PREGNANCY & ALCOHOL DON'T MIX

THE FASD HANDBOOK

FOR HEALTH PROFESSIONALS

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ACKNOWLEDGEMENTS

The Drug Education Network acknowledges the State Government for providing funding for the update and publishing of this resource.

DEN also acknowledges the work of Vicki Russell, a former DEN staff member, for initiating and laying the groundwork for this resource.

ALL DEN staff members and the Board are acknowledged for their contributions to this work, in particular Maria Duggan and Marion Hale.

DEN would like to thank headspace for providing permission to cite their adapted psychosocial assessment tool for young people.

Thanks also goes to Cathy McAuliffe from Cathy McAuliffe Design for her graphic design input, and Maura Bedloe of Maura Bedloe Communications for her editorial and proofreading work.

ALCOHOL AND PREGNANCY

QUICK REFERENCE GUIDE – 5 As

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STEP 1 – ASK

ASK all women of child-bearing age and pregnant women about their alcohol use. An effective screening tool for assessing consumption is the AUDIT-C.

THE AUDIT-C SCORING SYSTEM

QUESTIONS	0	1	2	3	4	SCORE
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 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

STEP 2 – ASSESS

AUDIT-C Score interpretation:

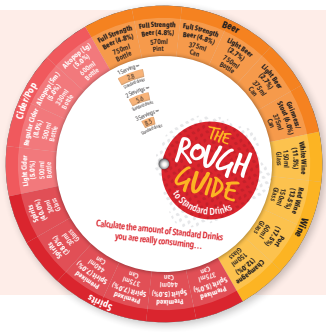
0 – 3 = low risk of harm

4 – 7 = medium risk of harm

8+ = high risk of harm

The Rough Guide to Standard Drinks is a useful tool for calculating a variety of standard drinks.

To order, visit www.den.org.au/resources



STEP 3 – ADVISE

ADVISE women of child-bearing age, including pregnant women:

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

Women 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 baby 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.

Continued overleaf

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 baby
- 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 them to stop drinking, and where this is not possible, to reduce alcohol intake and avoid intoxication.

To assess readiness for change, the **Stages of Change** model developed by Prochaska and DiClemente (1992) can be a helpful tool.

STEP 5 – ARRANGE

ARRANGE for further support for women by planning additional consultations or referring to specialist services and support groups.

- a clinical treatment and/or residential program may be necessary to provide additional support.
- specialist support should be organised for the woman before advising her to stop or cut down alcohol consumption, as without support, alcohol withdrawal can be dangerous to the mother and baby's health.

A GUIDE TO STANDARD DRINKS

100ml wine
Wine at 12% Alc/Vol

285ml
full-strength beer
10oz full strength beer
4.9% Alc/Vol

30ml nip of spirits
Spirit 40% Alc/Vol

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1.

ABOUT FETAL ALCOHOL SPECTRUM DISORDERS

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SECTION 1: ABOUT FETAL ALCOHOL SPECTRUM DISORDERS

ALCOHOL, PREGNANCY AND FASD

Alcohol is an accepted part of Australian culture and lifestyle. 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.

However, 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' (Barry, et al).

Alcohol misuse is of particular concern for pregnant women. When a mother consumes alcohol in pregnancy, so does her developing baby.

Alcohol consumption during pregnancy is linked to a range of adverse consequences, including miscarriage, stillbirth, low birth weights and Fetal Alcohol Spectrum Disorders, or FASD.

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term used to describe a range of disabilities that result from prenatal alcohol exposure. Children born with FASD can experience abnormalities including behavioural problems, birth defects, impaired growth, and learning difficulties (Foundation for Alcohol Research and Education [FARE], 2013).

FASD are the leading, preventable cause of non-genetic developmental disabilities in Australia (O'Leary, CM, 2002). As is the case with many other disabilities, people who are born with FASD have the condition for life.

WHERE WE ARE NOW?

Over the past decade, some encouraging progress has been made in the area of prenatal alcohol exposure and FASD.

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, and the results were encouraging. Most women surveyed abstained from drinking alcohol during pregnancy, and those who did drink, did so infrequently (one to two standard drinks, monthly or less). Results for Tasmania showed that alcohol consumption during pregnancy had halved between 2005 and 2010 (from 18.3% to 9.2%).

While these statistics are encouraging, every child affected by FASD represents a preventable tragedy. It is critical that work continues to promote messages about FASD prevention to vulnerable and at-risk people in our community.

There is an urgent need to bring this important health message home, by increasing awareness of the National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC Guidelines). These guidelines recommend that not drinking is the safest option for women who are pregnant or planning a pregnancy.

In response to the Inquiry into Fetal Alcohol Spectrum Disorder (FASD) - *FASD: The hidden harm,* the Commonwealth Action Plan to reduce the Impact of Fetal Alcohol Spectrum Disorders (FASD) 2013-14 to 2016-17 was released in 2013.

