

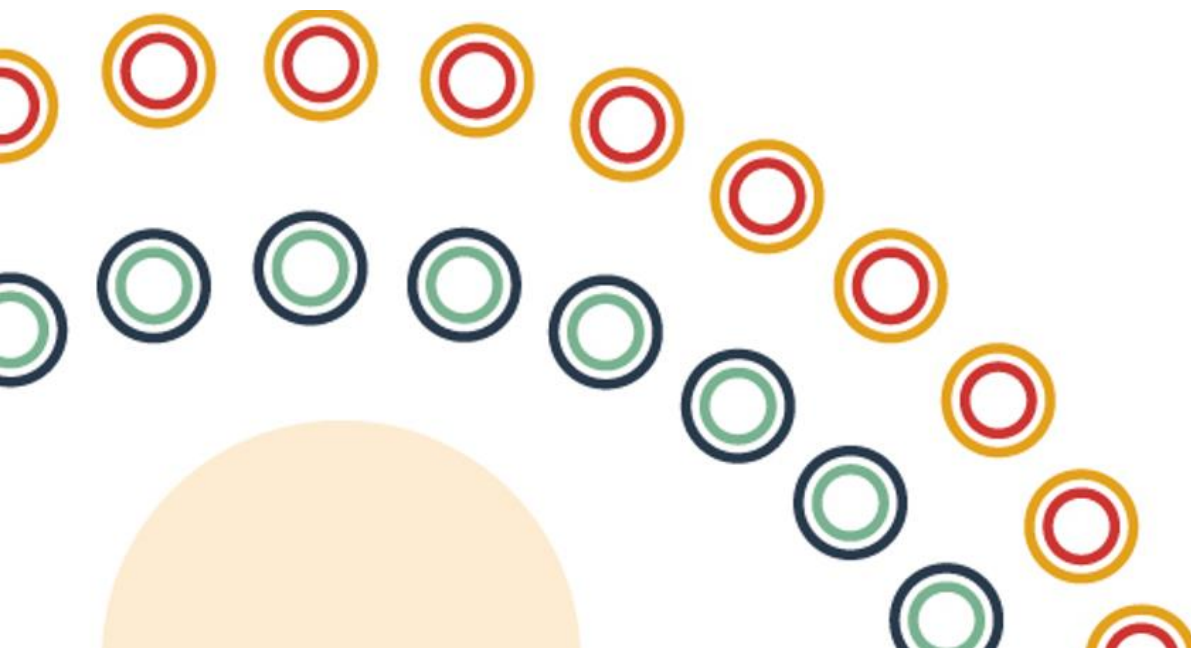


FASD Prevention & Health Promotion Resources Training

for health professionals working with Aboriginal and Torres Strait Islander communities

Facilitator Manual

August 2017



In the spirit of respect, Menzies School of Health Research acknowledges the people and the elders of the Aboriginal and Torres Strait Islander Nations who are the traditional owners of the land and seas of Australia.

Where the term Indigenous is used throughout this manual we include all Aboriginal and Torres Strait Islander people and acknowledge their rich traditions and heterogeneous cultures.

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- Ord Valley Aboriginal Health Service (OVAHS)
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Telethon Kids Institute (TKI)

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Abbreviations

| | |
|---------|--|
| AUDIT-C | Alcohol Use Disorders Identification Test – Consumption |
| FASD | Fetal Alcohol Spectrum Disorder |
| FPHPR | FASD Prevention and Health Promotion Resources |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| OVAHS | Ord Valley Aboriginal Health Service |
| TKI | Telethon Kids Institute |



About the FASD Prevention & Health Promotion Resources Package

This work was funded by the Australian Government Department of Health and complements activities resulting from the Commonwealth Action Plan to reduce the Impact of Fetal Alcohol Spectrum Disorders (FASD) 2013-14 to 2016-17.

The Australian Government Department of Health contracted Menzies School of Health Research, in partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Telethon Kids Institute (TKI), to develop and implement a flexible, modular package of FASD Prevention and Health Promotion Resources (FPHPR). The FPHPR Package aims to reduce the impact of FASD in Aboriginal and Torres Strait Islander populations. The FASD prevention model presented in this training package is based on the Ord Valley Aboriginal Health Service (OVAHS) FASD Prevention Program which has been running since 2008. OVAHS is a Community Controlled Aboriginal Health Service which operates out of Kununurra, in the East Kimberley region of Western Australia.

The training module content was developed in 2015, by the Project Team and Training Facilitators with input from the Steering Group members and Expert Advisory Group members. The modules were piloted in five training workshops across Australia throughout 2016. In early 2017 the modules were revised and updated to reflect new evidence and feedback from the health professionals who attended the pilot workshops.

The FPHPR Package includes:

- i. Five training modules
- ii. A Facilitator Manual
- iii. A Participant Workbook
- iv. A collection of culturally appropriate resources for health service staff to use with communities. These resources are categorised according to five key target groups:
 - Aboriginal and Torres Strait Islander women who are pregnant
 - Aboriginal and Torres Strait Islander women of childbearing age
 - Aboriginal and Torres Strait Islander grandmothers and Aunties
 - Aboriginal and Torres Strait Islander men
 - Primary Health Care staff
- v. A Resource Directory.



About the Facilitator Manual

Who is this manual for?

This manual was developed as a guide for facilitators in planning, implementing and evaluating training workshops on the FPHPR Package. The training materials consist of five modules with PowerPoint slides and activities, a Participant Workbook and this Facilitator Manual.

This manual provides background information and practical instructions for the delivery of the training modules, including references and resources for further information. It also includes detailed instructions for facilitating group discussions and practical activities. The manual has been designed to be used in conjunction with the PowerPoint slides and Participant Workbook. The manual also includes templates such as sample agendas, checklists and pre- and post-workshop evaluation surveys (see Appendices).

How should the workshops be delivered?

Each community across Australia is unique and health services have varying capacity to address FASD. Therefore, facilitators are encouraged to tailor the delivery of the FPHPR workshops to ensure they are culturally appropriate and suit the learning needs of the participants. However, to maintain the integrity of the original program, the learning objectives and content of the PowerPoint slides should not be modified from the original format.

The training package was designed for flexible delivery in a face-to-face format. The five training modules can be delivered sequentially over two days or as separate, stand-alone modules. The decision to present all five modules together or individually, should be based on the needs of the health service staff attending the training.

Appendices 1 to 8 provide samples of documents that may be useful in planning your workshops eg agendas, checklists, sign-in sheets and a certificate of attendance.

Who should deliver the workshops?

Facilitators should have a sound knowledge of the key information covered in the modules and have experience working with Aboriginal and Torres Strait Islander people and/or health workers. Suggested facilitators include:

- Aboriginal or Torres Strait Islander Health Workers/Practitioners
- FASD Officers
- Health Promotion Officers or Community Development Officers
- Maternal and Child Health Nurses

If one facilitator with both clinical and cultural knowledge is not available a co-facilitation model is recommended, where a facilitator with a clinical background works together with a cultural facilitator. The role of the cultural facilitator includes providing insights into local Aboriginal and/or Torres Strait Islander history and culture and facilitating discussions of cultural issues or questions that may be raised by participants. The cultural facilitator should also be aware of any taboo or sensitive subjects.

Who is the training for?

The FPHPR training was initially designed for staff in health services that receive New Directions: Mothers and Babies Services (NDMBS) funding from the Australian Government. The NDMBS funding aims to increase access to, and use of, child and maternal healthcare services for Aboriginal and Torres Strait Islander families. While the intended audience for the training includes health professionals working with Aboriginal and Torres Strait Islander communities, the content is also relevant to those working with other communities. The resources in this package focus mainly on preventing and reducing alcohol consumption during pregnancy, however there are also resources on about smoking and substance misuse during pregnancy and sexual and reproductive health.

