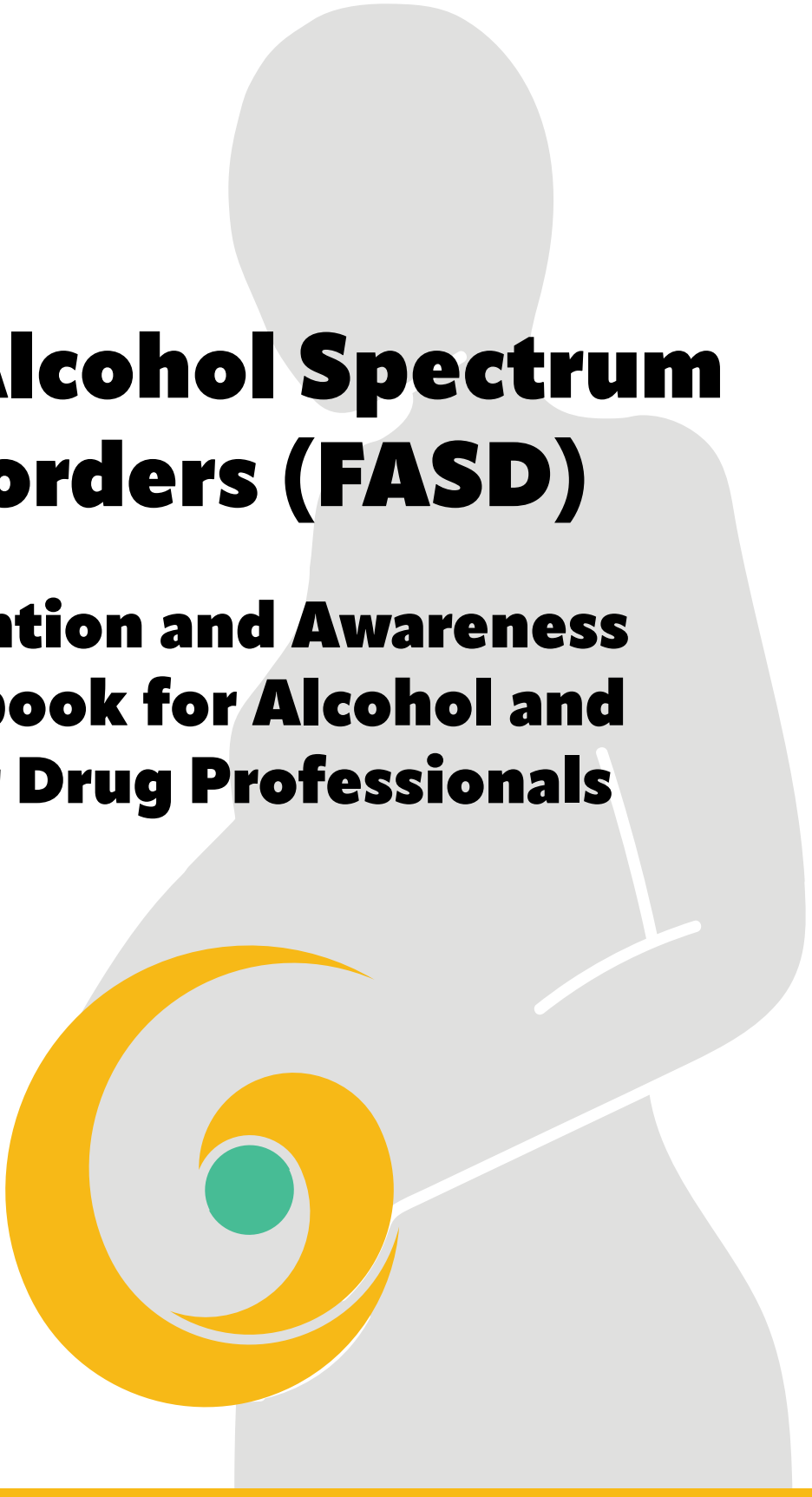
Fetal Alcohol Spectrum Disorders (FASD)

Prevention and Awareness Handbook for Alcohol and Other Drug Professionals



Contents

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NOFASD Australia acknowledges and pays respect to the past, present, and future Traditional Custodians and Elders of this land and the continuation of cultural, spiritual, and educational practices of Aboriginal, Torres Strait, and South Sea Islander people.

Aboriginal, Torres Strait, and South Sea Islander communities have been stigmatised as communities heavily affected by alcohol and Fetal Alcohol Spectrum Disorder. This stigma is false and harmful; alcohol is pervasive in Australian culture and Fetal Alcohol Spectrum Disorder is not an issue limited to one community.

NOFASD Australia extends their gratitude to the many Aboriginal, Torres Strait, and South Sea Islander communities that have shown clear and strong leadership in Australia's efforts to reduce the harmful use of alcohol and improve recognition of Fetal Alcohol Spectrum Disorder.

The Drug Education Network acknowledges the strength, resilience and capacity of the Tasmanian Aboriginal people and their deep and lasting cultural heritage, beliefs and relationship as ongoing custodians of the land and waters of lutruwita/Tasmania. We recognise that our organisation operates on the land of the traditional custodians and we pay our respect to Elders past and present. DEN is proud to work with the Tasmanian Aboriginal community to prevent the harms caused by alcohol, tobacco and other drugs.

NOFASD Australia and DEN recognise that people who do not identify as female or women can become pregnant. We are committed to improving the health inequalities faced by non-binary, transgender, Two-Spirit, gender fluid, agender, bigender, and gender queer folk. All Australians have the right to access safe and inclusive healthcare.

Fetal Alcohol Spectrum Disorder is experienced by all communities where alcohol use is present and recognition of the role of alcohol in all pregnancies must be championed. Any birthing parent or person who is breast or chest feeding must be aware of the potential for negative impacts from alcohol on a fetus, or an infant drinking human milk.

Information regarding the need to avoid alcohol use when planning pregnancy, experiencing pregnancy, or when breast or chest feeding, must be made available to all Australians. Health and community services professionals play a vital role in sharing accurate information about the potential harms of alcohol and referring people to services for help with alcohol misuse.

Terms to consider in your daily practice:

- Chest feeding: Process of feeding human milk from a person's chest. Used by people who do not identify as having breasts.
- Birthing parent: Gender neutral term for the parent carrying a fetus to term.
- Childbearing reproductive organs: Gender neutral term instead of 'female reproductive organs'.

Currently, the available alcohol and pregnancy literature focuses on the experiences of cisgender women. In order to accurately reflect the available evidence base, this document discusses the issue of alcohol harms and Fetal Alcohol Spectrum Disorder from the perspective of cisgender women. It is imperative for the professionals accessing this document to recognise that the lessons apply to all people across the gender spectrum. Be willing to adapt your language to the client and their needs.

Stopping alcohol use in pregnancy and breast or chest feeding is the role of all Australians, no matter their age, gender, sexuality, or ethnicity. NOFASD Australia and DEN aim to support the Australian LGBTQIA+ community to engage with materials and support free from stigma and discrimination.

Section 1: About Fetal Alcohol Spectrum Disorders

ALCOHOL, PREGNANCY AND FASD

Alcohol is an accepted part of Australian culture and lifestyle. It is woven into the fabric of society and is used in many cultures (Australian Institute of Health and Welfare, 2018; World Health Organisation, 2018). It is present in our social activities, celebrations, in our toasts to 'good health' at the dinner table, and in our shopping centres and supermarkets. Australians have previously reported social pressure to consume alcohol as drinking was viewed as a societal norm and to not drink was viewed as anti-social behaviour (Jones & Telenta, 2012; Kelly et al., 2000; Supski et al., 2017).

This viewpoint is slowly changing among young adults across the globe, as increased self-efficacy, the importance of consent, and the dangers of alcohol have been championed across multiple platforms (Jongenelis et al., 2018; Lu et al., 2019; OECD Data, 2021). Alcohol misuse is widely recognised as a serious, global public health issue. Misusing alcohol can result in a wide range of physical, psychological, and social problems affecting the individual, the family, and the community (Australian Institute of Health and Welfare, 2017; Barry et al., 2010; Roozen et al., 2018).