The Commonwealth has identified five priority areas for action to reduce the impact of FASD across Australia. A range of specific actions to be led by the Commonwealth have also been identified under each of these priorities. The Action Plan seeks to:

- 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, while also 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, based on need and level of functional impairment
- to support the health sector and broader workforce to prevent FASD and to better respond to the needs of families impacted by it.

This Action Plan builds upon the existing investment in gaining a better understanding of FASD, and aims to improve outcomes for FASD-affected infants as well as reducing the incidence of this preventable disorder.

WORKING TOWARDS SOLUTIONS

For FASD awareness and prevention to be successful, we need to develop better understanding and responsiveness in supporting girls and women who use alcohol in pregnancy. We need to increase awareness of the fact that alcohol use affects girls and women differently to boys and men, and that traditional, male-centred models of practice don't necessarily work for girls and women. And we also need to deepen our understanding of the various barriers and challenges girls and women face in in seeking assistance and support for their alcohol use.

This handbook identifies girls and women of child-bearing age as the major target group for FASD prevention. But prenatal exposure to alcohol and FASD are consequences of the social and cultural acceptance of alcohol use, and ready availability of alcohol, in Australia—and in Tasmania. For this reason, the problem of alcohol misuse is a community responsibility, requiring a community solution.

PREVENTION STRATEGIES

Three prevention strategies underpin the FASD Handbook for Health Professionals:

1.

PRIMARY PREVENTION

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

- prevention and health promotion activities, media campaigns, and public information presentations
- 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.

2.

SECONDARY PREVENTION

The second level of prevention targets girls and women 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 helping resources and support. This approach also includes education and training for health and community workers who are engaging with the target group.

3.

EARLY INTERVENTION

The third level of prevention is early intervention. This approach is intended to reach girls and women at highest risk by offering specialised, holistic support through outreach care and collaborative networks of current agencies. The benefits of this strategy include:

- continued support for breastfeeding mothers in the post-partum period
- support for women who have been able to reduce, and need support to manage, their alcohol use, post-pregnancy
- mitigating relapse in women for whom alcohol use continues to be problematic.

AIMS OF THE FASD HANDBOOK FOR HEALTH PROFESSIONALS

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 reduce the incidence of FASD.

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 girls and women who use alcohol. Increasing health and community service providers' confidence to openly discuss alcohol use with their clients, especially girls and women of child-bearing age, will help us to identify and address risk early and make progress towards reducing FASD in our community.

USING THIS HANDBOOK

This publication 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 community, and often already engage with girls and women as service users. No judgement has been made regarding the level of expertise or contribution of certain professional roles over others in this area, nor to undervalue the important role all Tasmanians can play in the prevention of prenatal exposure to alcohol.

WOMEN, ALCOHOL AND PREVENTION APPROACHES

This handbook advocates a 'women-centred' approach.

Traditional, and succinct, heath messages to 'simply stop drinking' do not provide a simple solution for all women. Women from every sector of society use alcohol, and so the prevention of prenatal exposure to alcohol requires all women to be informed of the risks of alcohol use in pregnancy, regardless of their social, economic, cultural or ability status.

Historical, familial, social, emotional, psychological and economic barriers to seeking help are deeply embedded in women's use of alcohol. Prevention approaches should not add to the existing burden that many women experience when it comes to protecting the health and wellbeing of the children in their care. A more effective approach is to offer prevention programs that have been designed to recognise that women exist in their own right and should be valued at all stages of life.

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2.

UNDERSTANDING THE PROBLEM

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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: http://alcoholpregnancy.telethonkids.org.au/media/1806813/australian-guide-to-diagnosis-of-fasd.pdf

Fetal Alcohol Spectrum Disorders (FASD) refers to the range of disabilities experienced by babies and children exposed to alcohol in the prenatal period. As previously stated, FASD are the leading, preventable cause of non-genetic, developmental disabilities in Australia and have a lifelong impact on sufferers.

The primary disabilities associated with FASD are linked directly to the underlying brain damage caused by prenatal alcohol exposure. These 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, 2012).

Alcohol can cause damage to the unborn child at any time during pregnancy. The level of harm is dependent on the amount and frequency of alcohol use. This 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. exposure to violence or poverty).

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.

FASD is referred to as the 'invisible disability' as it is often undetected. It may be overlooked, ignored, attributed to other known, non-genetic conditions or simply blamed on 'poor' parenting or post-birth environments.

There is a lack of understanding of FASD within the service provider community. Currently, assessment and service provision is 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. Such strategies should be based on the knowledge that FASD are physical, brain-based conditions with behaviours that are symptomatic of brain damage impairment.