Training aims and learning objectives

The training modules include:

Introduction: FASD Prevention and Health Promotion Resources Training Package

Module 1: What is Fetal Alcohol Spectrum Disorder?

Module 2: Brief Intervention and Motivational Interviewing

Module 3: Monitoring and Evaluating

Module 4: Sharing Health Information

The overall aim of the training package is to enable health services to develop and implement community-driven strategies and solutions to reduce the impact of FASD by increasing:

- i. Awareness of FASD, and the impact of drinking alcohol, smoking tobacco and substance misuse during pregnancy (Module 1).
- ii. Knowledge and skills to tailor the use of FASD health promotion and education resources, in line with health service capacity and community needs (Modules 2 and 3).
- iii. Awareness of, and access to, FASD health promotion and education resources that promote current Australian recommendations and are appropriate for use with Aboriginal and Torres Strait Islander communities (Module 4).



Learning objectives

Module 1: What is Fetal Alcohol Spectrum Disorder?

- i. Increased knowledge and understanding of the consequences of drinking alcohol, smoking tobacco and substance misuse during pregnancy.
- ii. Increased knowledge and understanding of the important role of health professionals in preventing harm from drinking alcohol, smoking tobacco and substance misuse during pregnancy.

Module 2: Brief Intervention and Motivational Interviewing

- i. Increased confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking and substance misuse during pregnancy.
- ii. Increased knowledge of the AUDIT-C screening tool.

Module 3: Monitoring and Evaluating

- i. Increased awareness of the importance of monitoring and evaluating FASD prevention and health promotion strategies.
- ii. Increased knowledge of appropriate indicators to monitor and evaluate FASD prevention and health promotion strategies.
- iii. Increased understanding of the link between antenatal screening records and The Australian FASD Diagnostic Assessment Form.

Module 4: Sharing Health Information

- i. Increased knowledge of health promotion and health education strategies for FASD prevention.
- ii. Increased awareness of the FASD Prevention and Health Promotion Resources Package.
- iii. Increased skills to plan, implement and evaluate FASD health education and health promotion strategies for a range of target groups, within health services.

Interactive activities



A number of activities are included throughout the modules, shown by this symbol. The purpose of the activity, the resources and time required, and a step-by-step guide to coordinate each activity is provided.



Welcome to Country

A Welcome to Country or Acknowledgement of Country should be provided at the start of the training workshop. This is to recognise and respect the historical and continuing connection of Aboriginal and Torres Strait Islander peoples to their country and culture. A Welcome to Country is an official protocol that is performed by a Traditional Owner of the lands on which the training will take place. This should be arranged with a local Elder prior to the workshop. An Acknowledgement of Country is a statement that can be read by a non-Indigenous person. The following wording is suggested for an Acknowledgement of Country:

“I would like to acknowledge the Traditional Owners and custodians of the land on which we are meeting today. I would like to pay my respects to the Elders past and present and also to Aboriginal and Torres Strait Islander people present today.”

Potentially distressing material

Throughout the training, participants will hear stories about children and families impacted by FASD. This may cause some people distress, especially if they have had similar experiences with family, friends or personally. The training facilitators should have a plan to support participants who become upset, such as identifying a quiet area that the participant can go to and having one of the facilitators sit with them, if needed. The participant should be invited to re-join the workshop when, or if, they feel able. Facilitators should also discourage participants from ‘self-diagnosing’ as a result of attending the training. The Australian recommendation to completely abstain from consuming alcohol was published relatively recently, in 2009. Therefore it is possible that some workshop participants may have consumed alcohol while pregnant, unaware of the risks and not advised to stop. They may, or may not, choose to disclose this and so facilitators should present the FASD material in a sensitive manner at all times.



Introduction: FASD Prevention & Health Promotion Resources Package

Aim: To welcome training participants, to create an inclusive and culturally safe learning space and to provide an overview of the learning objectives and content of the training.

Note that the Introduction slides set the scene for the training by describing the background to the FASD Prevention and Health Promotion Resources Training, an overview of the content and purpose of the training modules and distress protocol.

If the training modules are being delivered individually (ie not in a series from Module 1 to 4), the Introduction slides should be delivered at the beginning of each training module.

Resources:

- PowerPoint slides
- Participant Workbooks
- Butchers paper or whiteboard and pens
- Pre- and post-workshop surveys

Slide 1: Introduction: FASD Prevention and Health Promotion Resources

Slide 2: Welcome

Purpose: To welcome participants to the workshop and conduct some 'ice-breaker' activities.

- Introduce yourself, your background and how you came to facilitate this workshop
- Provide an overview of the agenda, when the timing of breaks
- House-keeping eg toilets, procedure in case of emergency
- Answer any questions



Interactive Activity – Ice-breaker

Purpose: to help participants get to know one another and create an inclusive atmosphere for learning and participation.

Time: Allow 10 minutes, depending on the size of group

Resources: None

Instructions:

- Explain the purpose of the activity.
- Ask participants to split into pairs with someone they have not met before.
- Invite each person in the pair to share the following information with their partner

1. Your name
 2. Where you are from
 3. One reason that you are glad you are a health professional or what do you enjoy most about your role.
- After a couple of minutes remind the pairs to swap so that the second person can introduce themselves.
 - When each person in the pair has had a turn, return back to the larger group.
 - Each person introduces their partner to the whole group. Ask for a volunteer to start the discussion.
 - After all of the participants have been introduced, summarise the list of reasons why participants are glad that they are a health professional, or what they enjoy most about their role.
- Wrapping-up:
- Health professionals play important roles, especially in Indigenous communities, however there are many challenges.
 - It's important to occasionally to stop and think about "what we do, and why we do it", to re-energise and focus on the positive areas.



Interactive Activity – Goal setting

Purpose: to identify what participants would like to learn from this workshop.

Time: Allow 3 minutes

Resources: Participant Workbooks, whiteboard/butchers paper.

Instructions:

- Ask participants to write 1-2 learning goals in their Participant Workbooks.
- Ask each participant to share one of their learning goals with the whole group.
- The facilitator writes each learning goal on butchers paper.

Wrapping-up:

- The facilitator comments on goals that are included in the workshop program and on those that will not be covered in the workshop. Participants will reflect on these learning goals at the end of the session





Interactive Activity – Group ground rules

Purpose: this short activity aims to set some ‘ground rules’ to facilitate the smooth running of the workshop.

Time: Allow 5 minutes

Resources: Butchers paper

Instructions:

- Invite participants to provide ‘ground rules’, write these on the butchers paper.
- Examples – mobile phones on vibrate, one person speaks at a time, treat everyone’s ideas with respect

Wrapping-up:

- Thank everyone for their contributions.



Interactive Activity – Pre- and post-workshop surveys

Purpose: A survey will be completed at the *beginning* and *end* of each module. Participants should reflect on areas where their knowledge has increased by the end of the training.

Time: Allow 5 minutes

Resources: One copy of the pre- and post-workshop survey for each participant (Appendices 6 and 7).

Slide 3: Overview

Purpose: To provide an overview of all 4 modules.

- Hand out the Participant Workbooks
- Do a ‘walk through’ of the workbook and its content.
- Note that if the modules are being delivered individually not all of this content will be covered.

This training and resources package was designed to be used by health professionals, to increase their access to existing, high quality resources that align with Australia’s current alcohol guidelines and are culturally appropriate for Australia’s Aboriginal and Torres Strait Islander communities.



Module 1: covers definition and description of FASD, what causes it, its effects on the baby and family and how it can be prevented.

Module 2: covers brief interventions and motivational interviewing, why it is important to ask about alcohol consumption, use of tobacco and other drugs during pregnancy, and how to approach this confidently with your clients.