Any amount of alcohol use is of concern to people who can become pregnant and breastfeed. Alcohol passes through the placenta to the fetus, and the liver of the fetus cannot effectively process alcohol (Australian Medical Association, 2016). Alcohol resides in human milk and can be consumed by infants who are fed with human milk (May et al., 2016). Alcohol consumption during pregnancy is linked to a range of adverse consequences, including miscarriage, stillbirth, low birth weights, and Fetal Alcohol Spectrum Disorders (FASD) (Dejong et al., 2019).

FASD is an umbrella term used to describe a range of disabilities that result from prenatal alcohol exposure (Bower & Elliott, 2020). Children born with FASD have a lifelong, preventable disability and can experience abnormalities including behavioural problems, birth defects, impaired growth, and learning difficulties (Dejong et al., 2019).

FASD is a serious and complex health and social concern which is under-recognised and under-diagnosed. Individuals with FASD are impacted at varying degrees and their manifestations differ, as described in SECTION 2: UNDERSTANDING THE PROBLEM. The prevalence of FASD exceeds that of other developmental disabilities, yet it is less visible and further stigmatised (Dunbar Winsor, 2021). FASD is often referred to as an invisible disability, which contributes to the barriers and systemic challenges faced by individuals with FASD in accessing supports and resources (Dunbar Winsor, 2021).

2021 - WHERE ARE WE NOW?

Over the past decade, some encouraging progress has been made in the prevention of prenatal alcohol exposure and FASD. The public health sector has seen greater recognition of FASD as evidenced by a series of national action plans and the introduction of Australian diagnostic guidelines.

2012 – Parliamentary inquiry into Fetal Alcohol Spectrum Disorders, report produced entitled - FASD: The Hidden Harm (House of Representatives Committees, 2012)

The Parliament of Australia was approached for the first time to report on a national approach to the prevention, intervention, and management of FASD in Australia. Australia was found to be falling behind other OECD nations in diagnosis of FASD which was

recognised as negatively influencing prevention and intervention efforts. A national action plan was deemed necessary.

2013 - The National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2014)

The 2013 National Drug Strategy Household Survey included questions related to the amount of alcohol that women consumed in pregnancy. This was the first time these questions had been added to the survey thus creating a benchmark for future exploration.

2013 - The Australian Fetal Alcohol Spectrum Disorders Action Plan 2013–2016 (FARE, 2013)

The Commonwealth Action Plan identified five priority areas for action to reduce the impact of FASD across Australia:

- Support a whole of government approach to the issue of FASD, given its relevance to a broad range of services and supports across portfolios.
- Take a whole of population approach to the issue, whilst noting that targeted approaches to prevention and management should be pursued for populations at greatest risk from FASD.
- Recognise the preventable nature of FASD and support continuation of efforts to prevent FASD, building upon existing government program activity.
- Support access by children and families impacted by FASD to services based on need and level of functional impairment.
- Support the health and broader workforce to prevent FASD and to better respond to the needs of families impacted by it.

2016 – Australian Guide to the Diagnosis of Fetal Alcohol Spectrum Disorder (FASD) (Bower & Elliott, 2020)

The Australian Guide to the Diagnosis of Fetal Alcohol Spectrum Disorder was released in 2016 and subsequently updated in 2020. The guide includes the Australian Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Instrument and Handbook. The aim of the guide was to standardise diagnostic processes across Australia and improve rates of referral and ongoing support. The guide highlighted the need for recognition of exposure to additional teratogens (such as tobacco, infections, recreational drugs) and psychosocial exposures (such as poverty, neglect, and trauma) which emphasised the complexities associated with FASD diagnosis.

2018 - National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028 (Department of Health, 2019)

The National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028 provides a clear pathway of priorities and opportunities to improve the prevention, diagnosis, support, and management of FASD in Australia. The FASD Strategic Action Plan aims to improve the quality of life for children and adults who have FASD. The Plan is built around four key national priorities:

- Prevention
- Screening and diagnosis
- Support and management
- Priority groups and people at increased risk

The enablers of these priorities include:

- Appropriate recognition of FASD as a disability
- Eliminate stigma
- Education and training
- Policy coordination
- Research and evaluation

2019 - Australian Senate Inquiry into Fetal Alcohol Spectrum Disorder (FASD) (Parliament of Australia, 2021)

On 9 September 2019, International FASD Awareness Day, an inquiry was referred to the Senate Community Affairs References Committee into effective approaches to prevention and diagnosis of FASD and strategies for optimising life outcomes for people with FASD. Individuals, organisations, and institutions across Australia made submissions which explored the breadth of the impact of FASD on Australian communities. The Senate's final report detailing their findings from the inquiry was released in March 2021.

The report stated:

"Whilst [efforts since 2012] reflect a national willingness to understand FASD, broaden public understanding, and support the development of pioneering programs and models of care in local communities, FASD remains a serious yet entirely preventable disability that continues to have profound and long-lasting consequences for individuals and their families, carers and communities across Australia. Overall, FASD interventions have been ad hoc and inconsistently applied across Australia, and there is still limited awareness of FASD in the community."

"Prevention efforts must fundamentally aim to shift societal attitudes and behaviour around alcohol consumption in the broader Australian community . . . a longer-term strategy and funding for FASD awareness and education, including in secondary school curriculums."

2020 - National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC Guidelines) updated (NHMRC, 2020)

The National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC Guidelines) were updated in 2020 to improve clarity regarding the harms of alcohol in pregnancy and breastfeeding. Guideline three is targeted at people who are pregnant or breastfeeding and states:

"A. To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.

B. For women who are breastfeeding, not drinking alcohol is safest for their baby." (NHMRC, 2020)

2020 - FASD – National Awareness Campaign for Pregnancy and Breastfeeding Women

The Foundation for Alcohol Research and Education (FARE) were awarded funding to support four years of activity aiming to increase the general Australian public's awareness of the harms of alcohol exposure in pregnancy and breastfeeding, increase the proportion of Australians who understand that alcohol should not be consumed during pregnancy, and reduce the proportion of people who intend to consume any amount of alcohol during pregnancy or breastfeeding.

While the increased recognition of the harms of prenatal alcohol exposure is encouraging, every child affected by FASD represents a preventable disability. It is critical that work continues to promote messages about FASD prevention to vulnerable and at-risk people in our community.

WORKING TOWARDS SOLUTIONS

For FASD awareness and prevention to be successful, we need to:

- Improve the community's understanding and responsiveness in supporting people who use alcohol in pregnancy.
- Deepen our understanding of the various barriers and challenges Australians face in seeking assistance and support for their alcohol use.
- Recognise that alcohol use is impacted by social pressure from partners, peers, and family members so the consumption of those in a woman's support network must be considered.
- Educate Australian youth about the impacts of alcohol in pregnancy and the importance of contraception and safe sex practices so they can make informed choices before engaging in alcohol consumption and sexual activity (Erng et al., 2020; Symons et al., 2018).

The 2020 FASD National Awareness Campaign identified three key target groups for prevention efforts from the Alcohol and Other Drug sector:

- Women who are alcohol dependent and of childbearing age
- Women who have a child with FASD and are of childbearing age
- Aboriginal and Torres Strait Islander populations

These groups are identified as needing increased support to prevent FASD because they face discrimination based on stigma and increased difficulty engaging with supportive services. However, prenatal exposure to alcohol and FASD are consequences of the social and cultural acceptance of alcohol use, and ready availability of alcohol, in Australia. For this reason, the problem of alcohol misuse is a community responsibility, requiring a community solution.

PREVENTION STRATEGIES

Three prevention strategies underpin the FASD Prevention Handbook:

1. PRIMARY PREVENTION

Primary—or universal—prevention strategies are effective, population-based interventions designed to reduce alcohol-related harms in the general population. The priority groups are part of this general population, and as such may be reached by prevention strategies including:

- Universal, routine screening for problematic alcohol use, delivered to all individuals who have contact with health and community services workers.
- Complementary education programs on alcohol-related harms, including the risk of alcohol use in pregnancy (Symons et al., 2018).

2. SECONDARY PREVENTION

The second level of prevention targets people who can become pregnant who have been identified as being at risk for alcohol use in pregnancy.

This strategy involves screening for problematic alcohol use, followed by education, brief intervention, and referrals to any appropriate resources and support. This approach also includes education and training for health and community workers who are engaging with the target groups (Symons et al., 2018).