(NOFASD, 2016).

It is difficult to determine the prevalence of FASD in Australia, due to a lack of accurate assessment, screening and data collection. Various studies, using data from states and territories, have estimated rates at 0.01 to 1.7 per 1,000 births in the total population. However, it is generally accepted that these figures are likely to underestimate the prevalence of FASD in Australia.

(Burns, et al, 2013).

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. 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.

(Malbin, 2002).

Many professionals argue that a diagnosis of FASD can create an additional burden for the individual—the cause of FASD is unchangeable, the outcome irreparable, and so the label a diagnosis brings has little advantage.

However, from a prevention perspective, the primary indicator of risk for an alcohol-exposed pregnancy is an older sibling with FASD. 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.

(Burd, 2007).

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 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.

The primary conditions common to FASD last a lifetime. 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 (NOFASD 2016).

SECONDARY CONDITIONS

Secondary conditions arise after birth and could potentially be improved through better understanding and appropriate intervention (Clarren, 2009).

In a longitudinal study of 661 individuals, Streissguth et al (2002) identified risk factors and protective factors related to the development of secondary conditions, following a diagnosis of FASD. Some of the protective factors were:

- living in a stable environment
- a diagnosis by six years of age
- never experiencing personal violence.

In the absence of these protective factors, the risk of developing secondary conditions became 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.

Malbin (2005) suggests that 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 (for example, as defiant, wilful and/or disruptive) are explained as normal, protective reactions to frustration and continued failure. 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.

PHYSICAL EFFECTS

The physical effects of FASD are probably the most widely recognised impacts of the condition. This recognition can be misleading and result in unhelpful assumptions about individuals, based on their appearance.

FETAL ALCOHOL SYNDROME

There are some common facial anomalies associated with Fetal Alcohol Syndrome (FAS), which can affect the:

- face
- eyes
- skeleton
- ears
- heart
- kidneys
- mouth and jaw
- sensory system
- immune system
- body hair (greater than usual).

These effects can soften with age and my even disappear by late adolescence.

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 supports and prevent further damage.

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3.

WOMEN AND ALCOHOL

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SECTION 3: WOMEN AND ALCOHOL

While alcohol is a public health issue that affects everyone in the community, women have particular challenges and vulnerabilities in this area.

80.6%

OF AUSTRALIANS AGED 18 YEARS AND OVER HAD CONSUMED ALCOHOL IN THE PAST YEAR

8.2%

A FURTHER 8.2% HAD CONSUMED ALCOHOL 12 OR MORE MONTHS AGO

and 10.7% had never consumed alcohol

TWO-THIRDS

(66.2%) OF ALL 15–17 YEAR OLDS HAD NEVER CONSUMED ALCOHOL,

an increase from 2011–12 when around half (49.1%) of people in this age group had never consumed alcohol.

The 2013 Tasmanian State of Public Health Report showed that alcohol consumption at levels that would increase the short-term risk of harm (more than four standard drinks on a single occasion) was higher (48.9%) than at the national level (44.7%) (State of Public Health Report, 2013).

Women from developed nations are now consuming alcohol at amounts and in patterns of consumption that have probably never before been experienced. In spite of this, problematic alcohol consumption continues to be misunderstood as something that is predominantly associated with lower socioeconomic and already marginalised groups.

Alcohol is the most common substance used by women. Rates of use among women have been rising steadily, and the gap between men and women's drinking is closing.

(Parkes, et al. 2008).

Patterns of alcohol use by pre-conceptual young women, and older women, are striking when the risk of future and past alcohol use in pregnancy is considered. While preventing problematic alcohol use is vitally important, pregnancy is not the only opportunity for alcohol intervention with women.

ALCOHOL AND SOCIOECONOMIC STATUS

Alcohol use is one health risk that is not closely associated with low socioeconomic status (SES).

While people with the lowest socioeconomic status (SES) were more likely to smoke, it was people with the highest SES who were more likely to drink at all and consume alcohol in quantities that placed them at risk of an alcohol-related disease, illness or injury. People with the lowest SES were twice as likely to abstain and a little less likely to drink alcohol in risky quantities, compared with people in highest SES group.

(National Drug Strategy Household Survey, 2013)

According to the National Drug Strategy Household Survey (2013), there has been a reduction in the number of people, from the lowest and highest SES groups, drinking more than two standard drinks per day (declining from 19.1% to 15.9% and from 21% to 18.4% respectively). People in the lowest SES group were also less likely to drink at risky levels at least once a month (from 27% in 2010 to 24% in 2013) but there was no change in drinking at these levels among people from the highest SES group.