Module 3: explains the difference between monitoring and evaluating, and explains how data would be collected to assist with monitoring and evaluating FASD prevention activities in a health service. It also introduces the AUDIT-C, a common tool for screening for alcohol consumption during pregnancy, and how the AUDIT-C relates to the Australian FASD Diagnostic Assessment Form.

Module 4: provides an introduction to health promotion and health education approaches and strategies for addressing FASD. It includes a look at the FASD Prevention and Health Promotion Resources and a practical example of planning, implementing and evaluating a FASD prevention activity.

Slide 4: Training aims

Purpose: To describe the aims of the four training modules.

Note: if the modules are being delivered separately not all aims will be covered.

The overall aim of the training package is to enable health services to develop and implement community-driven strategies and solutions by to reduce the impact of FASD by increasing:

1. Awareness of FASD, and the impact of drinking alcohol, smoking tobacco and substance misuse during pregnancy (module 1).
2. Knowledge and skills to tailor the use of FASD health promotion and education resources, in line with health service capacity and community needs (modules 2 and 3).
3. Awareness of, and access to, FASD health promotion and education resources that promote current Australian recommendations and are appropriate for use with Aboriginal and Torres Strait Islander communities (module 4).

Slide 5: Bus stop

Purpose: To explain the bus stop concept.

Resources: Butchers paper on a wall, or space on a whiteboard. Add a heading at the top 'Bus stop'.

This 'Bus stop' will be stuck on the wall so that it can be used to note ideas, or anything that participants want to follow-up on at the end of the session. This will help keep to time and make sure no issues are dismissed or forgotten. At the end of the session re-visit the Bus stop to make sure that everything has been covered.



Slide 6: Looking after yourself

Purpose: To highlight that the content may cause participants some distress. Participants can spend time in a quiet area if they need to.

- FASD affects many families across all communities where alcohol is consumed. Some participants may share personal stories about family members affected by FASD.
- Because the guidelines for drinking alcohol in pregnancy were updated in 2009, some women may relate personal stories of drinking while pregnant without being advised of the potential risks. These issues may trigger distress in participants.
- This training has a 'no blame, no shame, no judgement' approach, acknowledging that the reasons behind consuming alcohol generally, and in particular during pregnancy, are complex.
- Please warn participants against self-diagnosing. If a participant becomes upset, they can leave the room and sit in a quiet area.
- If participants would like to connect with FASD support services they can contact the Russell Family Fetal Alcohol Disorders Association or NOFASD. Both of these are listed in the Helpful websites section of this Facilitator Manual and the Participant Workbook.

Slide 7: Acknowledgements

Purpose: To provide the participants with background on the development of the training package.

About this training package:

- In 2008 the Ord Valley Aboriginal Health Service (OVAHS) developed a community based FASD Prevention Program¹. This work was funded by the Traditional Owners, the Miriuwung and Gajerrong peoples. OVAHS is a Community Controlled Aboriginal Health Service located in Kununurra in the eastern Kimberley region of WA.
- Preliminary work with the community identified 5 key target groups
 1. All Aboriginal antenatal clients
 2. All Aboriginal women of childbearing age
 3. Local Aboriginal men
 4. OVAHS staff
 5. Local, national and international interest groups and partner organisations.
- The model of FASD prevention presented in this training package and resources was based on the OVAHS FASD Prevention Program. We are grateful for the support and experience from OVAHS Board of Directors and CEO. The willingness of OVAHS employees, Jane Cooper and Jenni Rogers, to share their knowledge and experience has been integral to the development of this training package.



Slide 8: Acknowledgements

- Menzies School of Health Research in partnership with National Aboriginal Community Controlled Health Organisation (NACCHO), Telethon Kids Institute (TKI) and OVAHS developed a flexible modular resources package to support the planning, implementation and evaluation of FASD prevention activities in health services.
- This work was funded by the Australian Government Department of Health and complements activities resulting from the Commonwealth Action Plan to reduce the Impact of Fetal Alcohol Spectrum Disorders (FASD) 2013-14 to 2016-17.

Introduction References:

1. Bridge (2011). Ord Valley Aboriginal Health Service's fetal alcohol spectrum disorders program: Big steps, solid outcome. Australian Indigenous Health Bulletin 11(4).

Introduction Further Reading and Additional Information:

Selected national initiatives addressing FASD in Australia since 2012.

- 2012 – Final report from the House of Representatives Standing Committee into FASD was tabled in parliament, titled “FASD the hidden harm – Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders”.
- 2013 – In response to the national inquiry, the Commonwealth Government released a FASD Action Plan “Responding to the Impact of Fetal Alcohol Spectrum Disorders in Australia—A Commonwealth Action Plan 2013-14 to 2016-17.” Funding of \$20 million over 4 years was allocated to this plan. One of the targeted measures in the plan included supporting prevention and management of FASD within Indigenous communities and families in areas of social disadvantage.
- 2014 – The Commonwealth National Action Plan was launched in June 2014. An additional \$9.2million was announced for work in a range of areas such as the development of a diagnostic tool, establishment of a Technical Network and further research into best practice. The development of this training package was also funded under this initiative.

For more a detailed timeline of events from 2008 to 2012 see the NOFASD website

<http://www.nofasd.org.au/Default.aspx?PageID=10531062&A=SearchResult&SearchID=94667000&ObjectID=10531062&ObjectType=1>



Module 1: What is FASD?

Aim: The aim of this session is to provide information on the impact of drinking alcohol, smoking tobacco and substance use during pregnancy; and to provide information on FASD, its causes and its effects on families and communities.

Note – If the training modules are being delivered individually (ie not in a series from Module 1 to 4), the Introduction slides should be delivered at the beginning of each training module.

Learning objectives:

- i. Increased awareness and understanding of the consequences of drinking alcohol, smoking tobacco and substance misuse during pregnancy.
- ii. Increased awareness and understanding of the important role of health professionals in preventing harm from drinking alcohol, smoking tobacco and substance misuse during pregnancy.

Resources:

- PowerPoint slides
- Participant Workbooks
- Internet access, where possible
- Butchers paper, whiteboard and pens
- Pre- and post-workshop surveys (Appendix 6 and 7 of the Facilitator Manual)

Note: If not already completed, encourage participants to write down their learning goals for this module in their Participant Workbooks and complete the Pre-workshop survey (Appendix 6).

Slide 1: Module 1: What is FASD?

Slide 2: Module 1 Learning objectives

Purpose: to provide an overview of the learning objectives for Module 1.

- Read over the learning objectives with participants.



Slide 3: “...relax, it’s not a big deal...”



Interactive Activity – FASD Conversation Starter

Purpose: To talk about the messages and advice that women might receive about drinking alcohol (and smoking and drugs) while pregnant, and the wide range of complex issues related to why people drink or misuse substances.

Time: Allow 10 minutes

Resources: none

Prompt questions:

In addition to the questions on the slide, here are some other common attitudes towards drinking while pregnant:

- ‘Most people know its ok to have few glasses of wine every now and then. The real concern is hard core drinkers who drink to excess throughout pregnancy.’
- ‘Women judge other women who drink while pregnant, especially in public.’
- ‘Older more experienced women know its ok to drink while pregnant.’
- ‘You see other friends drinking during pregnancy and know its ok to keep it at a minimum.’
- ‘I can drink during this pregnancy, I did in my last pregnancy and my toddler is fine.’
- ‘Its only a problem for alcoholics, its not a big issue in our community.’

- What is your reaction to these statements?
- What sort of comments or advice have you heard from your friends and family about drinking during pregnancy?
- How would you describe the drinking culture in Australia?
- What are the mixed messages and pressures that pregnant women are exposed to?
- What role could/should health professionals play?