3. EARLY INTERVENTION

The third level of prevention is early intervention. This approach is intended to reach people who are in the highest risk category and may become pregnant by offering specialised, holistic support through outreach care and collaborative networks of current agencies. The benefits of this strategy include:

- Support for people to improve control over their alcohol consumption.
- Continued support for those breast-feeding in the postpartum period.
- Support for people who have been able to reduce, and need support to manage, their alcohol use, post-pregnancy.
- Maintenance of an alcohol-free pregnancy and breastfeeding period.
- Potential prevention of future alcohol exposed pregnancies (Symons et al., 2018).

AIMS OF THE FASD PREVENTION HANDBOOK

The primary aim of this handbook is to support service providers and the community in preventing the problem of prenatal exposure to alcohol before it begins, and thereby reducing the incidence of FASD. A secondary goal of this handbook is to assist service providers to educate the community about the hidden harms of alcohol use in pregnancy.

This goal can be achieved by raising public awareness of FASD through shared information and education. This handbook aims to inspire prevention at all levels, across all sectors of the community. We need to educate and train professionals to build best practice in their work with people of childbearing age who use alcohol. Increasing health and community service providers' confidence to openly discuss alcohol use with their clients, especially people who may become pregnant, will help us to identify and address risk early and make progress towards reducing FASD in our community.

USING THIS HANDBOOK

This handbook has been designed to provide users with information and a range of tools and intervention strategies. Health professionals and community service providers are well placed to deliver important health promotion messages to the target populations. They also have an opportunity to inform and support pregnant and breastfeeding women to avoid the harmful effects of alcohol for their baby.

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Section 2: Understanding the Problem

WHAT IS FASD?

In 2016 the Australian Guide to the diagnosis of FASD was released. This includes the FASD Diagnostic Instrument which provides comprehensive and current diagnostic criteria and information. The link to this resource is:

Bower, C., & Elliott, E. J. (2016). Australian Guide to the diagnosis of Fetal Alcohol Spectrum Disorder (FASD). Australian Government Department of Health. https://www.fasdhub.org.au/siteassets/pdfs/australian-guide-to-diagnosis-of-fasd_all-appendices.pdf

Within Australia, a diagnosis of FASD needs evidence of prenatal alcohol exposure and impairment in three or more domains of central nervous system structure or function (Bower & Elliott, 2020). A FASD diagnosis is separated into two categories:

- FASD with three sentinel facial features; and
- FASD with fewer than three sentinel facial features.

FASD with three sentinel facial features substitutes a diagnosis of Fetal Alcohol Syndrome and does not require growth impairment and FASD with less than three sentinel facial features includes Partial Fetal Alcohol Syndrome and Neurodevelopmental Disorder-Alcohol Exposed (Bower & Elliott, 2020).

Fetal Alcohol Spectrum Disorders (FASD) refers to the range of disabilities experienced by infants and children exposed to alcohol in the prenatal period. As previously stated, FASD is the leading, preventable cause of non-genetic, developmental disabilities in Australia and has a lifelong impact (Bower & Elliott, 2020). The complexity of FASD is sorely misunderstood within society; many common behaviours can be perceived as problems with the individuals, or reluctance to comply, rather than implications of the disability (Rutman, 2013). FASD may be overlooked, ignored, attributed to other known, non-genetic conditions, or simply blamed on 'poor' parenting or post-birth environments (Bower & Elliott, 2020; Chasnoff et al., 2015).

FASD is a complex disability with both primary and secondary effects which requires assessment by a multidisciplinary team of clinicians (Bower & Elliott, 2020). Primary effects include poor executive functioning, impairments in memory, challenges with conceptualisation and understanding of abstract concepts, issues in language and comprehension skills, and difficulties with affect regulation (Kodituwakku, 2010). As a result of these primary effects, individuals with FASD are vulnerable to secondary effects such as mental health issues, involvement with the justice system, risky sexual behaviours, and troubles with schooling (Popova et al., 2016).

The primary disabilities associated with FASD are linked directly to the underlying brain damage caused by prenatal alcohol exposure. Exposure can include:

- poor memory
- impaired language and communication
- poor impulse control
- mental, social, and emotional delays.

In addition to neurological damage, individuals may also have physical impairments, ranging from subtle facial abnormalities to organ damage (FARE, 2013).

Alcohol can cause damage to the unborn child at any time during pregnancy. **There is no known safe amount of alcohol during pregnancy or breastfeeding** (NHMRC, 2020). Damage caused by alcohol may be moderated by several factors, including intergenerational alcohol use, parent

age, the mother's health (e.g., nutrition, tobacco use) and environmental factors, such as stress (e.g., due to exposure to violence or poverty) (Bower & Elliott, 2020).

The characteristic physical, developmental and/or neurobehavioral features that lie within the FASD spectrum are seldom apparent at birth. These may not be noticed until the child reaches school age and behavioural and learning difficulties become problematic (Kalberg et al., 2019).

There are gaps in the understanding of FASD within the service provider community. Currently, assessment and service provision are evidence-based. The presentation of 'problem' behaviours and absence of biomarkers typically leads to unfair assumptions about an individual, rather than an offer of helpful strategies. Therefore, useful strategies will be based on the understanding that FASD are physical, brain-based conditions with behaviours that are symptomatic of brain damage impairment (Bower & Elliott, 2020; NOFASD Australia, 2018).

It is difficult to determine the prevalence of FASD in Australia, due to a lack of accurate assessment, screening, and data collection and it is likely that figures underestimate the prevalence of FASD (Burns et al., 2013). Estimates from Canada and the United States suggest up to 5% of the general population is affected by FASD (May et al., 2018; Reid, 2018). Prevalence has been found to be higher among specialist populations including children in out of home care, people in the justice system, and people in remote Indigenous communities that have been heavily impacted by alcohol misuse (Fitzpatrick et al., 2015; Popova et al., 2019).

The true tragedy of FASD is the number of individuals living in our communities who are hindered in their capacity to achieve the best possible quality of life because their brain damage is 'invisible'. Early detection is crucial to understanding and helping individuals living with FASD (Williams, 2018). Secondary conditions, when properly understood, can be viewed as windows of opportunity to create individualised treatment and support services that reflect the needs of each individual affected by FASD (Kodituwakku, 2010).

Many professionals argue that a diagnosis of FASD can create an additional burden for the individual—the cause of FASD is unchangeable, the outcome irreversible, and the stigma is significant. However, a diagnosis can prevent alcohol exposure in future pregnancies. A major indicator of risk for an alcohol-exposed pregnancy is an older sibling with FASD (Ward et al., 2021). The increased severity of physical, developmental, and cognitive disabilities across a woman's subsequent pregnancies can provide important information to support further successful prevention work.

PRIMARY DISABILITIES

The primary disabilities associated with FASD are those the individual is born with, and which most clearly reflect underlying brain damage. These primary disabilities can be summarised by the mnemonic **ALARM** (Lawryk, 2005):

- **A**daptive behaviour
- **L**anguage
- **A**ttention
- **R**easoning
- **M**emory.

The primary conditions common to FASD last a lifetime. The frequency and severity of primary disabilities varies widely, and none of these are exclusive to prenatal exposure to alcohol. This factor can complicate assessment and lead to diagnoses based on observable behaviours that mask the underlying, pre-birth brain injury (Bower & Elliott, 2016).

The extent and range of conditions can vary from person to person and may include:

- learning difficulties
- impulsiveness
- difficulty relating actions to consequences
- social relationship issues
- attention/hyperactivity
- memory issues
- developmental delays
- major organ damage (Bower & Elliott, 2020).

SECONDARY CONDITIONS

> *"When there's a separation between what a child can do developmentally, and what the world expects them to do, pretty soon the expectations of the world begin to create more problems for the child"* – **Dr Bruce Perry**

Primary and secondary conditions are interrelated, and directly impact the individual's daily life and ability to succeed (Rutman, 2013). Secondary conditions arise after birth and could potentially be improved through better understanding and appropriate intervention (Adebiyi et al., 2019).

A longitudinal study of 661 individuals identified protective factors and risk factors related to the development of secondary conditions (Streissguth et al., 2004). Some of the protective factors were:

- living in a stable environment
- a diagnosis by six years of age
- never experiencing personal violence (Streissguth et al., 2004).

In the absence of these protective factors, the risk of developing secondary conditions becomes more probable. Of the study group:

- 90% experienced mental health problems.
- 60% had been in trouble with the law.
- 50% had experienced confinement (either inpatient treatment for alcohol and other drugs dependency or incarceration for a crime).
- 50% of the group had been reported for repeated inappropriate sexual behaviour or referred for offender treatment.
- 60% had a disrupted school experience.
- 30% had experienced problematic alcohol and other drug use (Streissguth et al., 2004).