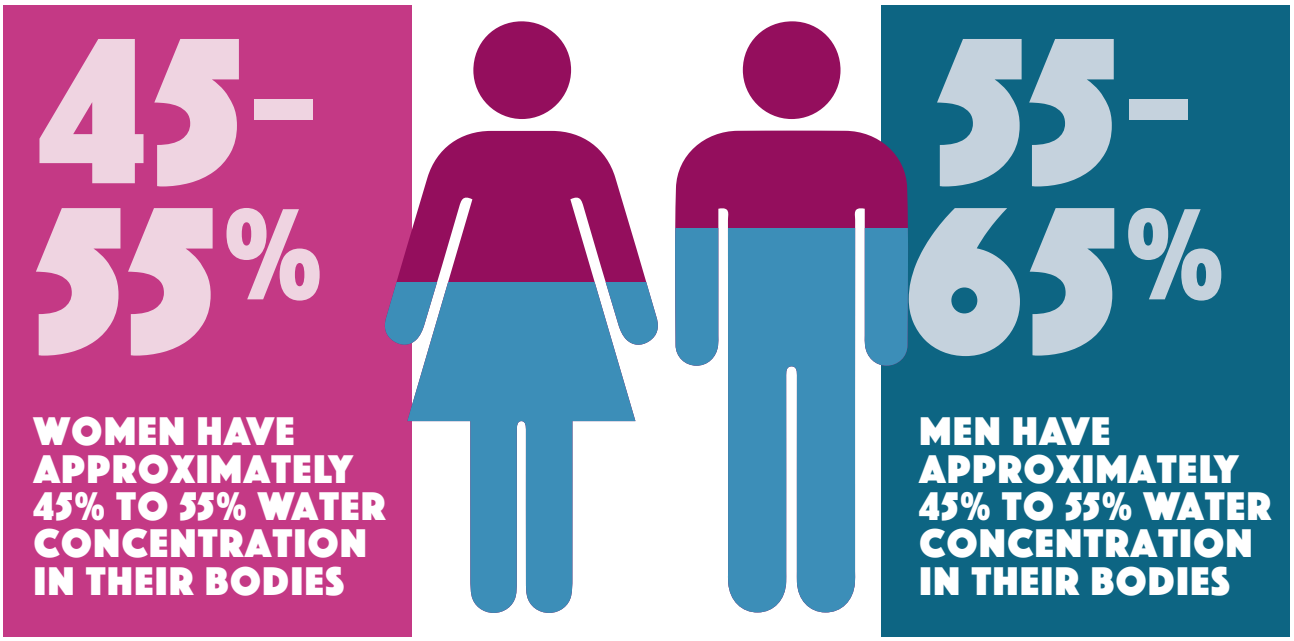
THE BIOLOGY OF DRINKING— HOW WOMEN REACT DIFFERENTLY TO ALCOHOL

A number of 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.

HOW ALCOHOL AFFECTS WOMEN

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. 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 more slowly than men's and have less of the enzyme that breaks down alcohol. This means that, when a woman drinks, her brain and all 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.



SOCIAL ROLES—WHAT WE EXPECT OF WOMEN

Even in our developed society, a number of powerful social factors are still applied to women, and these affect 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.

Women are more likely than men to be judged harshly for their alcohol use, and many women are afraid of the potential repercussions of their drinking, such as the removal of children. This fear of stigma and judgement can make women less likely to seek help.

'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

As with alcohol consumption within the general population, drinking alcohol during pregnancy is a health risk that actually increases with socioeconomic status.

While no consistent relationship has been found between socioeconomic factors and drinking before knowledge of pregnancy, older women with a higher household income are more likely to continue to drink after learning of their pregnancy.

(FARE, 2012)

OLDER AND WISER? Age is a particularly important predictor of drinking after awareness of pregnancy.

90%

OF DRINKERS AGED UNDER 25 YEARS STOPPED DRINKING ONCE THEY LEARNED OF THEIR PREGNANCY

ONLY HALF

OF THOSE ALREADY DRINKING WHO WERE AGED 36 YEARS OR OLDER DID THE SAME.

(FARE, 2012)

OLDER AND WISER?

In 2013, the National Drug Strategy Household Survey included, for the first time, questions related specifically to the amount of alcohol consumed by pregnant women. The majority of women surveyed did not drink alcohol during pregnancy, and of those who did, most drank infrequently (monthly or less) and consumed between one and two standard drinks. The survey showed:

- about 3 in 4 (78%) pregnant women who consumed alcohol while pregnant drank monthly or less, and 17.0% drank 2–4 times a month
- most (96%) usually consumed 1–2 standard drinks
- only 1.4% had consumed six or more standard drinks on at least one occasion during their pregnancy.

In Tasmania, alcohol consumption during pregnancy has halved—from 18.3% in 2005 to 9.2% in 2010, with the majority of surveyed women reporting an average consumption of less than one drink per day (State of Public Health Report, 2013).

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 actually working to increase health inequity.