Points for group discussion:

- These are common opinions that reflect the previous NHMRC guidelines from 2007. In 2009 the guidelines changed to specifically recommend that “not drinking is the safest option”.
- Opinions like these reinforce stereotypes about Australia’s drinking culture. eg its ok for older women to drink as they are not ‘problem drinkers’. In fact research shows that compared with women who abstained or women who only drank in trimester 1, older women who smoke, have higher household incomes and higher levels of education are more likely to drink for the duration of their pregnancy (Muggli et al 2016 – see Further Reading section at the end of Module 1).
- There are many reasons why women drink, and many reasons why women hide pregnancies. Some hide pregnancies so they can still drink if they are dependent on alcohol.

- This is a very complex area and if these are the messages heard by the public it may be difficult to change behaviour.
- The role of health professionals is vital to provide the correct information.

Wrapping-up:

- In light of many common misconceptions and myths about alcohol and pregnancy, the purpose of this training package is to build health professionals' confidence in discussing alcohol at antenatal visits and advising women and their families that no alcohol at all is the safest option for the duration of the pregnancy.

Slide 4: What is FASD?

Purpose: to define FASD and discuss how to explain the term to clients.

- FASD stands for Fetal Alcohol Spectrum Disorder.
- FASD is an acquired brain injury caused by maternal consumption of alcohol before birth.
- The degree of harm caused sits along a spectrum, meaning that children can be affected relatively mildly or severely.
- Consuming alcohol while pregnant affects normal healthy development and can result in lifelong disabilities. This is because the placenta does not filter out alcohol and any alcohol in the mother's blood stream also enters the fetus.
- The use of the term 'fetal' may imply that it only relates to unborn babies, however the damage caused is permanent and so children, young people and adults can have FASD.
- The effects of prenatal alcohol exposure may not be seen at birth. In particular behavioural and learning issues may become more apparent as the child enters school.
- FASD occurs in all parts of Australian society where alcohol is consumed. It has lifelong consequences and the personal costs to people living with FASD and their families are enormous.
- There is no cure for FASD. However, it is entirely preventable by not drinking alcohol while pregnant.





Interactive Activity – Discussing FASD with clients or other community members

Purpose: To discuss how you would explain the term Fetal Alcohol Spectrum Disorder to clients or other community members.

Time: Allow 5 minutes

Resources: None

- When explaining the meaning of FASD to clients it can be useful to use local language or local terminology.
- If you aren't originally from the local area or aren't familiar with the traditional languages of the area, ask clients what words they use eg for alcohol.
- Using the language of your clients personalises your messages, helps build a connection and helps them relate to you.

An example with language used locally around Kununurra:

Fetal – baby growing in the *binji* (local term for belly)

Alcohol – grog, any strength even low alcohol

Spectrum – broad range like a rainbow

Disorder – illness or disarray *dungudup* (local term meaning messed up)

- How would you explain FASD to your clients?
- Are there local words you would, or would not, use?

Slide 5: There is no 'safe' level

Purpose: to highlight that every person is different and how alcohol affects the fetus will differ from person to person, and can also be different for each pregnancy.

- A common attitude is 'I drank during my first pregnancy and my child is fine'. However, every woman is different and every pregnancy is different.
- This slide shows the many underlying factors which affect the impact of alcohol during pregnancy eg the mother's nutritional status and stressors in her life. The presence of one or more of these factors determines the risk of harm to the developing baby¹.
- It is impossible to know which woman will get a 'poison effect' from alcohol, or how badly.

Other factors affecting the risk of FASD^{1,5}:

- Genetics – some genes affect the way alcohol is metabolised.
- Stress/grief/loss – specific life events may result in extra stress and drinking more than usual or bingeing eg death of a family member or a friend. Alcohol, drugs or smoking

may also be used to deal with chronic stress eg financial pressure, insecure housing. On the other hand, celebrations may also result in a binge drinking session eg weddings.

- Social pressures – family and friends may try to convince others to keep drinking especially if they are heavy drinkers or don't want to drink by themselves. It can be very difficult to say 'no'.
- Social isolation – feeling alone, disconnected from family or culture or not wanted, can result in using alcohol or drugs to try to feel better or make these feelings go away.
- Lack of education about impact of alcohol – sometimes people might not be aware of the negative effect of alcohol on physical and mental health, and the damage it can cause to family or community relationships when drinking excessive amounts.
- Poor nutrition.
- Poverty, unemployment and homelessness – financial stress, not having a job or having an uncertain one, homelessness or unsafe living conditions can all have negative impacts on health, however these can have particular effect on the health of the mother and therefore also her baby.
- Family violence – family violence may start or escalate once a woman tells a partner she is pregnant, or a pregnant woman may feel unable to leave a violent relationship. This could lead to women hiding pregnancies and continuing with unsafe behaviours so that others don't suspect she is pregnant.
- The presence of some or all of these factors in the lives of women of childbearing age may lead to drinking, using drugs or smoking before pregnancy is confirmed, and even continuing with these behaviours throughout pregnancy.
- During pregnancy it is impossible to actually see how alcohol, drugs and smoking affect the growth and development of the fetus. Unless there are physical effects at birth, FASD can be 'invisible' and the behavioural and learning difficulties may not be realised until the child starts school.
- The next slide shows how FASD is diagnosed.

Slide 6: Australian diagnostic criteria for FASD

Purpose: to explain the criteria for diagnosing FASD.

Prior to 2016, FASD was an umbrella term covering 4 diagnoses:

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome
- Alcohol Related Birth Defects (ARBD)
- Alcohol Related Neurodevelopmental Disorder (ARND)

Some participants may have heard these terms before. In mid-2016 researchers from the Telethon Kids Institute and the University of Sydney and a panel of experts recommended this be simplified to two subcategories.



- In 2016 new diagnostic guidelines were developed for Australia².
- Diagnosis has been simplified to 2 sub-categories
 1. FASD with 3 sentinel facial features
 2. FASD with less than 3 sentinel facial features
- The criteria for each sub-category are shown on the slide. Along with evidence of prenatal alcohol consumption, there are 10 neurodevelopmental domains that are assessed for severe impairment, as well as the sentinel facial features.
- The 10 neurodevelopmental domains are all areas of the brain that are known to be affected by alcohol during pregnancy. Besides helping to provide a diagnosis, the assessment of these areas assists health professionals, the person affected and their families to fully identify the individual's strengths and needs to develop an appropriate plan for management, support and referral.
- The assessment may be done with children, teenagers or adults.
- Ideally, the diagnostic assessment for FASD would be conducted by a multidisciplinary team including a paediatrician, psychologist, speech pathologist and an occupational therapist.
- Assessments may be conducted at specialist clinics or by seeing health professionals at multiple services.
- The assessment process may be confronting. It is important that the individual, their caregiver and family, should receive appropriate practical and psychological support.
- This training will not go into further detail on diagnosis. The Telethon Kids Institute has developed the Australian Guide to the Diagnosis of FASD which includes e-learning modules (see Further Reading for Slide 6).
- Next, we'll look further into the physical and behavioural effects on the child, the consequences these have throughout their life, and the impacts on family and community.

Slide 7: Sentinel facial features

Purpose: to illustrate the three sentinel facial features.

- Alcohol effects the development of many facial features as shown in this picture³.
- It is important to note that the severity and type of effects on the child depend on the amount of alcohol consumed and when it was consumed during pregnancy.
- For example drinking alcohol during the first 12 weeks, when the middle region of the face is developing, usually results in the presence of the 3 sentinel features used to diagnose FASD.
- The role of alcohol is most clearly established in these, so they are considered the sentinel features for diagnosis.
 - i. narrower eye width
 - ii. indistinct, smooth philtrum (groove between lips and nose)
 - iii. thin upper lip



- Next, we'll look further into the physical and behavioural effects on the child, the consequences these have throughout their life, and the impacts on family and community.