Secondary conditions develop over time when there is a chronic 'poor fit' between the individual and their environment. The defensive behaviours that develop and are used to categorise and define an individual (e.g., as defiant, wilful and/or disruptive) are explained as normal, protective reactions to frustration and continued failure (McLachlan et al., 2019). These can include:

- inappropriate humour
- fatigue, irritability, resistance and/or argumentative behaviour
- anxiety, fearfulness and/or feeling chronically overwhelmed
- frustration, anger, aggression and/or destructive behaviour
- poor self-concept, often masked by unrealistic goals or self-aggrandisement
- isolation, having few friends and likely experiencing bullying
- family or school problems, including fighting, suspension(s) or expulsion
- running away, or using other forms of avoidance
- being in trouble with the law
- problematic alcohol and other drug use
- depression, self-destructive and/or suicidal behaviours (McLachlan et al., 2019).

PHYSICAL EFFECTS

Historically, diagnosis was focused on three sentinel facial features including small palpebral fissures, smooth philtrum, and a thin upper lip. However, evidence now shows such features are only present in 17% of the FASD population (Bower & Elliott, 2020). The misconception that facial features are key to the presentation of FASD can result in unhelpful assumptions about individuals and can result in missed or misdiagnosis; however, the presence of facial features are only one indicator that would suggest a FASD diagnosis. In their absence, a comprehensive multidisciplinary assessment process is key.

Other physiological effects can occur from alcohol exposure during pregnancy including abnormal development of:

- eyes
- skeleton
- ears
- heart
- kidneys
- mouth and jaw
- sensory system
- immune system (Bower & Elliott, 2020).

By understanding the combined effects of FASD and the range of ways in which prenatal alcohol exposure is expressed, we can begin to paint a picture of how FASD affects individuals and their families. Understanding the complexity of the problem is essential if we are to ensure that people receive the correct support and prevent further impacts.

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Section 3: Women and Alcohol

WOMEN AND ALCOHOL

While alcohol is a public health issue that affects everyone in the community, biological sex and hormones create specific challenges and vulnerabilities in this area for women. The Australian Institute of Health and Welfare reported in 2020 that one in eleven (9.09%) women exceed the lifetime alcohol consumption risk guideline. Lifetime risk is defined as the accumulated risk resulting from consuming alcohol on many occasions or on a regular/daily basis (Australian Institute of Health and Welfare, 2020).

Results from the Australian National Health Survey (2017/18) show that:

- Rates of daily alcohol consumption in Australia have been declining steadily from 19.5% in 2011-12, to 17.4% in 2014-15, to 16.25% in 2017-18.
- More than one in five men (23.7%) and around one in twelve women (8.8%) exceeded the lifetime consumption risk guideline in 2017-18.
- While men were more likely than women to exceed the guidelines, the proportion of men exceeding declined from 25.8% since 2014-15 while the rates for women remained largely unchanged.
- Just over two in five adults (42.1%) aged 18 years and over, consumed more than four standard drinks on one occasion in the past year, exceeding the single occasion use risk guideline. This is a decrease from 44.0% in 2014-15 (Australian Bureau of Statistics, 2018).

Alongside caffeine, alcohol is the most common drug used by women (Peacock et al., 2018). While preventing problematic alcohol use is vitally important, pregnancy is not the only opportunity for alcohol intervention with women.

Within Australia, there has been a link found between higher educational attainment and hazardous drinking (McCormack et al., 2017). Despite this, problematic alcohol consumption continues to be misunderstood as something that is predominantly associated with lower socioeconomic and marginalised groups (McCormack et al., 2017).

ALCOHOL AND SOCIOECONOMIC STATUS

The myth of alcohol use being closely associated with low socioeconomic status (SES) has been countered for a decade.

According to the National Drug Strategy Household Survey (2019):

People living in the highest socioeconomic areas were more likely to drink alcohol than those living in the lowest socioeconomic areas and were more likely to exceed the single occasion risk guidelines, monthly or more often (28% compared with 24%).

After adjusting for age, people living in the lowest socioeconomic areas were about 1.5 times as likely as those in the highest socioeconomic areas to abstain from alcohol in 2019 (31% compared with 21%) (Australian Institute of Health and Welfare, 2020).

THE BIOLOGY OF DRINKING—HOW WOMEN REACT DIFFERENTLY TO ALCOHOL

Numerous factors, related to biology, affect the way women react to alcohol use:

- body size and composition
- age
- genetics
- metabolism
- mental health
- sexual and reproductive health—hormonal changes, menstruation, pregnancy, and contraception (McCaul et al., 2019).

HOW ALCOHOL AFFECTS WOMEN

Due to biological and hormonal differences, women are at greater risk than men for developing alcohol-related problems. When alcohol is consumed, it passes through the digestive tract and is dispersed through the water in the body (McCaul et al., 2019). The more water that is available, the more diluted the alcohol is. Generally, men weigh more than women and, kilo for kilo, women have less water in their bodies than men.

Women's bodies also absorb alcohol slower than men's and have less of the enzyme (alcohol dehydrogenase) that breaks down alcohol before it reaches the bloodstream. Therefore, when a woman drinks, her brain and her internal organs are exposed to more alcohol—and more of the toxic by-products that are produced when alcohol is broken down in the body (McCaul et al., 2019).

SOCIAL ROLES—WHAT SOCIETY EXPECTS OF WOMEN

Powerful social factors are still applied to women which affects the way women react to and cope with alcohol use. These factors can include:

- life circumstances
- stress
- violence and sexual assault
- poverty
- caring roles and responsibilities
- pregnancy and parenting
- child protection, custody and access issues (Burns et al., 2016).

People who are not cisgender men are more likely to be judged harshly for their alcohol use, and many parents are afraid of the potential repercussions of their drinking, such as the removal of children (Black & Day, 2016). This fear of stigma and judgement can make women and non-binary people less likely to seek help.

Hence, prevention messages must view substance use as an issue inherently linked to gender biases, the social determinants of health, and structural inequalities. Professionals must resist the narrative of shame and blame and should aim to reduce the stigma associated with the issue (Poole et al., 2016).

> *'I had to take my kids everywhere with me…and people would make comments or give me looks that made me feel so bad, even when I was trying to get help so I could be a better mother for them!'*
>
> **(Participant in Alcohol and Other Drugs [AOD] Service, 2012)**

ALCOHOL IN PREGNANCY

In 2019, the National Drug Strategy Household Survey included questions related specifically to the amount of alcohol consumed by pregnant women (Australian Institute of Health and Welfare, 2020). This report found that nearly two-thirds (65%) of women abstained from alcohol while pregnant, up from 56% in 2016 and 40% in 2007. This encouraging trend was also evident for breastfeeding, where twice as many women in 2019 (49%) abstained from alcohol compared to 2007 (25%) (Australian Institute of Health and Welfare, 2020).

Of the 35% of women who consumed any alcohol while pregnant, most:

- Usually consumed 1-2 standard drinks (96%) on a typical day when they consumed alcohol.
- Drank monthly or less (90%) (Australian Institute of Health and Welfare, 2020).

Pregnant women were asked about their drug-taking behaviours before they became aware they were pregnant. Of those who were unaware of their pregnancy in 2019:

- Over half (55%) consumed alcohol before they knew they were pregnant.
- Once people knew they were pregnant, 14.5% continued to consume alcohol, down from 25% in 2016.

These results are encouraging, but not a reason for complacency. It is vital that continued prevention efforts are focused on the general population, and population groups with high rates of drinking in pregnancy—and subsequently high rates of FASD. When prevention resources are not targeted to vulnerable population groups, we are inadvertently increasing health inequity.

FASD AND ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

The FASD research focus on Aboriginal and Torres Strait Islander communities has stemmed from understanding the negative impacts of colonisation on Indigenous communities including rates of alcohol consumption. However, this focus has fed the false belief that FASD is only experienced in Indigenous communities. Aboriginal Australian communities have shown incredible leadership in FASD prevention. The Marulu FASD Prevention Strategy saw prenatal alcohol exposure reduce significantly from 61% in 2010 to 32% in 2015. A community-led program combined alcohol policy interventions, health promotion strategies, and community capacity building to target key groups across the community. The strategies developed by Aboriginal and Torres Strait Islander communities need to be adapted to non-Indigenous communities (Symons et al., 2020).