FASD AND ABORIGINAL WOMEN

FASD is more prevalent among Aboriginal and Torres Strait Islander peoples, with an incidence of Fetal Alcohol Syndrome (FAS) between 2.76 and 4.7 per 1,000 births. This is four times higher than the rate of FAS for the general population.

(FARE, 2012)

WHY DO WOMEN USE ALCOHOL IN PREGNANCY?

When a woman decides to consume alcohol in pregnancy, there is a reason. Women may use alcohol before they know they are pregnant. They may not understand how harmful prenatal exposure to alcohol is for the fetus, or they may use alcohol because it is a social norm or expectation. Some women may use alcohol to self-medicate or to cope with stress, poverty or violence. Or, alcohol may have developed into a dependency.

Whatever the reason, open, inclusive and non-judgemental support is critical in addressing these issues with pregnant women and preventing further alcohol exposure and damage.

Burgoyne (2005).

BARRIERS FOR WOMEN

Prior to the 1970s, there was a lack of research regarding women with substance use problems, and almost no gender-specific treatment programming (Parkes 2008). 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.

A number of factors can discourage women from seeking help. The visibility of services, concerns about confidentiality of information, coercive treatment responses and a whole range of personal and interpersonal factors can come into play. Additionally, women may fear that children will be removed from their care, or that they will be blamed and judged.

The stigma that still exists around women's use of alcohol, combined with other barriers, can make women fearful of disclosing their drinking. A woman's continued use of alcohol can also be encouraged by her partner, friends and family—who may feel challenged by her decision to change her alcohol consumption.

According to the Network of Alcohol and Other Drugs Agencies (NADA):

- Women access treatment for alcohol and other drugs (AOD) at lower rates than men, and are under-represented in the drug and alcohol treatment system (according to Australian and international data).
- A range of issues creates barriers for women's access to AOD services, including social stigma, discrimination, experiences of trauma, childcare and child custody concerns, and financial issues.
- 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.

- Pregnancy and parenting are specific areas of need that require effective support and intervention for women engaged in problematic substance use. The key to engaging women is to reassure them that there is 'no wrong door' when it comes to seeking support and treatment, and that a range of treatment options and services are available to them.
- Pharmacotherapy for women works best when implemented with other supportive interventions, such as coordinated case management, counselling, group therapy and practical support.

A high proportion of women who access AOD treatment are seeking assistance for problematic substance use by a loved one. Principles of family-inclusive practice offer best practice in this context.

(NADA 2015).

A woman's expectations, no matter how reasonable or unreasonable they might be, can distort her thinking and influence limited contact within a supportive network of service providers.

Therefore, any contact with women

OFFERS A UNIQUE OPPORTUNITY TO BUILD RAPPORT, OFFER SUPPORT AND GENTLY CHALLENGE UNHELPFUL BELIEFS.

WOMEN-CENTRED PRACTICE

Women-centred practice, or gender-responsiveness, are terms that consider the needs of women in all aspects of service design and delivery, including the location and accessibility of services, staffing, program development, content and materials (BCCEWH, 2009).

From a practical perspective, this means that services need to offer a safe environment for women, which is free from violence and encourages trust. Child welfare and child protection authorities often see substance use and heavy alcohol consumption during pregnancy as abuse or neglect. This perception contributes to the marginalisation of vulnerable women who fear the loss of custody of their children and therefore feel unable to seek help during their pregnancy.

To break the cycle, we need effective services that link prenatal care, treatment programs and child protection services with other health and social services.

(FARE, 2012)

Preventing the problem of prenatal exposure to alcohol before it begins means universally targeting women of child-bearing age, and selectively targeting women at high risk of alcohol use in pregnancy. A women-centred approach consults, and is directed by, the women themselves, and is driven by what those women want and need.

Ongoing consideration of the health concerns that are unique to each woman, and the personal experiences she brings from all her varied roles, is critical.

WOMEN-CENTRED PRACTICE IS UNDERPINNED BY SOCIAL JUSTICE PRINCIPLES AND INCLUSIVENESS AND ENCOURAGES WOMEN TO PARTICIPATE IN PLANNING, EVALUATION, POLICY DEVELOPMENT AND RESEARCH THAT SUPPORTS ADVOCACY FOR WOMEN'S ISSUES.

CRITICAL CONVERSATIONS

Many service providers find conversations about alcohol use with girls and women challenging. But if these conversations don't happen, valuable opportunities for addressing alcohol-related harms and supporting girls' and women's health and wellbeing may be lost.

Some service providers may believe their knowledge is inadequate, or they have personal bias about which groups of women 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 woman can create a barrier for change.

A women-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 woman and supportive service provider.

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4. THE PREVENTION OF FASD

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SECTION 4: 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.

