SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON SOCIAL POLICY AND LEGAL AFFAIRS

INQUIRY INTO FOETAL ALCOHOL SPECTRUM DISORDER

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Background

The Australian Women's Health Network (AWHN) is a community-based, non-profit consultative organisation with members in every state and territory across Australia who share the common purpose of working to improve the health and wellbeing of Australian women.

AWHN works with policy makers, service providers and communities to advance a national voice on women's health through advocacy and information sharing. AWHN works to have a social view of health more widely understood and accepted in Australian health policy and Australian health debates. A social view is well accepted internationally and has been a major focus of recent World Health Organisation work. A social perspective recognises that social, economic, cultural and political factors have an impact on women's lives and health. AWHN is particularly concerned that gender is recognised as a major determinant of health outcomes.

It is important to acknowledge that the lead writer on this submission was Women's Health Statewide SA Aboriginal Women's Health team. In recent months, this team has set about developing and delivering strategies aimed at promoting awareness of maternal alcohol use and foetal alcohol spectrum disorders (FASD) to the SA health workforce.

Although this project is directed toward Aboriginal women, FASD is of concern for all women nationally and indeed internationally, as it affects not just the individual but also the family and community as a whole. Given that FASD results from maternal alcohol use and that avoiding alcohol in pregnancy is the single means of eliminating this risk, it is women who must be empowered with the skills and knowledge to take control of this issue.

The AWHN supports the view that women must be supported through preventative health and sexual health education and throughout their pregnancies in order to make informed choices, optimising health outcomes for themselves and their child.

Maternal alcohol use and FASD – what is FASD and what is the scope of problem in Australia?

Alcohol is toxic to the developing brain and prenatal alcohol exposure can lead to one of the foetal alcohol spectrum disorders, the greatest cause of non-congenital permanent brain damage (1). Amongst other abnormalities, foetal alcohol exposure can result in an increased rate of cell brain death, disrupt cell migration, impede the function of neurotransmitters in the brain and can cause significant structural brain abnormalities. According to Elliott, Professor in paediatrics and child health and one of the lead researchers on FASD in Australia, the tetrogenic effects of maternal alcohol exposure are significant in that "no other drug is quite as toxic to the fetus" (2).

Children affected with FASD face a lifetime of social, emotional and behavioral challenges. They often require ongoing family support and community assistance in areas such as housing, employment and education. Many are involved in the criminal justice and the mental health systems. It has been estimated that 90% of children with FASD develop mental health problems by the age of 6 years (3).

There is currently no accurate data on the prevalence of FASD in Australia. However, we do know that alcohol consumption in Australia is a widely accepted and long standing part of our culture. We also know that levels of alcohol consumption amongst Australian women, particularly young women, have shown a significant increase in recent decades and that alcohol use in pregnancy is also common (4). One recent Australian study, for instance, indicated that up to 80% of women drink alcohol during pregnancy (4, 5).

Estimates of the true incidence of FASD are difficult to ascertain, given the under-recognition and under-reporting of this condition in Australia (3).

Social determinants – alcohol use and women

Addressing the key determinants that underpin factors contributing to alcohol use amongst women is an essential part of this debate. This is particularly true for women who are at-risk of excessive alcohol use as they are also at greater risk of unplanned pregnancy (3, 12). Issues of underlying disadvantage for women are invariably complex. These can include family abuse, conflict or violence, social and cultural isolation, poverty, poor mental health and co-morbidity, poor housing, racism, marginalisation and reduced health literacy (13). It has been suggested that poverty is the major contributing determinant to maternal alcohol use in women, with the consumption of harmful levels of alcohol used as a coping mechanism in dealing with a history of despair, trauma, abuse and stress (3, 5).

What this means for women

Strategies in preventing, intervening and managing FASD needs to be contextualized with consideration given to all contributing factors to maternal alcohol use. Until these are acknowledged and women are supported in managing them, the incidence of maternal alcohol use cannot be expected to significantly decline. In addition, the lack of accurate and consistent information means that many women continue to drink throughout the gestation period, unaware of the full extent of risk and potential consequence to the foetus (13).

Evidence suggests that the opportunity for behaviour change is considered high during pregnancy as women are motivated by the health of their baby (13). Therefore women who are made aware of the risks associated with maternal alcohol use and are supported appropriately are more likely to abstain or cut back during pregnancy and as such are more likely to have a healthier baby.

Health professionals – what are we doing about FASD?

While the National Health and Medical Research Council‘s (NHMRC) guidelines (2009) on the safe levels of alcohol consumption in pregnancy leave no room for ambiguity, they remain poorly communicated to women and their families in both the clinical and community settings (8, 9,10). Recent Australian studies indicate that less than half of health professionals routinely enquire about alcohol use by pregnant clients. The accuracy of information supplied also remains questionable, with one study indicating that only 13% of professionals surveyed gave information and advice to clients that was consistent with NHMRC guidelines (10).

Despite the NHMRC guidelines on maternal alcohol use, significant debate continues regarding the risks to feotal development resulting from low to moderate levels of alcohol use during pregnancy. Occasionally this debate spills into the public arena via the media and contributes to an ongoing lack of clarity across all sectors as well as in the community.