THE REASONS PEOPLE USE ALCOHOL IN PREGNANCY

When a person decides to consume alcohol in pregnancy, there is a reason:

- They may use alcohol before they know they are pregnant.
- They may not understand how harmful prenatal exposure to alcohol is for the fetus.
- They may use alcohol because it is a social norm or expectation.
- They may use alcohol to self-medicate or to cope with stress, poverty, trauma or violence.
- Alcohol use may have developed into a dependency (Burns et al., 2016).

A majority of Australians with substance use disorders report experiencing domestic violence, homelessness, sexual abuse, and involvement with the justice system (Burns et al., 2016). Whatever the reason for alcohol use in pregnancy, open, inclusive, and non-judgemental support is critical in addressing these issues and preventing further fetal alcohol exposure.

GENDER BARRIERS TO SEEKING HELP

Prior to the 1970s, there was a lack of research regarding women with substance use problems, and almost no gender-specific treatment programming. While there has since been a slow increase in research, this has not been matched by women-centred service delivery. Apart from rare programs designed specifically for women, treatment programs are typically male-oriented, and this has the potential to exacerbate structural barriers for women who might otherwise seek help (Meyer et al., 2019; Niccols et al., 2010).

With a gender-oriented perspective, drug use can be understood within the context of non-cisgender male relationships and the influence of wider societal structures (Straussner & Fewell, 2011).

A combination of factors can discourage women from seeking help:

- The lack of visibility of services
- Concerns about confidentiality of information
- Coercive treatment responses
- Numerous, complex, personal and interpersonal factors
- Fear that children will be removed from the individual's care
- Fear of blame and judgement
- Financial concerns (Meyer et al., 2019; Stone, 2015).

On entering AOD treatment, women present with higher rates of mental health issues, experiences of complex trauma as a result of childhood physical and sexual abuse and/or family and domestic violence, AOD-related risk taking, pregnancy and childcare issues and greater social and economic disadvantage (Australian Institute of Health and Welfare, 2017).

Individuals using substances while pregnant have been vilified and portrayed as undeserving of treatment or parenthood in public discourse (Norton, 2018). However, the continued use of alcohol during pregnancy can also be encouraged by partners, friends, and family. Support networks may feel challenged by a person's decision to change their alcohol consumption as it may force them to consider their own health and lifestyle choices.

Peer groups, families and partners play a significant role in informing each other's views on alcohol use during pregnancy. Principles of family-inclusive practice offer best practice in this context (Holland et al., 2015).

Those who can become pregnant are not the only ones responsible for preventing FASD. Partners, support networks, and society at large all share a responsibility (Clarren et al., 2011; Symons et al., 2018).

Any contact with people who may become pregnant offers a unique opportunity to build rapport, offer support and gently challenge unhelpful beliefs. These opportunities aid in facilitating disclosure and should be conducted without judgement to explore alcohol consumption patterns and sexual health practices.

Compassionate approaches to difficult or uncomfortable conversations can foster a trusting relationship between health professionals and consumers (Schölin & Fitzgerald, 2019).

GENDER-CENTRED PRACTICE

Gender-centred practice, or gender-responsiveness, considers the needs of people of all genders in all aspects of service design and delivery, including the location and accessibility of services, staffing, program development, content and materials (Poole et al., 2016; Theobald et al., 2017).

From a practical perspective, this means that services need to offer a safe environment which is free from violence, aware of issues related to gender identity, and encourages trust (Metz et al., 2012; Theobald et al., 2017).

Child welfare and child protection authorities often see substance use and heavy alcohol consumption during pregnancy as abuse or neglect (Stone, 2015). This perception contributes to the marginalisation of people experiencing substance use or dependence who fear the loss of custody of their children and therefore feel unable to seek help during their pregnancy.

> *Better coordination across all sectors, including health, education, employment, criminal justice, and a broad range of other community services, is fundamental to improving life outcomes for people living with FASD.*
>
> **(Department of Health, 2019)**

Preventing the problem of prenatal exposure to alcohol before it begins means universally targeting people of childbearing age, and selectively targeting people at high risk of alcohol use in pregnancy (Symons et al., 2018). A gender-centred approach consults, and is directed by, the person themselves, and is driven by what those people want and need (Gilbert et al., 2019).

Ongoing consideration of the health concerns that are unique to each person who may become pregnant, and the personal experiences they bring from all their varied roles, is critical.

> *Gender-centred practice is underpinned by social justice principles and inclusiveness and encourages people to participate in planning, evaluation, policy development and research that supports advocacy for their issues*
>
> **(Theobald et al., 2017).**

CRITICAL CONVERSATIONS

Many service providers find conversations about alcohol use challenging. Health care professionals are at the forefront of screening, counselling, and referring people who are dependent upon alcohol to appropriate services (Oni et al., 2019). Unfortunately, many professionals do not feel confident to make this part of their routine consultation process (Oni et al., 2019). If these conversations do not happen, valuable opportunities for addressing alcohol-related harms and supporting the health and wellbeing of people who may become pregnant and any child they may have could be lost.

Many health professionals report lacking the skills and confidence to screen for alcohol use and to discuss the impacts of alcohol use, particularly in pregnancy (Aly, 2015). Some service providers may believe their knowledge is inadequate, or they have personal bias about which groups of people typically use alcohol in pregnancy. While this bias often arises from a concern for the vulnerability of the unborn child, ignoring the personal experience of the person who is pregnant can create a barrier for change (Oni et al., 2019).

A gender-centred approach takes the pressure off the service provider to have all the answers. Instead, this approach allows for client-directed service and genuine collaboration between a consumer and supportive service provider.

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Section 4: The Prevention of FASD

THE PREVENTION OF FASD

Preventing the misuse and harm of alcohol and other drugs (AOD) is all about health and wellbeing. Prevention is cost-effective, reduces harm and improves quality of life. It is part of health promotion and empowers people to be in charge of their own health (Sims & Aboelata, 2019). Prevention needs to be woven into every aspect of our lives—where and how we live, learn, work, play and age. Effective prevention requires us to take action to stop or delay the uptake of substance use. It protects against the harms that can occur from frequent use or misuse, and embraces and presents options for action, ranging from substance-free choices to harm minimisation (Sims & Aboelata, 2019).

Raising public awareness of the risks of alcohol for health and wellbeing, especially during pre-conception, pregnancy, and post-partum, is a key aspect of effective primary prevention efforts. In the context of FASD prevention, it is important to recognise that alcohol use is an issue for all Australians, either directly or indirectly (Schölin et al., 2021).

"I think the overarching message is - and it's already out there - is that alcohol consumption in this country is normalised. You are either a drinker or you're affected by it. And even if you argue that you're not affected by it, your taxes are being spent on addressing the fallout from it."

(Participant in the 2021 NOFASD and FARE Priority Groups interview series)

PREVENTION OBJECTIVES

Preventing prenatal exposure to alcohol and the risk of FASD involves three levels of prevention strategy:

PRIMARY PREVENTION strategies aim to:

- Raise public awareness of the risks of alcohol use in pregnancy.
- Implement universal screening of all individuals for alcohol misuse and in particular, women of childbearing age.
- Educate service providers on prenatal exposure to alcohol, and adverse outcomes, and build capacity for delivering gender-centred practice.
- Communicate positive and consistent prevention messages (Schölin, 2016).

SECONDARY PREVENTION strategies incorporate:

- Raising individual awareness of the risks of alcohol use in pregnancy.
- Raising awareness of the increased risk of unplanned pregnancy (especially when alcohol is consumed at risky levels) (Schölin, 2016).

EARLY INTERVENTION PREVENTION strategies include:

- Implementing routine screening at every community service provider encounter throughout the planning, pregnancy, and postpartum periods.
- Implementing a wrap-around model of community care.
- Engaging service providers, through education and training opportunities, to increase their awareness of the problem and their skills in gender-centred practice (Theobald et al., 2017).

PRIMARY PREVENTION

RAISING PUBLIC AWARENESS

The goal of primary prevention is to avert a problem before it begins. This level of prevention acts as a basis for secondary prevention and early intervention, and aims to reach the largest number of people, raise awareness, and reduce potential stigma and blame (Schölin, 2016).