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 drug use. It protects against the harms that can occur from frequent use or misuse, and embraces and presents options for action, ranging from drug-free choices to harm minimisation.

In the context of FASD prevention, it is important to recognise that alcohol use is an issue for all Australians (and Tasmanians), either directly or indirectly.

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.

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 problematic alcohol use, in particular, girls and women of child-bearing age
- educate service providers on prenatal exposure to alcohol, and adverse outcomes, and build capacity for delivering women-centred practice
- communicate positive and consistent prevention messages.

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).

EARLY INTERVENTION PREVENTION strategies include:

- implementing routine screening at every community service provider encounter throughout the pregnancy and in the post-partum period
- 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 women-centred practice.

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.

Primary prevention is important for women who lack information, have misconceptions about alcohol misuse and FASD, or need to know how to access services related to alcohol use across their lifespan—and particularly during pregnancy.

Tailored messages may be required for girls and women, based on age, income, ethnicity and other differences. While there is value in displaying prevention messages in health settings where most women access health and prenatal care, this information is also needed at a community level—within service provider agencies, community support organisations and other points of access for women.

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.

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.

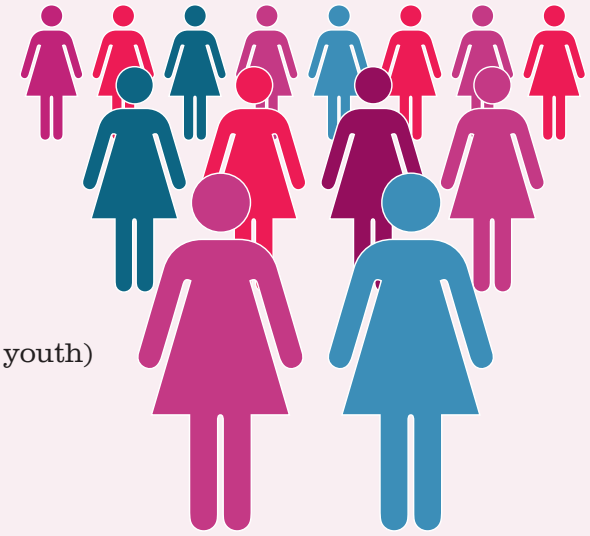
TARGET GROUPS

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

- all pre-conceptual girls and women, and pregnant women whose drinking habits can be influenced by public education
- significant others—fathers-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

In 2013, 20.4% of Tasmanians were drinking alcohol at risky levels (binge drinking). While this figure represents a six per cent reduction from 2010, in the 18–24 age group, this behaviour occurred at a rate of 50%, with only a two per cent reduction from 2010

(Tasmanian Alcohol Data and Trends, 2013).

Given the scope of this problem across Tasmanian communities, it's clear that we all need to get better at asking people about their alcohol use.

The issue of prenatal exposure to alcohol can begin to be addressed with the widespread practice of universal screening for problematic alcohol use.

Universal screening needs to happen at every health and community service client visit (female and male, adolescent and adult). When it is delivered effectively in the context of a brief conversation, screening is inclusive, nonstigmatising and effective at targeting pre-conceptual and pregnant girls and women.

However, pregnancies are not always planned, and confirmation may not occur until well into the first trimester. Because past alcohol use patterns are predictive of alcohol use in pregnancy, 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 also very important.

Given the current available data on alcohol use by young and older adolescents, this population group should also be included in universal screening.

The health promotion strategy and message is 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

Screening is not treatment. Nor does it provide a complete assessment of a problem. The suggested screening tools for FASD 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 normal, 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.

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 woman's health and can be used to guide conversations about alcohol and pregnancy.

Any prevention of prenatal exposure to alcohol must include alcohol use by adolescent girls. The association between alcohol use, unsafe sex and unplanned pregnancy is an important public health concern for the whole community.

The AUDIT–C is a valid tool that can assess 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 WITH GIRLS AND WOMEN

Secondary prevention strategies apply to selective target groups of girls and women 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 girls and women 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 girls and women identified as being at risk for alcohol use 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.

This approach:

- accounts for the particular needs of girls and women
- is dependent on individual need
- is often intensive
- may be included in outreach programs, following ongoing universal alcohol screening at every visit.

Brief interventions support the process of identifying a woman's readiness for change. Consent is always obtained, and referrals are made for women with special needs who require treatment.

While most women are self-motivated to change their use of alcohol, once pregnancy is confirmed, there are some girls and women 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 mothering, pregnancy and child rearing are not assumed to be shared by all girls and women who engage with health and community services.

Furthermore, beliefs that girls and women can and will cease drinking when they are told about the risks of fetal harm and/or when they find they are pregnant, are not the case for some individuals and can greatly over-simplify the complexity of some women's lives.

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.