Slide 8: FASD: the invisible harm

Purpose: to highlight that many people affected by alcohol use in pregnancy do not display physical signs of FASD. There are many invisible disabilities caused by alcohol use in pregnancy.

- FASD is often called the 'invisible harm' because many of its effects relate to intellectual impairments that cannot be seen².
- Brain growth and development occur throughout pregnancy.
- As a result, consuming alcohol at any time during pregnancy can interrupt the proper development of pathways for performance and functioning such as motor skills, learning, memory, language.
- These may occur without the facial anomalies we saw on the previous slide, or without structural central nervous system abnormalities (the central nervous system includes the brain and spinal cord).
- Because these children look like everyone else, society expects them to act like everyone else despite their special needs.

Slide 9: FASD: the visible harm

Purpose: to use the FASD simulator doll to illustrate that the effects of prenatal alcohol exposure can range from visible to invisible.

If you have access to one of these dolls, pass them around the group for people to look at. If not, use the slide to show the features of the simulator.

- The dolls can be used to demonstrate that FASD occurs along a spectrum, that is, FASD encompasses a wide range of effects from relatively minor to severe impairments.
- This doll has the 3 sentinel facial features and would be considered at the more severe end of the spectrum (smaller eye widths, smooth philtrum, thin upper lip), smaller head and brain (microcephaly – often resulting in intellectual impairments). The doll is smaller in size and doesn't look as healthy in general.
- However these facial features are not always obvious and not all babies exposed to alcohol during pregnancy have these features.
- There is also a 'healthy looking' doll, this can be used to show that even a healthy and normal looking baby can have hidden effects of FASD if the mother drank alcohol while pregnant – behavioural problems, cognitive impairments, damage to vital organs such as heart, liver, lungs and impaired senses such as vision and hearing.
- The FASD simulator dolls can be used to help your clients, community members or other health professionals to understand that even 'healthy' looking babies can have FASD.



- This has implications for children, teenagers and adults with FASD who ‘look normal’ and are expected to behave normally, but may have cognitive or behavioural deficits and therefore face many challenges at home, at school and at work.
- How could you use these simulator dolls in your clinic or health service?

Slide 10: FASD: Signs and symptoms (1)

Purpose: to provide examples of how FASD impacts daily life in childhood.

Infants and Toddlers (0-3 years)⁴

- Irritable and do not respond to holding and rocking
- Hypersensitive to light, noise, touch, taste
- Delayed development sitting, crawling, walking and talking
- Jitteriness/tremors
- Attachment and bonding issues
- Hearing and vision difficulties
- Lack of stranger anxiety

Pre-School (4-5 years)

- Hyperactivity
- Attention deficits and easily distracted
- Temper tantrums and disobedience
- Low frustration tolerance
- Trouble organising own play
- Language problems
- Poor motor coordination
- Lack of physical boundaries (touching people inappropriately)
- Overly friendly behaviour (linked with an ability to recognise who is safe and familiar)
- Toilet training delays

Slide 11: FASD: Signs and symptoms (2)

Purpose: to provide examples of how FASD impacts daily life throughout the teenage years.

Adolescence (12-17 years)⁴

- Limitations with daily skills
- Problems learning from experience
- Restless
- Low self-esteem
- Truancy
- Risk of substance abuse
- Few or no friends



Slide 12: FASD: signs and symptoms (3)

Purpose: to provide examples of how FASD impacts daily life throughout adulthood.

Adults (over 18 years)⁴

- Depression, suicidal thoughts, suicide
- Unplanned pregnancies and parenthood
- Unpredictable behaviour
- Withdrawn and socially isolated
- Homeless
- Substance abuse and mental illness
- Violence and abuse (both perpetrator and victim)
- Arrest, incarceration, in and out of jail

Slide 13: Effects of disabilities caused by FASD

Purpose: to explain to effects of cognitive impairments on day-to-day living

- Primary disabilities are those that most directly relate to the underlying damage to brain function. Often these behaviours are evident in childhood and can become ingrained by adolescence. This slide shows some examples of primary disabilities and how, over time, these can lead to more complex issues for the child and their family⁵.
- We now know that when learning and behavioural issues are detected earlier, strategies can be put in place at school and at home to support the child to cope better and focus on their strengths, and in the long term prevent these secondary behaviours and poor outcomes that we have just seen in the previous slide.
- Memory – can have difficulties with forming associations, integrating and retrieving information and also have inconsistent memory resulting in remembering a task in the short term and then ‘forgetting’ it later on. When teachers, parents etc expect the child to have ‘normal’ memory, they may resort to lying in order to ‘fill in the blanks’ (and not always remember the lies they have told, resulting in greater trouble).
- Social skills – may have difficulties with boundaries and impaired judgement. May not be able to apply generalised rules to all situations eg understands not to steal from one person, and then steals from another. Young people and adults function socially, emotionally and mentally at a much younger developmental age than chronological age eg 25 year old acting like a 13 year old. As a result they often lose friends easily, get bullied and become isolated.
- Slow cognitive or auditory pace – thinks slowly and gives the appearance of ‘shutting down’, they need much longer to respond to questions. Auditory delays mean that language is processed more slowly and more time is needed to comprehend what has been said.

- Language – experience difficulty comprehending and accurately answering questions. May talk excessively but are unable to engage in a meaningful exchange, the volume of words used may create the impression of competence.
- Children living with FASD experience barriers in information processing. They cannot interpret instructions, are unable to consistently retain information already learned and then use it in daily life. They are constantly in trouble for getting it wrong and worse, cannot understand why. Often get angry and destructive due to frustrations. They are chronically overwhelmed and anxious.

Slide 14: Protective factors

Purpose: to show some of the factors that could potentially reduce the impact of FASD.

- The presence of some of these factors may reduce the severity and the impact of the secondary conditions, and their consequences, from the previous slide⁵.
- Note that early diagnosis can be a protective factor, as it allows families to seek support.

Slide 15: Effects of FASD throughout life

Purpose: to illustrate a *potential* pathway throughout life of someone with FASD.

- The challenging behaviours displayed by children with FASD often escalate in teenage years and young adulthood.
- Earlier diagnosis of FASD and access to positive supports result in greater understanding of the behaviours, and therefore how to best manage them at home and school. This can lead to better outcomes for child and their family.
- However, in Australia early intervention options for people with FASD are virtually non-existent and this can result in a greater likelihood of poor engagement in education and employment.

For example:

- A young child may make the same mistakes over and over again because they don't link cause and consequence
- They may act immaturely, not understand appropriate behaviours and may be disruptive in class.
- They may experience bullying because they don't fit in. Later they may drop out of school.
- They can go from victim to perpetrator.
- May 'graduate' from truancy, to juvenile jail to 'big man' jail, leading to a cycle of going in and out of jail.
- May self-medicate with alcohol and drugs. Suicide is a major concern.



Slide 16: No blame, no shame

Purpose: to highlight the complexity of addressing alcohol consumption in pregnancy.

- The best approach is a 'no blame, no shame, no judgement' approach.
- Women do not intentionally want to cause harm to their unborn child.
- There is a complex mix of social and cultural factors that influence whether and how much a woman drinks, and whether she continues or stops during pregnancy.
- Women who are dependent or addicted to alcohol will need additional supports and referral to specialist services. In these cases, the aim may be to minimise harm by reducing in the number of daily standard drinks, rather than abstinence.

Slide 17: Hidden Harm



Interactive Activity – Hidden Harm video

Purpose: To provide real-life examples of the impacts of FASD on families and communities.

Time: Allow 15 minutes, the video duration is 7.5min and 6-7 minutes for the group discussion.