Evidence-based practice recommends providing health information in a clear, consistent, but tailored manner (Elek et al., 2013). Tailored messages may be required for consumers based on age, income, ethnicity and other differences (the social determinants of health). While there is value in displaying prevention messages in health settings where most people access health and prenatal care (Tsang et al., 2020), this information is also needed at a community level—within service provider agencies, community support organisations, workplaces, schools, and other points of access for consumers.

> *"People don't change because they see a poster; they change because they see a poster in the context of a place they trust, and then a conversation starts, and then you go from there."* **(Fetal Alcohol Spectrum Disorder [FASD] Prevention: A Canadian Perspective)**

PUBLIC EDUCATION

Public education and awareness activities focus on prevention by circulating information and resources. This can happen in a range of ways:

- public information sessions on alcohol use and associated harms
- posters, pamphlets, signs, and advertisements
- conferences and forums
- workshops and focus groups
- participation in public events
- media interviews and releases (Wakefield et al., 2010)
- social media communication platforms.

To be effective, information needs to be relevant, visible, and accessible. Promotional materials should be displayed in public settings, including all health and community service agencies' waiting rooms.

TARGET GROUPS

The target groups for primary prevention are broad, and include:

- all teenagers who are considering engaging with sex and/or alcohol, and pregnant women whose drinking habits can be influenced by public education
- significant others—parents-to-be, family members, or friends
- parents and caregivers.

An informed service provider community is crucial for successful primary prevention. To maximise reach, this community should include:

- general practitioners
- health and allied health workers
- social workers
- speech and language therapists
- teachers
- alcohol and other drug support workers
- youth workers
- early childhood educators
- community workers (e.g., accommodation and youth)
- women's services support workers
- program administrators
- community volunteers.

UNIVERSAL SCREENING

The issue of prenatal exposure to alcohol can begin to be addressed with the widespread practice of universal screening for alcohol use. Many pregnant women who continue to use alcohol are not detected, which can lead to children being born with FASD (Aly, 2015). Universal screening needs to happen at every health and community service client visit (people of all genders, adolescent and adult). When it is delivered effectively in the context of a brief conversation, screening is inclusive, non-stigmatising, and effective at targeting pre-conceptual and pregnant people.

Approximately half of all pregnancies are not planned, and confirmation may not occur until well into the first trimester, so screening should be treated as a public health imperative due to the high risk of prenatal alcohol exposure (Burns et al., 2020). Past alcohol use patterns are predictive of alcohol use in pregnancy, so it is beneficial to raise community awareness and educate the public. This can influence change in attitudes and behaviours, especially prior to pregnancy. Community education, facilitated through shared knowledge across intimate, non-intimate, family, and professional relationships, is vital.

Australians aged 15 years and older consume 9.5 litres of pure alcohol per capita per year (Australian Institute of Health and Welfare, 2020): It is clear that teenagers must also be included in universal screening.

The health promotion strategy and message are succinct—inform all individuals of the phases in life when alcohol should not be used, and why:

- during childhood and adolescence
- when planning a pregnancy, or during pregnancy and breastfeeding.

SCREENING TOOLS

While screening is not treatment and does not provide a complete assessment of a problem, screening has been shown to increase an individual's awareness of their alcohol use. Additionally, screening provides an opportunity for health professionals to discuss harm reduction strategies and provide referral to appropriate services (Finlay-Jones, 2018). The suggested screening tools for high-risk alcohol consumption are used only to identify risk and as a first step in education. These tools prompt discussion and should always be followed up with information on the adverse effects of alcohol on health and healthy fetal development.

AUDIT

An appropriate and evaluated universal screening tool for all adults is the 10-item AUDIT (Alcohol Use Disorders Identification Test) tool, which can be used across all population groups to identify alcohol problems over a person's lifetime.

AUDIT–C

A useful screening tool for pregnant women is the AUDIT–C, which is a shortened version of the 10-item AUDIT tool. This tool has three short questions that estimate alcohol consumption in a standard, meaningful, and non-judgemental way (Calabria et al., 2014).

The AUDIT–C has been validated for use with pregnant women and is recommended by an Australian study that examined what questions should be asked about alcohol consumption and pregnancy. The total score from the AUDIT–C provides an indication of the risks to the person's health and can be used to guide conversations about alcohol and pregnancy (Conigrave et al., 2021).

Any prevention of prenatal exposure to alcohol must include alcohol use by adolescents. The association between alcohol use, unsafe sex, and unplanned pregnancy is an important public health concern. The AUDIT–C is a valid tool that can assess any and/or risky drinking for this cohort. Additional psychosocial assessment (such as the HEADSS questionnaire) can also be conducted to understand overall health and risky behaviours.

SECTION 5: RESOURCES TOOLBOX contains the AUDIT–C tool and link to the HEADSS questionnaire, in addition to other useful tools for prevention and assessment.

SECONDARY PREVENTION

BRIEF COUNSELLING FOR ALCOHOL MISUSE

Secondary prevention strategies apply to selective target groups of people who are at greater risk of alcohol use in pregnancy and for whom risk has been identified through universal screening or referral. Activities are tailored to meet the needs of people at higher risk for an alcohol-exposed pregnancy.

The aim of secondary prevention is to identify and address a problem as early as possible—before it becomes severe or persistent. It is recognised that women identified as being at-risk for alcohol misuse during the pre-conception phase have a higher risk of alcohol use in pregnancy, especially in the first trimester before pregnancy is confirmed.

BRIEF INTERVENTIONS—OVERVIEW

Evidence strongly supports the use of brief interventions as best practice. When they are delivered effectively, brief interventions can promote health and wellbeing for pregnant women and prevent the risk of harm to the unborn child. Brief interventions are evidence based and concise conversations with people who have been found to consume alcohol during screening (Hammock, 2020).

This approach:

- accounts for the particular needs of the person accessing the service
- may be included in outreach programs, following ongoing universal alcohol screening at every visit.

Brief interventions support the process of identifying a person's readiness for change (Barry et al., 2010). Consent is always obtained, and referrals are made for people who require treatment.

The three components of brief intervention are:

- assessment and feedback
- advice regarding strategies at reducing/eliminating problematic use
- involve the consumer in goal setting, creating strategies for change, referrals to support services, and providing pamphlets or handouts for reinforcement and self-help (Dejong et al., 2019).

While most people are self-motivated to change their use of alcohol once pregnancy is confirmed, there are some people for whom the confirmation of a pregnancy can be frightening or a source of great stress.

Caution needs to be applied to ensure that values and beliefs about notions of parenting, pregnancy, and child rearing are not assumed to be shared by all people who engage with health and community services. Not all people can and will cease drinking when they are told about the risks of fetal harm and/or when they find they are pregnant. As discussed in section one, alcohol dependency is complex, and some people cannot choose to cease consuming alcohol even if they understand the risks.

ASK–ASSESS–ADVISE–ASSIST–ARRANGE

The 5As intervention model provides a useful tool for secondary prevention and early intervention approaches. Refer to SECTION 5: RESOURCES TOOLBOX for details.

SERVICE PROVIDER INVOLVEMENT

Secondary prevention is highly dependent on service provider involvement. Australians prefer to receive their health information from their healthcare providers, particularly general practitioners, and nurses. Therefore, healthcare providers are in the best position to inform people of the risks of drinking alcohol during pregnancy.

Healthcare providers need to become FASD-informed to feel comfortable discussing such a sensitive topic (McBride, 2014). Supporting people through pregnancy must begin with health care providers acknowledging and understanding the harms of alcohol. Furthermore, health professionals must be equipped with adequate tools and skills to enable them to support people who are experiencing alcohol dependence (Aly, 2015).

The following considerations are recommended for service providers, to ensure the effectiveness of secondary prevention efforts:

- Service provision must be supportive, non-judgemental, and able to address fear, stigma, misinformation, and prejudice. Culturally- and gender-sensitive service provision offers direct support to high-risk consumers and has the capacity to identify gaps, barriers, and the adequacy of alternatives.
- It is important to recognise that, depending on which stage of the change process a person has reached, alcohol use in pregnancy will remain as a situation of great risk (refer to SECTION 5: RESOURCES TOOLBOX for more information on the Stages of Change).
- Consider any barriers to change that may have been raised in the context of previous or current involvement with the consumer including discrimination based on gender, age, socioeconomic status, religion, ability, and sexuality.
- Reflect on any barriers and determine whether assistance can be provided to ease the stress that these may be causing. For example, consider income, housing, respite care, a violent relationship, limited support, or isolation.