ASK–ASSESS–ADVISE–ASSIST–ARRANGE

SERVICE PROVIDER INVOLVEMENT

Secondary prevention is highly dependent on service provider involvement. 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 women and has the capacity to identify gaps, barriers, and the adequacy of alternatives.
- It's important to recognise that, depending on which stage of the change process a woman 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 girls and women.
- 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 girls and women (and their families and supporters) who are at highest risk of delivering a child affected by prenatal alcohol use.

It is worth reiterating that the women and girls 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 women with alcohol problems and other related, and usually complex, concerns.

In early intervention, the targeted groups are girls and women who are generally heavy users of alcohol, are often economically dependent and have limited personal and social support networks.

Within this group are women who have previously given birth to a child with suspected or diagnosed FASD.

Studies consistently report that women who have had one child with FASD and who continue to drink are at risk of having subsequent children who are progressively more severely affected.

(Alberta Partnership on Fetal Alcohol Syndrome)

USING A WRAP-AROUND APPROACH

With a woman's consent, a wrap-around approach may be an appropriate intervention. The aim is to support whatever change the woman 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 are able to 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 women).

POST-PARTUM SUPPORT

The third level of prevention (early intervention) bridges pregnancy into the post-partum period. This strategy particularly targets new mothers 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 woman has made during her pregnancy, as well as offers of support to prevent relapse.

Importantly, intensive post-partum support is also offered to mothers 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 mother, and her partner, to change patterns of alcohol use.

EARLY INTERVENTION APPROACH

When a girl or woman 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 her life. **In this situation, it is important for service providers to consider the following:**

- Validate the woman's disclosure of problematic alcohol use and remain patient and non-judgemental, as she may not be ready to make changes.
- Advise girls and women 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 accompanying the woman to these appointments if she so desires.
- Recognise the likelihood that this group of girls and women are themselves affected by FASD. For these women, 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 is accepted as problematic, and that the aim is to support pregnant women 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 women, and linked with eventual success. Referrals should not always be viewed as a handover, but rather an opportunity to share in the woman's support.

The Stages of Change model developed by Prochaska and DiClemente (1992) can be a helpful tool in assessing a woman's readiness for change **(see SECTION 5: RESOURCES TOOLBOX).**

PREVENTION STRATEGIES—CONCLUSION

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

- women-centred practice and responses to women that are supportive and non-judgemental
- awareness and understanding of the reasons women use alcohol, the barriers to disclosure and seeking assistance, and the consequences of risky drinking for women
- 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 for women, and that patience, encouragement and support are essential to women's capacity for change
- consideration of universal screening, consent and the storage and use of client information

- issues of confidentiality for women, especially for those women 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 at home)
- awareness of the diversity in levels of literacy, especially when providing resource materials.

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5.

RESOURCES TOOLBOX

PREGNANCY & ALCOHOL DON'T MIX

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SECTION 5:
RESOURCES TOOLBOX

MAPPING RISK – POSSIBLE ACTIONS

FOR ALL GIRLS AND WOMEN OF CHILDBEARING AGE:

Do you use alcohol?

Has it ever caused a problem for you or any family member?

NO - LOW RISK

Primary prevention:

- Offer education
- Reinforce healthy behaviours

YES - AT RISK

Screening questions:

- AUDIT-C or
- HEADDS questionaire for adolescent girls

Apply secondary prevention strategies:

- Education
- Use 5 As Tool
- Assess readiness for change using Stages of Change model

YES - HIGH RISK

Screening questions:

- AUDIT-C or
- HEADDS questionaire for adolescent girls

Apply secondary prevention strategies:

- Education
- Use 5 As Tool
- Assess readiness for change using Stages of Change model

Additionally use tertiary prevention strategies:

- Organise referral for specialist support
- Assess mother for risk of FASDs
- Assess or refer for assessment of risk factors for any older children
- Provide wrap-around support

ASK–ASSESS–ADVISE–ASSIST–ARRANGE

One effective way to discuss alcohol consumption with pregnant women or women 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 all women of child-bearing age and pregnant women about their alcohol use. An effective screening tool for assessing consumption is the AUDIT-C.

Step 2 – ASSESS the level of risk of women'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 women of child-bearing age, including pregnant women:

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

Women 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 baby 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.

Step 4 – 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 baby
- 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 them to stop drinking, and where this is not possible, to reduce alcohol intake and avoid intoxication.

Step 5 – ARRANGE for further support for women by planning additional consultations or referring to specialist services and support groups:

- The complexity of problems for this group of women 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 woman before advising her to stop or cut down alcohol consumption, as without support, alcohol withdrawal can be dangerous to the health of the mother and her baby.

The **Stages of Change** model developed by Prochaska and DiClemente (1992) can be a useful tool in assessing an individual's readiness for change.

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-judgemental manner.