Resources:

- Internet to access, where possible.
- If the internet is not available, ask workshop participants to read the transcript of the video.

Background:

“Hidden Harm”, reported by Deb Whitmont, aired on the ABC’s ‘4 Corners’ program on 2 November 2015. The whole program runs for 45mins. We will only watch about 8 minutes of video.

- Summary of section 1. Anne Russell and her 31yr old son Seth, discuss their struggles with the impacts of FASD on Seth and their family. Seth was undiagnosed until 17 years of age. He had many bad experiences at school, has experienced depression and uses drugs and alcohol to self-medicate. Anne has two sons with FASD and points out that in the 1980s the risks of drinking alcohol while pregnant weren’t widely known in Australia. Anne has established a foundation to raise awareness of FASD and assist families like hers to access support services.
- Summary of section 2. This section takes us to Fitzroy Valley in WA’s Pilbara region. June Oscar explains the devastating effects FASD has on Aboriginal culture, and Maureen Carter talks about some of the early benefits they have seen as a result of raising awareness of the dangers of drinking during pregnancy. In 2009 researchers led by the

community investigated the extent of alcohol exposed pregnancies in the Valley. This is the first such study in Australia, and one of a few worldwide. After finding high rates of FASD amongst their children the women of Fitzroy Valley have come together to develop the Marulu Strategy to respond with positive actions.

Instructions:

- To play the video embedded in slide 17 click on the link and forward to 22min 50sec.
- If the internet is not available, read through the transcript included in the Further Reading section for slide 17.
- After watching the video or reading the transcript open up group discussion – Are there any comments on the video?

For further information about Anne Russell’s story or the work of the Marninwarntikura Women’s Resource Centre featured in this program, see the Further Reading for slide 17.

Slide 18: Teratogens

Purpose: to explain the effects of teratogens.

- Teratogens (pronounced *te-rat-o-gens*) are a group of substances that cause birth defects⁶.
- Exposure to teratogens should be avoided during pregnancy.
- What are some examples of teratogens?

Examples:

- Environmental factors eg radiation, x-rays, mercury, lead
- Infections in mother eg chickenpox, rubella, STIs
- Some prescribed drugs. The most well known is Thalidomide (commonly prescribed in the 1960s to treat morning sickness, and resulted in babies born with missing or partial arms and legs). Others include warfarin, some anti-epileptic and anti-depressant medications.
- Illicit drugs
 - Marijuana – low birth weight, intracranial bleeding, jitteriness, low blood sugar, sepsis (blood infection), poor feeding, irritability, rapid breathing.
 - Amphetamines – low birth weight, premature birth, intracranial bleeding.
 - Cocaine – issues with the placenta, increased risk of miscarriage, growth restriction, impaired development of urinary tract or genital tract, microcephaly (small brain), neuro-behavioural problems, and increased startle reflex and jitteriness.



- Tobacco, both first-hand and second-hand smoke (associated with premature birth and small birth weight, impaired development of brain, cardiovascular and respiratory system, born with increased startle reflex, tremor)
- Alcohol

Slide 19: Effects of teratogens during pregnancy

Purpose: to highlight the impact of teratogens at all stages of fetal development.

- The effects of alcohol exposure on fetal development occur throughout pregnancy (including before the pregnancy is confirmed), with the developing fetus being most vulnerable to structural damage during the first three to six weeks of gestation¹⁰.
- Effects also vary depending on the dose of alcohol and the pattern of consumption. The most serious of the adverse pregnancy outcomes occur when pregnant women consume high levels of alcohol frequently.
- Diagrams like this can be useful to explain the key areas of development that occur during gestation. It shows the rapid development during the first 8 to 10 weeks of pregnancy, often before a woman knows she is pregnant, and highlights that smoking, drinking, using drugs during this time can have enormous impact on the growing baby.
- However, clients could get the wrong impression from this diagram, so it should be carefully explained.
- For example, the red sections finish about week 10, this could be interpreted as ‘after week 10 not much growth happens therefore I can drink or smoke’.
- The message should be that significant harm can occur during the whole pregnancy, as Central Nervous System (brain and spinal cord) and organs (eyes, ears, heart, lungs) and limbs are continually developing.

Slide 20: Effects of teratogens

Purpose: to highlight the significant impact of legal drugs (alcohol, tobacco) and illicit drugs on the fetus.

- This slide shows some of the specific problems caused by Cannabis, Ice, Tobacco and Alcohol use during pregnancy⁷.
- Note that the legal drugs – alcohol and tobacco – cause substantial harm to the unborn child.
- Note also that alcohol ‘ticks all the boxes’ and has wide ranging effects.
- This is thought to be because the alcohol molecule passes through the placenta very easily.
- We will explore alcohol and tobacco use during pregnancy in the following slides.



Slide 21: Alcohol and unplanned pregnancies

Purpose: to explain how alcohol is transmitted to the fetus.

- Drinking levels in the period before pregnancy are high. A West Australian survey with non-Indigenous women found that 14 per cent of respondents reported drinking five or more standard drinks on a typical occasion during this period⁸.
- As many pregnancies are unplanned (47% in the West Australian survey with non-Indigenous women), many fetuses may inadvertently be exposed to alcohol before pregnancy is confirmed⁸.

Slide 22: Transmission of alcohol to the fetus

Purpose: to explain how alcohol is transmitted to the fetus.

- Alcohol is broken down and removed by the body by complex chemical processes called metabolism. The mother's metabolism can affect how much a fetus will be damaged by alcohol. Many factors affect metabolism including the mother's body weight, the amount of alcohol consumed and time she has spent drinking⁹.
- For example, age-related increases in maternal body fat-to-water ratio can affect alcohol metabolism. Thus, children of drinking mothers over 30 are more vulnerable to being born with FASD²¹.
- The alcohol molecule passes through the placenta very easily, so the amount of alcohol in the amniotic fluid can be as high as the mother's blood alcohol concentration. Also the fetus can not metabolise alcohol so the fetal alcohol concentration will remain higher for longer, until it is removed from the mother's bloodstream.
- It is a myth that the placenta will filter out all of the 'bad stuff' and keep baby safe.
- The 'no alcohol' message should to be continued postnatally for breastfeeding.

Slide 23: Australian Guidelines to Reduce Health Risks from Drinking Alcohol (1)

Purpose: to provide the current Australian Guidelines on alcohol consumption for women who are pregnant or breastfeeding, and to discuss issues arising from these.

- Now that we've looked at some of the consequences of consuming alcohol during pregnancy, it is not surprising that the Australian Guidelines to Reduce Health Risks from Drinking Alcohol recommend that "for women who are pregnant, planning a pregnancy or breastfeeding, not drinking is the safest option"¹⁰.
- Previous Guidelines from 2001 suggested that women who were pregnant should 'consider' not drinking at all. However the guidelines also stated that if they chose to drink they should do so at low levels (defined as less than 7 standard drinks per week, no more than 2 standard drinks on any occasion) and they should never become intoxicated. This gave the impression that drinking during pregnancy carried no increased risk. This recommendation was changed in 2009.



- Now the clear message is that “for women who are pregnant, planning a pregnancy or breastfeeding, not drinking is the safest option”.
- The recommendation was changed because, based on the quality of evidence available, there is no ‘safe’ level of alcohol consumption that will avoid harm to the developing baby.
- Despite the new guidelines in 2009 it is still a widely held belief that low levels of drinking during pregnancy are ok. Along with our Australian social norm around drinking, this has understandably led to confusion among women who are pregnant or planning to become pregnant.
- Ask the group – What might be some of the challenges with the latest Guidelines?

Slide 24: Australian Guidelines to Reduce Health Risks from Drinking Alcohol (2)

Purpose: to provide the current Australian Guidelines on alcohol consumption for women who are pregnant, and to discuss issues arising from these.