EARLY INTERVENTION

INTENSIVE SUPPORT THROUGH PREGNANCY AND THE POST-PARTUM PERIOD

Early intervention activities are the most intensive. These aim to work with women with a high likelihood of alcohol dependence. In the prevention of prenatal exposure to alcohol, activities are directed at pregnant women (and their families/ circle of support) who are at highest risk of delivering a child affected by prenatal alcohol use. It is worth reiterating that the people who are at highest risk may have already given birth to a child affected by prenatal alcohol exposure.

Interventions provide multi-component activities for treatment, recovery and support that are specialised, culturally specific and accessible for people with alcohol problems and other related, and usually complex, concerns. Effective treatment should incorporate the experiences and needs of people for long term changes (Straussner & Fewell, 2011).

In early intervention, the targeted groups of people are generally heavy users of alcohol, are often economically dependent, and have limited personal and social support networks. Within this group are people who have previously given birth to a child with suspected or diagnosed FASD.

Studies consistently report that people who have had one child with FASD and who continue to drink are at risk of having subsequent children who may be affected. (Alberta Partnership on Fetal Alcohol Syndrome)

EARLY INTERVENTION APPROACH

When a person discloses ongoing problematic alcohol use in pregnancy, the pattern of use can most likely be assumed as a dependence on alcohol to cope with multiple sources of stress in their life. People who are dependent upon alcohol should be met with therapeutic, gender-focused, welcoming and safe environments for the facilitation of change (Niccols et al., 2010). Treatments for people who are dependent upon alcohol should align with their unique needs for optimal outcomes (Barry et al., 2010).

In this situation, it is important for service providers to consider the following:

- Validate the person's disclosure of alcohol use and remain patient and non-judgemental, as they may not be ready to make changes.
- Advise the consumer that stopping their alcohol use at any time during their pregnancy, or in the post-partum period, has benefits.
- Evaluate and provide referrals for any underlying problems that may influence drinking and organise a companion to attend the appointments with the consumer if they desire.
- Recognise the chance that this group of people are themselves affected by FASD. For these people, adaptive living skills, memory impairments, poor judgement, and other factors affect their learning, and therefore, their individual capacities to take in and process information.
- Accept that alcohol use may not be a choice in the person's control, and that the aim is to support pregnant people to minimise the severity of harms to their unborn child.
- Offer additional help, beyond a health or community service agency, through referral to a specialist treatment option. Maintaining connections with current service agencies is important for consumers and linked with eventual success. Referrals should not always be viewed as a handover, but rather an opportunity to share in the consumer's support.

The Stages of Change model can be a helpful tool in assessing a person's readiness for change (Prochaska & DiClemente, 1983) (see SECTION 5: RESOURCES TOOLBOX).

USING A WRAP-AROUND APPROACH

With a consumer's consent, a wrap-around approach may be an appropriate intervention. The aim is to support whatever change the person agrees can be achieved.

A best practice wrap-around approach would encompass:

- a key support person or worker as primary contact and advocate
- a team of professionals, community service organisations, partners, family and/or friends who can provide 24/7 support between them
- intervention that occurs as early as possible
- frequent contact, maintained by the support person or team
- assessment for risk of isolation, and management of identified isolation (as this can increase the risk of alcohol use in vulnerable people).

POSTPARTUM SUPPORT

The third level of prevention (early intervention) bridges pregnancy into the postpartum period. This strategy particularly targets new parents who are identified as being at high risk during pregnancy of giving birth to a child affected by FASD.

Support activities in the post-partum period should help to maintain any changes to alcohol use that the person has made during her pregnancy, as well as offers of support to prevent relapse.

Importantly, intensive postpartum support is also offered to people who were not able to make significant changes in their substance use during their pregnancy.

Early interventions for children who potentially have FASD are also important at this stage. Once a diagnosis of FASD has been made, assertive measures are needed to reduce any risks to future children. This is best accomplished by helping the parents change their patterns of alcohol use.

PREVENTION STRATEGIES—CONCLUSION

Incorporating universal screening into service delivery will require organisational investment in training. Training programs need to be inclusive of:

- Gender-centred practice and ensure responses are supportive and non-judgemental.
- Awareness and understanding of the reasons people use alcohol, the barriers to disclosure and seeking assistance, and the consequences of risky drinking.
- Strategies on how to integrate screening into professional practice.
- Awareness of the risks for unborn children arising from prenatal exposure to alcohol.
- The importance of cultivating and sustaining relationships and links with other community service providers and referral processes.
- Awareness that change is not always immediate, and that patience, encouragement, and support are essential to people's capacity for change.
- Consideration of universal screening, consent, and the storage and use of client information.
- Issues of confidentiality, especially for those consumers who may fear reprisal from their disclosure of alcohol use (including a fear of the apprehension of children and/or an escalation in partner violence).
- Awareness of the diversity in levels of literacy, especially when providing resource materials.

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Section 5: Resources Toolbox

Mapping Risk

MAPPING RISK—POSSIBLE ACTIONS		
FOR ALL PEOPLE OF CHILDBEARING AGE:		
"Do you use alcohol?" "Has it ever caused a problem for you or any family member?"		
NO – LOW RISK	YES – AT RISK	YES – HIGH RISK
PRIMARY PREVENTION	**SCREENING QUESTIONS**	**SCREENING QUESTIONS**
• Offer education • Reinforce healthy behaviours	• AUDIT-C • HEADSS for adolescents	• AUDIT-C • HEADSS for adolescents
	APPLY SECONDARY PREVENTION STRATEGIES	**APPLY SECONDARY PREVENTION STRATEGIES**
	• Education • Use 5A's tool • Assess readiness for change using stages of change model	• Education • Use 5A's tool • Assess readiness for change using stages of change model
		APPLY TERTIARY PREVENTION STRATEGIES
		• Organise referral for specialist support • Assess parent for risk of FASD • Assess or refer for assessment of risk factors for any older children • Provide wraparound supports

Ask - Assess - Advise - Assist - Arrange

One effective way to discuss alcohol consumption with people who are pregnant or planning pregnancy is to use the 5As intervention model. Used extensively to support smoking cessation, this evidence-based framework is useful to guide a conversation that is appropriate to the patient as a primary, secondary, or tertiary intervention.

STEP 1: ASK

Ask all people of childbearing age and those who are pregnant about their alcohol use. An effective screening tool for assessing consumption is the AUDIT–C (Bush et al., 1998; Calabria et al., 2014).

STEP 2: ASSESS

Assess the level of risk of the consumer's alcohol consumption.

The AUDIT–C tool defines a score of 0–3 as low risk of harm, a score of 4–7 as medium risk of harm and a score of 8+ as a high risk of harm.

STEP 3: ADVISE

Advise people of childbearing age, including those who are pregnant:

- that no alcohol is the safest choice if a person is pregnant or trying to get pregnant
- that the amount of alcohol that is safe for the developing fetus has not been determined
- that alcohol reaches concentrations in the developing fetus that are as high as those in the carrying parent
- of the consequences of alcohol exposure to the developing fetus.

People who have consumed alcohol in pregnancy should be advised that:

- the level of risk to the baby is hard to predict
- stopping drinking at any time in the pregnancy will reduce the risk
- the risk of harm to the fetus is low if only small amounts of alcohol were consumed before pregnancy was confirmed
- any concerns about the child's development should be raised with a health professional.

Ask - Assess - Advise - Assist - Arrange

STEP 4: ASSIST

Assist women to stop or reduce consumption through:

- positive reinforcement for those who have already stopped drinking
- advising on the consequences of alcohol exposure to the fetus
- discussing the positives and negatives of taking action and determining what assistance is required to stop or cut down
- conducting brief interventions or motivational interviewing, with the aim of supporting the individual to stop drinking, and where this is not possible, to reduce alcohol intake and avoid intoxication.

The Stages of Change model can be useful in assessing an individual's readiness for change (Prochaska & DiClemente, 1983).