Sexual health education and counseling, in particular contraception promotion by health professionals, is imperative in minimising the risk of not only un-planned pregnancy, but also of FASD if women are consuming alcohol. Studies show that approximately 50% of pregnancies are un-planned (3, 11) with much higher levels likely in certain communities and therefore many pregnancies could be inadvertently exposed to alcohol. The incidence of FASD could be significantly reduced if women had greater control over their sexual health choices, including information about and greater access to appropriate

contraceptives, which should include the female condom. At present the female condom is too expensive to allow widespread use but it is an extremely effective preventative measure not only against pregnancy but against sexually transmitted infections which are, unfortunately, on the rise. FASD could also be significantly reduced if women were aware of the need to stop drinking if planning a pregnancy and if they were adequately supported to do so.

RECOMMENDATIONS

1. PREVENTION STRATEGIES

Public Policy

1.1. Develop a broad alcohol and other drug strategy – with particular focus on young women and other at-risk groups

1.2. Develop a national sexual health strategy that includes access to comprehensive sexual health and relationship education and free emergency contraception through publically funded health sites

1.3. Mandatory nationally agreed alcohol screening tool (ask, assess, advise, assist and arrange), universally available for all women as part of antenatal care

1.4. Collaboratively support community initiated and driven regulation of alcohol control measures similar to those in parts of northern WA

1.5. Fund existing services to incorporate models such as the Aboriginal Maternal and Infant Care (AMIC) program in SA in engaging with pregnant Aboriginal women

Health Promotion

1.6. Develop a strong collaborative approach in delivering effective public awareness campaigns – evidence based and informed by a wide range of interest groups and community members

1.7. Encourage a change in community attitudes towards alcohol consumption not just change in the attitudes of pregnant women (health promotion messages must be developed in a way that does not stigmatise or victim blame pregnant women)

1.8. Initiate a broad national media campaign that is consistent and sustained, with funding for local initiatives appropriate for Aboriginal women, men and their families

1.9. Promotion should extend to health warning labels on alcoholic beverages and the campaign must be clearly visible at point of sale.

Education

1.10. Develop a national approach in educating all health professionals to increase their skills and knowledge in FASD

1.11. Promote the risks of maternal alcohol use to all young women and men as part of a comprehensive sexual health education program in schools and community services

1.12. Promote professional awareness and competence in delivering health messages in a culturally secure and appropriate way to Aboriginal women

Research

1.13. Invest in ongoing national research to better contribute to global and national understanding

1.14. Draw on international research and successes and adapt these to local populations, where possible

2. INTERVETNION STRATEGIES

2.1. Development of a national FASD diagnostic tool that includes language and cultural considerations (as early diagnosis and intervention is vital to minimise impact of secondary conditions affecting the individual's social, emotional and behavioural capacity. Screening and intervention must commence as early as possible)

2.2. Fund child development and paediatric services to screen children with suspected FASD

2.3. Provide training to improve professional capacity to support women and their families appropriately

Programs

2.4. All programs must acknowledge the social complexities around maternal alcohol use and adopt a holistic and flexible approach in raising FASD awareness

2.5. Opportunistic brief intervention and motivational interviewing for all women presenting for antenatal care irrespective of alcohol use

2.6. Support must be provided in a non-threatening, respectful way to all women, their partners and their families using a holistic and continuum model of care

2.7. Provide intensive social support to women and families if woman identified as high-risk

2.8. At-risk pregnant women should be supported through withdrawal and rehabilitation services during pregnancy if needed as a matter of priority

2.9. Specifically promote FASD awareness to men and ensure they are equally informed of the risks of maternal alcohol use. Men must be encouraged to consider that the fathering role begins from conception. They should also be supported to modify their alcohol use during the pregnancy

2.10. Specifically promote FASD awareness to men and ensure they are equally informed of the risks of maternal alcohol use. Men must be encouraged to consider that their contribution to the biology of the child begins with preparation for fathering (that is, at least three months before conception and requires minimal alcohol, no smoking and no illicit substance use such as cannabis). Men should also be supported to modify their alcohol use during the pregnancy and after if their partner is breast-feeding.

3. MANAGEMENT STRATEGIES

3.1. Develop guidelines for comprehensive and effective early intervention, management and support for individuals and family affected by FASD

3.2. Provide a range of support across the continuum as the condition is life-long and requires a cross-agency approach

3.3. Recognition of FASD as an eligible diagnostic category for disability support services

3.4. Greater support and funding to existing groups such as NOFASARD to increase their capacity to provide advocacy and support to service providers, community, families and individuals affected by FASD

3.5. Provide education, funding and support to services caring for individuals with FASD in particular to schools, child protection, disability services

3.6. Develop a joint agency response with the criminal justice system (CJS) to more effectively support individuals with FASD and their families, to better inform sentencing processes and to divert individuals with FASD away from the CJS to targeted programs

3.7. Provide education, funding and support to mental health, drug and alcohol services and social services such as employment, housing and training to better support individuals with FASD

3.8. Ongoing nationally coordinated evaluation processes to track progress and changes in trends

Summary

Many decades after the effects of alcohol use in pregnancy were identified internationally, FASD continues to present a number of significant challenges in Australia as we are slow to recognise FASD as a problem. However, recent years has seen an emergence of this issue nationally with the profile of FASD being raised in both the government and non-government sectors across all states.

The establishment of this inquiry and submission process is a significant advance in addressing the issue as it endeavors to bring Australian policy in-line with international best practice and AWHN welcomes the opportunity to contribute to this inquiry. We acknowledge that issues surrounding maternal alcohol use are highly complex and cross the spectrum of gender, social and cultural status. A national approach is vital in consolidating current initiatives and moving this very important issue forward.

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