These are the key messages for health professional to give to clients and communities¹⁰.

1st point. Not drinking is the safest option.

2nd point. The risk of harm is highest when there is high, frequent alcohol consumption.

3rd point. The risk of harm is likely to be low if only small amounts of alcohol were consumed before she knew she was pregnant or during pregnancy.

- “Maternal alcohol consumption can result in a spectrum of harms to the fetus. Although the risk of birth defects is greatest with high, frequent maternal alcohol intake during the first trimester, alcohol exposure throughout pregnancy (including before pregnancy is confirmed) can have consequences for development of the fetal brain. It is not clear whether the effects of alcohol are related to the dose of alcohol and whether there is a threshold above which adverse effects occur. However, variation in effects can be due to the stage of development of the fetus at the time of exposure and to individual characteristics of the mother.”¹⁰

4th point. The level of risk to the individual fetus is influenced by maternal and fetal characteristics and is hard to predict.

- As we discussed earlier in this session, every woman is different and every pregnancy is different and we can’t predict how much harm alcohol will have on the fetus.
- The inclusion of women who may not be planning a pregnancy is important. Almost half of all pregnancies are unplanned and women may continue their usual drinking habits before realising they are pregnant.
- Women may feel anxious and worried for the health of their baby if they have unintentionally exposed their baby to harm by continuing to drink before finding out they were pregnant. The important thing to remember is that they should stop drinking from then on.



Slide 25: Australian Guidelines to Reduce Health Risks from Drinking Alcohol (3)

Purpose: to provide the current Australian Guidelines on alcohol consumption for women who are breastfeeding, and to discuss issues arising from these.

- The potential harm to infants caused by alcohol in breastmilk is beyond the scope of this training program as it is not directly related to the prevention of FASD. However participants may be interested in this topic especially as many will continue to see clients for post-natal visits. Like alcohol and pregnancy there is confusion about alcohol and breastfeeding.
- The 2009 Australian Guidelines recommend avoiding alcohol while breastfeeding¹⁰.

1st point. Not drinking is the safest option.

- Alcohol enters and exits breastmilk from the blood stream and may persist in the milk for several hours after alcohol consumption. The concentration of alcohol in breastmilk is equal to the blood alcohol level.
- Alcohol affects the behaviour (eg disrupted sleeping) and psychomotor development of the breastfed baby.

2nd point. Avoid alcohol until breastfeeding is well established.

- Alcohol adversely affects breastmilk production, milk let-down reflex and baby's feeding behaviour.

3rd point.

- It takes approximately 30 minutes (from the start of drinking) for alcohol to appear in breastmilk.
 - Like blood alcohol levels, only time will reduce the amount of alcohol in breastmilk. The length of time it takes for alcohol to be removed from breastmilk differs between individuals and is based on many factors including bodyweight, how much food has been consumed and how much alcohol has been consumed in a given timeframe.
- There is concern that messages recommending women avoid alcohol altogether will result in lower breastfeeding rates. Therefore, if women who are breastfeeding choose to drink alcohol, the advice is to plan ahead and express milk to cover feeds while drinking and also while waiting for alcohol levels to reduce.
 - The Australian Breastfeeding Association (ABA) has developed a brochure and a free app for Apple and Android devices, called 'Feed Safe'. Both provide an approximate time when the breastmilk is free of alcohol, based on body weight and number of standard drinks consumed (see Further Reading and Additional Information section at the end of Module 1).



Slide 26: Tobacco and pregnancy (1)

Purpose: to introduce the issue of smoking during pregnancy.

- Most people are aware that smoking is bad for your health, however it also harms unborn babies.
- In particular the following health issues are associated with smoking during pregnancy¹¹.
 - Ectopic Pregnancy. An ectopic pregnancy is when the fertilized egg implants itself in the fallopian tubes, not the uterus. They are extremely dangerous for the mother, and cause internal bleeding. Women who smoke have an increased risk of ectopic pregnancy.
 - Spontaneous abortion or miscarriage. The risk of miscarriage is 20-80% higher in women who smoke during pregnancy.
 - Placental complications. Women who smoke during pregnancy have a higher risk of placental abruption (detached from wall of uterus) and placental previa (placenta located very close to covering the cervix).
 - Low birth weight. Babies born to women who smoke are an average of 200gms lighter. It is important to note that women who quit smoking in the first trimester are at no greater risk of a low birth weight baby. The greatest risk for low birth weight is for women who smoke in the second and third trimester.
 - Premature delivery. Women who smoke during pregnancy are at a greater risk of having their baby prematurely.
 - Sudden infant death syndrome (SIDS). Research has shown that women who smoke during pregnancy, and continue to smoke after birth, have an increased risk of their baby dying of SIDS.
 - Cleft palate, cleft lip and childhood cancers.

Slide 27: Tobacco and pregnancy (2)

Purpose: to show rates of smoking during pregnancy and higher rates in some groups of women.

The following data are from the Australians Mothers and Babies 2014 report (AIHW 2016)¹²

- Overall, in 2014, 11% of Australian women who gave birth had smoked at some stage in their pregnancy.
- One-fifth (22%) of women who smoked in first 20 weeks, did not continue to smoke for the rest of their pregnancy.
- Smoking was higher in some groups, younger women, women who lived remotely or very remotely and Indigenous women.
 - Age – 32% of mothers aged younger than 20 years smoked in first 20 weeks, compared with 6% in mothers aged 35-39 years.



- Remoteness – 34% of mothers living in very remote areas and 20% of mothers living in remote areas smoked in the first 20 weeks compared with 6% in major cities.
- Indigenous mothers – 44% of Indigenous mothers smoked in the first 20 weeks compared with 12% of non-Indigenous mothers.

Slide 28: What is in a cigarette

Purpose: to illustrate the harmful chemicals contained in cigarettes.

- Tobacco smoke contains 4,000+ harmful chemicals.¹³
- Including 69 chemical agents which are known to cause cancer.¹⁴
- The three main chemicals in cigarettes are nicotine, carbon monoxide and tar.
- Nicotine is the highly addictive drug found in tobacco leaves, which causes dependence on smoking.
- Nicotine is a stimulant and has the following effects:
 - increases heart rate, blood pressure, breathing rate and the amount of blood pumped around by the heart.
 - stimulates the nervous system.
 - causes important blood vessels to narrow, including those which lead to the heart and brain.
- Carbon Monoxide is a poisonous, odourless gas that's produced during the burning of tobacco.
 - It reduces the blood's ability to carry oxygen around the body, starving the blood tissues and heart and reducing the body's ability to exercise efficiently and function as efficiently.
- Tar is the black-brown sticky substance that is the mixture of gases and particles inhaled when a smoker draws on a cigarette.
 - Tar has many known carcinogens, it contains a large number of chemical compounds, can stain smokers fingers and teeth, and affect the air sacs in the lung causing coughing, increased phlegm, and shortness of breath.

Slide 29: Myths – Tobacco and pregnancy

Purpose: to dispel common myths about smoking during pregnancy.

- Read the information on the slide and discuss with participants.
- Need to promote the message that a small baby = sickly baby = long term bad health.
- Allow participants the opportunity to discuss any other myths.



Slide 30: Supporting Smoking Cessation: A guide for health professionals (1)

Purpose: to provide current recommendations for health professionals to support their antenatal clients to quit smoking, and discuss issues potential arising from the guidelines.

- In 2014 the Royal Australian College of General Practitioners (RACGP) published a guide for health professionals to support clients to stop smoking.¹¹
- The key message for smokers is to quit smoking, ideally before conception or as early as possible.
- There is no safe level of smoking, and any exposure to nicotine or tobacco smoke increases the risk of adverse effects for both mother and baby.
- The greatest gain in health benefit comes from quitting rather than cutting down.
- Women who smoke, or use NRT, should still be encouraged to breastfeed. Babies exposed to second-hand smoke are more susceptible to illness and infections, however breastmilk provides some protective benefits to the infant's immune system.
- Ask the group – What might be some of the challenges with the latest Guidelines?