THE AUDIT-C SCORING SYSTEM

QUESTIONS	0	1	2	3	4	SCORE
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 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

AUDIT-C Score interpretation:

0 – 3 = low risk of harm

4 – 7 = medium risk of harm

8+ = high risk of harm

HEADSS PSYCHOSOCIAL ASSESSMENT

When working with young women, a broader psychosocial assessment can be useful to understand current health issues 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**:

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

STAGES OF CHANGE

According to the **Stages of Change** model developed by Prochaska and DiClemente (1992) the five Stages of Change are:

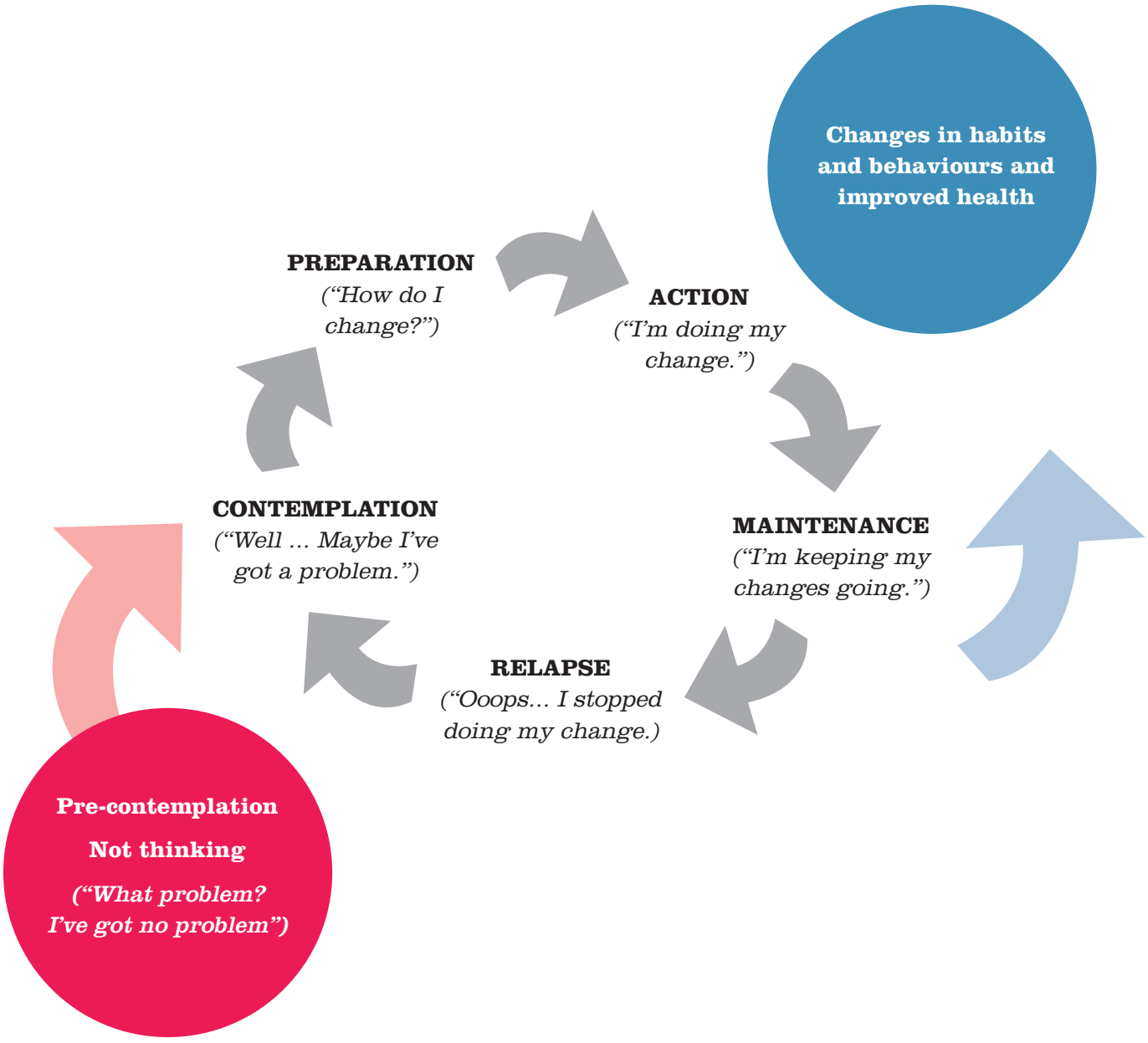
Stage 1: **Pre-contemplation** Change is not being considered

Stage 2: **Contemplation** There is ambivalence to change

Stage 3: **Preparation** Ambivalence is shifting towards change

Stage 4: **Action** Alcohol use has ceased

Stage 5: **Relapse** May happen and is likely if use is high



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