required for mothers and families to maintain changes to their alcohol use and the related health and social issues established during pregnancy. It should encompass support for new mothers who were unable to make changes in their alcohol use during pregnancy. Continued support can improve maternal and child physical health and mental wellbeing as sustainable social structures are secured (Poole 2008). Importantly, comprehensive support in the three years post partum can help mothers with problematic alcohol use or those with children who have FASD increase their ability to parent and reduce the risk of a later child being affected (Poole 2008, p. 14).

### *Workforce development*

Research has found that health professionals are often poorly informed about the implications of alcohol use in pregnancy and do not ask or advise pregnant women about alcohol and pregnancy (Payne, Elliott et al. 2005). This highlights the importance of ensuring that health professional knowledge, confidence and competence is a priority.

Women at risk of using alcohol during their pregnancy are more likely to make contact with general practitioners, health, youth, and education workers (Roche, Pidd et al. 2009). Therefore, in addition to specialist drug and alcohol services, workforce development initiatives must also target general practitioners and mainstream services. Workforce development training and programs should include evidence regarding risky behaviour and the impact using alcohol during pregnancy (Alcohol and Pregnancy Project 2009).

### **Cost of inaction**

National prevalence data under-estimate FASD and is incomplete, making it impossible to determine the economic and social impact of FASD in Australia. International studies conducted in the US and Canada offer limited comparability (Applied Economics Pty Ltd. 2008) as early research focussed on the costs of FAS rather than FASD. Despite this, international research offers a useful indicator for potential costs in Australia:

- US national costs of FAS rose from USD75 million in 1984 to US2.1 billion in 1991 (Lupton, Burd et al. 2004).
- Estimated lifetime costs per FAS case rose from USD596,000 in 1980 to USD2 million in 2002 (Lupton, Burd et al. 2004).
- More recently, Canadian reports (Clarren, Salmon et al. 2011) stated national costs of FASD, for healthcare alone, to be CAD2.1 billion in 2009; lifetime costs per FASD case were also estimated to be CAD1.8 million.

People affected by FASD also have a propensity to experience secondary issues such as: antisocial behaviour, harmful alcohol and other drug use, inappropriate sexual behaviour and mental health problems, with an overall lower capacity for independent living (Streissguth 1993). Again, early US FAS research is useful in providing indicators of potential social costs for FASD in Australia. Streissguth (1993) found that of 415 participants aged 6-51 years, 90 percent had mental health problems; 60 percent experienced disrupted education due to their FAS; 50 percent displayed inappropriate sexual behaviour; and 30 percent were dealing with problematic alcohol and other drug use.



The social costs of FASD are further illustrated with Canadian estimates that between 50-80% of prison inmates were prenatally exposed to alcohol (Russell 2002). FASD is thought to also explain the increasing numbers of young people in Canada's juvenile justice system (Russell 2002).

### **Prevention activity in Western Australia**

In 2010, the Drug and Alcohol Office was provided funding (\$2.2m over 4 years) from the Council of Australian Governments (COAG) to promote healthy women and pregnancies. The *Strong Spirit Strong Future* (SSSF) project (July 2010 – June 2014) falls under COAG's *Closing the Gap Indigenous Early Childhood Development National Partnership*. Guided by the National Health and Medical Council's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (2009) the primary messages of SSSF are:

- "If you are pregnant, planning a pregnancy or breast feeding *no* alcohol is the safest choice for growing a strong and healthy baby"
- "Family and friends can help you to make sure you give your baby a strong spirit and strong future"

In 2010, SSSF held a consultation forum in Perth with more than 40 Aboriginal community members representing academic, primary health, alcohol and other drug organisations throughout Western Australia. The forum aims included:

- Informing attendees of current evidence-based responses to FASD prevention
- Consulting with Aboriginal professionals and community members so they can contribute and share ideas in the development of culturally secure resources and prevention responses for the community
- Building community and sector networks to support the sharing of knowledge, project awareness and implementation.

Participant information was presented in two streams; community awareness and prevention, and workforce development. Forum feedback included recommendations to:

- **Improve** professional awareness
- **Strengthen** workforce competency and confidence to deliver evidence-based prevention actions
- **Develop** and **deliver** culturally secure information for Aboriginal community members.

In partnership with a Key Aboriginal Advisory Group, SSSF has incorporated forum feedback into the following prevention strategies:

- Development and state-wide release (September 2011) of a community relevant SSSF social marketing campaign
- Engagement in regional consultation
- Delivery of relevant training to build and support workforce confidence around FASD prevention
- Creation of culturally secure project resources such as:
  - posters
  - an information brochure
  - a flipchart for use by health workers about healthy women and pregnancies
- Providing small grants for communities to localise or develop FASD prevention messages.

DAO is also aware of a range of FASD-related activities taking place in Western Australia including:

- Alcohol and pregnancy project, undertaken by the Telethon Institute for Child Health Research (TICHR) including yet to be released resources (i.e. FASD screening and diagnostic tool)
- Research by France and Henley (France, Henley et al. 2010) regarding the development of evidence-based social marketing addressing alcohol and pregnancy in non-Aboriginal communities. DAO is working with these authors on the development of a concept for a nationally applicable prevention campaign.
- Model of Care (Department of Health, WA) – In 2010, a WA Department of Health *FASD Model of Care* was released addressing FASD prevention and

management. The model was endorsed by a broad range of stakeholder groups that contributed to or were consulted in the development of the MOC. The Department of Health model addresses the following areas:

- prevention
- screening and early detection
- diagnosis
- therapy, care and intervention
- workforce development
- research and evaluation.