STEP 5: ARRANGE

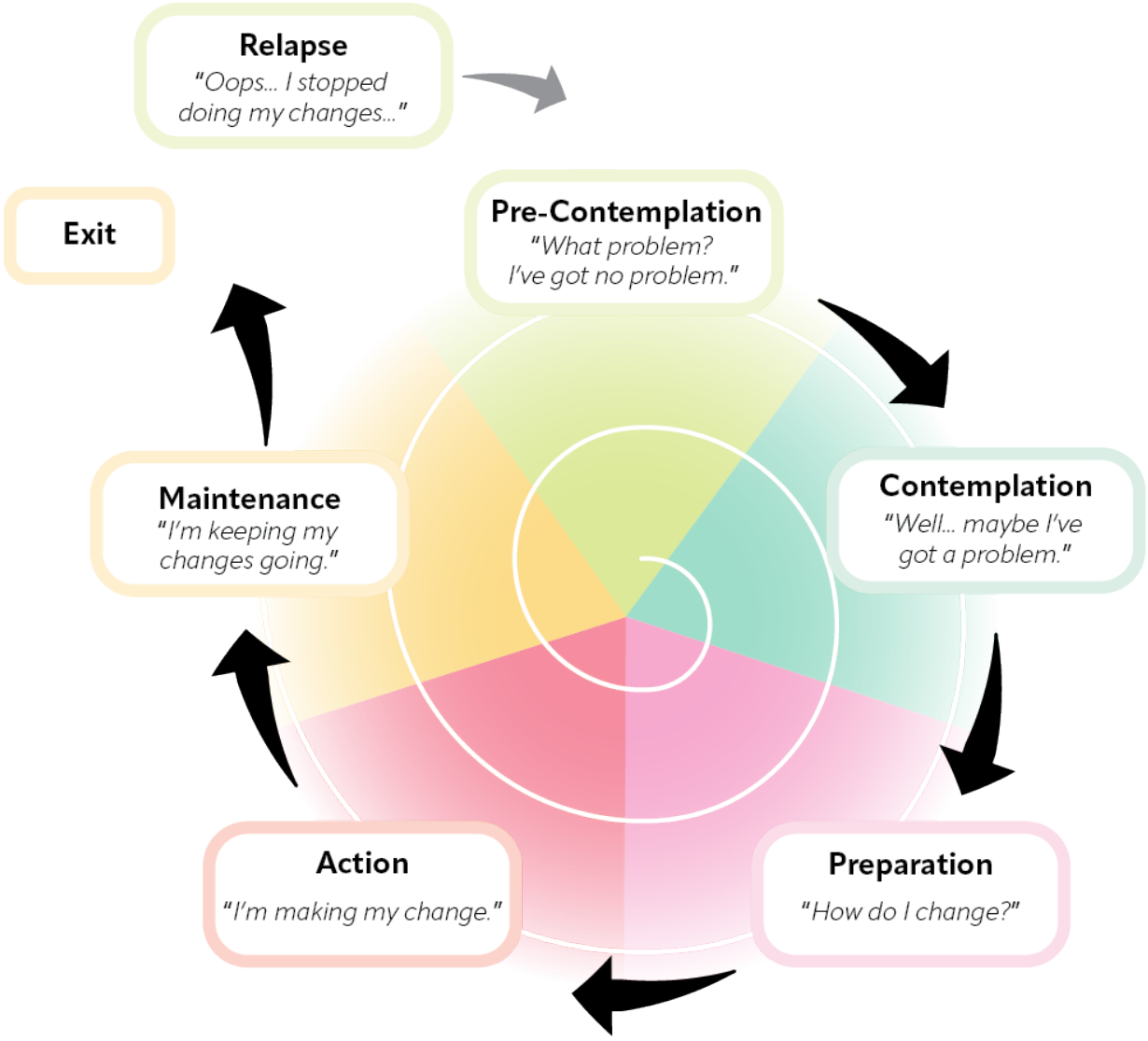
Arrange for further support by planning additional consultations or referring to specialist services and support groups:

- The complexity of problems for this group of consumers may be such that referral is justified.
- A clinical treatment and/or residential program may be necessary to provide additional support.
- Specialist support should be organised for the consumer before advising to stop or cut down alcohol consumption, as without support alcohol withdrawal can be dangerous to the health of the parent and their developing fetus.

Stages of Change

The Transtheoretical Model (Prochaska & Velicier, 1997) explains health behaviour change as a process where people progress through a series of six stages. These stages are known as the Stages of Change. People often move through these stages in order, and may relapse to a previous stage. **However, each time that person relapses, they potentially learn from their mistakes and can try something different the next time around** (Prochaska et al. 1991). The stages of change are:

- Precontemplation: No intention to take action for the foreseeable future.
- Contemplation: Intention to take action sometime in the future.
- Preparation: Intention to take action very soon.
- Action: Actively taking steps towards change.
- Maintenance: The change has been made, and being actively maintained.
- Exit: The change has been made and takes no effort to maintain. The criteria for this stage may be too strict, and the exit (termination) stage may not be a realistic goal for every person or siutation.



The Stages of Change

Drug Education Network Inc. (2018) adapted from Prochaska et al. (1992)

AUDIT-C

The AUDIT–C is a screening tool that has been shown to perform well with pregnant women.

This tool has three short questions that estimate alcohol consumption in a standard, meaningful, and non-judgmental manner (Bush et al. 1998). The Audit-C is currently the most effective tool for determining levels of alcohol use in pregnancy and associated risk of harm. However, research tells us more than 50% of women drank alcohol before they knew they were pregnant (Australian Institute of Health and Welfare, 2020) and this needs to be considered by practitioners when using the Audit-C. Consider the questions in the context of 'before the person knew they were pregnant', i.e. the first few weeks.

Questions	Scoring System					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

AUDIT–C score interpretation:

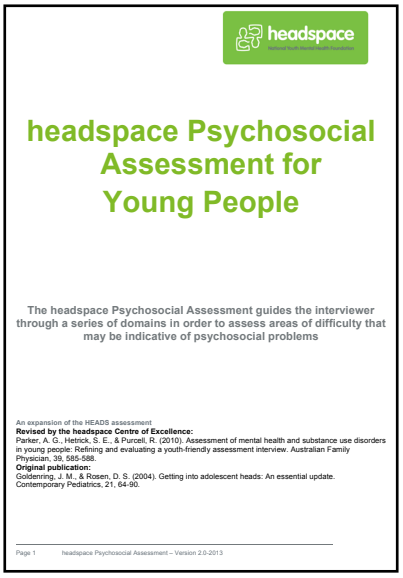
Score	Interpretation
0 to 3	Low risk of harm
4 to 7	Medium risk of harm
8 or more	High risk of harm

HEADSS Psychosocial Assessment

When working with young people, a broader psychosocial assessment can be useful to understand broader health issues that may be happening and can provide context in the case of problematic alcohol or drug use. We recommend the following tool, which is an expansion of the HEADSS assessment, developed by the National Youth Mental Health Foundation, headspace (Parker, 2013).

The tool, including an administration guide, is available here:

https://headspace.org.au/assets/Uploads/headspace-psychosocial-assessment.pdf


headspace

headspace Psychosocial Assessment for Young People

The headspace Psychosocial Assessment guides the interviewer through a series of domains in order to assess areas of difficulty that may be indicative of psychosocial problems

An expansion of the HEADS assessment
Revised by the headspace Centre of Excellence:
Parker, A. G., Hetrick, S. E., & Purcell, R. (2010). Assessment of mental health and substance use disorders in young people: Refining and evaluating a youth-friendly assessment interview. Australian Family Physician, 39, 585-588.
Original publication:
Goldenring, J. M., & Rosen, D. S. (2004). Getting into adolescent heads: An essential update. Contemporary Pediatrics, 21, 64-90.

Page 1 headspace Psychosocial Assessment – Version 2.0-2013

The HEADSS Psychosocial Assessment provides a series of questions aiming to explore mental health in young people. The semi-structured nature of the interview means questions can be skipped or asked out of the presented order.

It is recommended the interviewer begin with the opening, non-threatening questions to build rapport with the young person. However, the young person may discuss their presenting problem prior to commencing the interview. In this circumstance, it is recommended to explore the presenting problem first and then continue with other domains.

The 10 domains included in the HEADSS assessment are:

- Home and environment
- Education and employment
- Activities including the Social and Occupational Functioning Assessment Scale
- Alcohol and other drugs
- Relationships and sexuality
- Conduct difficulties and risk taking
- Anxiety
- Eating
- Depression and suicide
- Psychosis and mania

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