[www.healthnetworks.health.wa.gov.au/modelsofcare/docs/FASD\\_Model\\_of\\_Care.pdf](http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/FASD_Model_of_Care.pdf)

This section about Prevention Activity in Western Australia provides information about projects that DAO is currently involved. There are other projects taking place in Western Australia related to FASD which are not referenced here.

## **Conclusion**

Prevention strategies have a higher likelihood for effecting behaviour change at an individual level when physical, social and political environments are also targeted (Reilly, Cincotta et al. 2011).

There are a number of opportunities for future action in the delivery of effective FASD prevention, assessment and intervention services in Western Australia. These include:

- Key prevention and workforce development initiatives
- Action relating to the availability of holistic and targeted interventions directed at pregnant women and those of childbearing age
- Strategies that respond to the needs of at-risk regions and communities
- Conducting a social marketing campaign to address alcohol use by women who are planning a pregnancy, pregnant or breastfeeding. This campaign should address mainstream populations. This campaign would also address the fact that “FASD is not an Aboriginal problem” (Pyett, with Loughron et al. 2007, p. 12).

The Drug and Alcohol Office would be prepared to provide further information regarding its FASD prevention projects to the Committee if required.

## References

- Alcohol and Pregnancy Project (2009). Alcohol and pregnancy and Fetal Alcohol Spectrum Disorder: A resource for health professionals (1st Revision). Perth, Telethon Institute for Child Health Research.
- Applied Economics Pty Ltd. (2008). Cost description study of fetal alcohol spectrum disorder: Alcohol and Indigenous Programs Section. Drug Strategy Branch, Department of Health and Ageing.
- Burgoyne, W. (2006). What we have learned: Key Canadian FASD Awareness Campaigns. Ottawa, Canada, Public Health Agency of Canada.
- Clarren, S. K., A. Salmon, et al. (2011). Prevention of Fetal Alcohol Spectrum Disorder FASD: Who is responsible? Weinheim, Germany, Wiley-Blackwell
- Dell, C. A. and G. Roberts (2005). Alcohol use and pregnancy: An Important Canadian Public Health and Social Issue, Public Health Agency of Canada.
- Foundation of Alcohol Research and Education (2011). Alcohol Product Labelling: Health Warning Labels and Consumer Information. Deakin, ACT, .
- France, K., N. Henley, et al. (2010). "Health professionals addressing alcohol use with pregnant women in Western Australia: barriers and strategies for communication." Substance Use & Misuse **45**: 1474-1490.
- House of Lords (2011). Behaviour Change. 2nd Report of Session 2010–12. London, House of Lords Science and Technology Select Committee, (HL Paper 179).
- Lupton, C., L. Burd, et al. (2004). "Cost of fetal alcohol spectrum disorders." American Journal of Medical Genetics Part C: Seminars in Medical Genetics **25**(4): 11.
- Murphy-Brennan, M. G. and T. P. S. Oei (1999). "Is there evidence to show that Fetal Alcohol Syndrome can be prevented?" Journal of Drug Education **29**(1): 5-24.
- National Health and Medical Research Council (2009). Australian Guidelines to reduce health risks from drinking alcohol. Canberra, Commonwealth of Australia.

O'Leary, C. M. (2002). Fetal Alcohol Syndrome: A Literature Review, National Expert Advisory Committee on Alcohol.

Payne, J., E. Elliott, et al. (2005). "Health professionals' knowledge, practice and opinions about fetal alcohol syndrome and alcohol consumption in pregnancy." Australian and New Zealand Journal of Public Health **29**(6): 558-564.

Poole, N. (2008). Fetal Alcohol Spectrum Disorder (FASD) prevention: Canadian perspectives, Public Health Agency of Canada. Division of Childhood and Adolescence. **2010**.

Pyett, with Loughron, et al. (2007). Fetal Alcohol Syndrome: A literature review for the 'Healthy pregnancies, healthy babies for Koori communities' project. Melbourne, Victoria, Premier's Drug Prevention Council, Department of Human Services.

Reilly, R. E., M. Cincotta, et al. (2011). "A pilot study of Aboriginal health promotion from an ecological perspective." BMC Public Health **11**(749).

Roche, A. M., K. Pidd, et al. (2009). "Achieving professional practice change: From training to workforce development." Drug and Alcohol Review **28**(5): 550-557.

Russell, A. (2002). Report on Fetal Alcohol Syndrome in Australia and the Yukon 2002 Prairie Northern Conference on Fetal Alcohol Syndrome, National Organisation for Foetal Alcohol Syndrome and Related Disorders.

Saggers, S. and D. Gray (2007). Defining what we mean. Social determinants of Indigenous health. Bronwyn Carson, Terry Dunbar, Richard D. Chenhall and R. Bailie. Crows Nest, NSW, Allen & Unwin.

Stockwell, T. (2010). Designing Community Action Research to Advance Local Alcohol Policy. Hope, Hype or Hard Evidence? Alcohol and Other Drugs Practice in the New Millennium (Pre-Symposium Workshop), Fremantle, WA, Drug and Alcohol Office.

Streissguth, A. (1993). "Fetal alcohol syndrome in older patients." Alcohol and Alcohol Suppl **2**: 209-212.

Streissguth, A., H. M. Barr, et al. (1997). Primary and secondary disabilities in Fetal Alcohol Syndrome. The challenges of Fetal Alcohol Syndrome: overcoming secondary disabilities. A. Streissguth and J. Kanter. Seattle, University of Washington Press: 250.