Slide 31: Supporting Smoking Cessation: A guide for health professionals (2)

Purpose: to provide current recommendations for health professionals to support their antenatal clients to quit smoking and discuss issues arising from these.

- These are the key messages for health professional to give to clients and communities.¹¹

1st point. Encourage pregnant women to stop smoking.

- Smoking during pregnancy causes a range of effects including stillbirth, spontaneous abortion, reduced fetal growth, premature birth, low birth weight, cleft palate, cleft lip and childhood cancers.

2nd point. Offer intense support and proactive telephone counselling eg Quitline

3rd point. Supplement this with self-help material.

- Quitting at any time produces health benefits.
- Counselling, advice and support should be offered before pharmacotherapy.

4th point. If the above strategies are not successful, consider NRT with clear explanation of risks involved.

- Use if the mother is motivated to quit and the increased risk of quitting outweighs the harmful effects on the fetus from continued smoking.

5th point. Those who quit should be supported to stay non-smokers in the long-term.

- 20-30% of women quit while pregnant, however about 70% will relapse either during pregnancy or afterwards.
- Staying quit will have health benefits for the mother, but will also reduce dangers of passive smoking to her child (eg risk of SIDS, lung infections, asthma).



- Mothers who smoke should be encouraged to breastfeed to strengthen baby's immune system and help to protect baby from the harmful effects of passive smoking.

Slide 32: Nicotine Replacement Therapy (NRT) and pregnancy

Purpose: to discuss the safe use of Nicotine Replacement Therapy (NRT) for women who are pregnant or breastfeeding

Types of Nicotine Replacement Therapy available in Australia include:

- Patches
- Chewing gum
- Lozenges
- Sublingual tablets
- Inhalers
- Pharmaceuticals

Advice for pregnant women:¹¹

- Ideally, quitting smoking during pregnancy should be achieved without NRT, and may include strategies such as self-help materials, counselling and education. NRT should be used when all other strategies fail.
- Use of nicotine replacement products during pregnancy is not contraindicated, however it is also not free from risk.
- NRT is considered safer for both mother and unborn baby than smoking, because the pregnant mother avoids the many toxins in cigarette smoke that harm the fetus.
- There have been few studies looking into NRT in pregnancy, and conclusions were drawn that gum, lozenges, sublingual tablets or inhalers are safe to be used under the supervision of the doctor overseeing her pregnancy.
- However, nicotine patches were shown to increase risk of abnormalities, therefore are generally not recommended. The RACGP recommends that if patches are used, they should not be worn during the day to avoid continuous exposure of the fetus to nicotine.
- The prescription medicines bupropion (Zyban) and varenicline (Champix) are not approved for use during pregnancy.

Advice for breastfeeding women:¹¹

- It is recommended that breastfeeding women use quick response forms of NRT (gum, lozenges, sublingual tablets or inhalers) for cravings.
- It's important that the women feed first, before use.
- Small amounts of nicotine, from cigarettes or NRT, can be found in breastmilk, however the amount of nicotine from NRT is smaller than for cigarettes and is less harmful than second-hand smoke.



Slide 33: Combined substance use and pregnancy

Purpose: to highlight how alcohol, tobacco and marijuana (and the combination of the three) impacts infant health, specifically birth weight.

Background:

- The Western Australian Aboriginal Child Health Survey¹⁵, a large-scale epidemiological survey of the health and well-being of 5,289 Western Australian Aboriginal and Torres Strait Islander children, was undertaken in 2001 and 2002 by the Telethon Institute for Child Health Research.
- Planning, data collection and reporting of results was overseen by an Aboriginal Steering Committee.
- Surveys were conducted in households with carers of Aboriginal or Torres Strait Islander children aged 0-18 years. Over 95% of respondents consented for their child's data to be linked to birth records and hospital records, providing a comprehensive record of health service contacts.
- On this graph, the left hand side is birth weight in grams. The red line shows average birth weight of about 3,310g when no alcohol or tobacco was reported (optimal birth weight). In pregnancies where alcohol was consumed average birth weight was about 50g less than optimal weight. Where tobacco was used during pregnancy, average birth weight was about 200g less than optimal. Where both alcohol and tobacco was used the average birth weight was about 250g less than optimal weight.
- When marijuana use was reported during pregnancy, average birth weight was 200g lower than optimal weight. When marijuana, tobacco and alcohol were all reported during pregnancy birth weight was 370g lower than optimal birth weight.
- This suggests that each substance has an additive effect on the reduction in birth weight (tobacco lowers birth weight, adding alcohol lowers further and adding marijuana lowers it further still). So interventions to stop or reduce the use of these substances may be an opportunity to improve birth weights.
- Low birth weight babies are more susceptible to infections and other adverse developmental outcomes.

Slide 34: We do know that...

Purpose: to summarise the information on alcohol consumption and FASD so far.

- FASD is entirely preventable if alcohol is not consumed during pregnancy.
- There is no cure for FASD.
- Women, especially young women, are consuming alcohol at levels that put their health at short-term and long-term risk.
- Around half of pregnancies are unplanned.
- Around 45% of Australian women drink during pregnancy.



- People with FASD are eligible to receive disability support (it is not a recognised disability under the National Disability Insurance Agency in Australia, however, people with FASD can receive support determined by the level of impairment and not the name of the disability).

Slide 35: We don't know...^{16, 17}

Purpose: to highlight that in order to prevent FASD and provide appropriate supports to families, we need an accurate picture of the issue in Australia.

- Although a number of Australian FASD prevalence studies have been undertaken, these can, at best, only provide a rough idea of the scope of the problem. This is largely due to the challenges inherent in obtaining a diagnosis of FASD and the consequent issues associated with collecting reliable data.
- The difficulty in establishing accurate prevalence rates for FASD in Australia has been well documented and is linked to a range of issues such as:
 - Women may not be willing to openly admit they have consumed alcohol if they have potentially, and inadvertently, harmed their baby. They may feel guilt, regret, shame, fear. Especially in Aboriginal and Torres Strait Islander communities there may be a fear of children being removed.
 - Lack of routine screening and data collection for pregnancies exposed to alcohol and FASD. There is no national data set that collects information on antenatal alcohol consumption during pregnancy (there is for smoking during pregnancy). And health professionals may not be aware of the importance of asking women about alcohol consumption during pregnancy.
 - In May 2016 the Australian FASD Diagnostic Instrument and Guidelines² were released for use by multi-disciplinary teams. This provides clinicians with a set of criteria and comprehensive guidelines for diagnosing FASD, referring families and supporting families through the process.
 - It is important to note that one of the diagnostic criteria is 'evidence of prenatal alcohol exposure'. Therefore the screening questions you ask in your antenatal consultations, and the records you keep, may be used in future to help determine whether FASD is likely.

Slide 36: Estimating FASD prevalence in Australia

Purpose: to show that Aboriginal communities are leading the way in recognising FASD as an issue and seeking strategies to address FASD¹⁸.

Slides 37, 38, 39: Key messages

Purpose: to revise the key messages for alcohol¹⁰, smoking¹¹ and pregnancy

- Briefly review the key messages and answer questions from participants.



Slide 40: The role of health professionals^{19, 20}

Purpose: to reinforce the important role of health professionals in providing the correct information to women who are pregnant or planning a pregnancy.

- Pregnant women expect to be told by health professionals everything they need to know about having a healthy pregnancy.
- When you, as a health professional, have the opportunity to educate a pregnant woman on the impact of alcohol, you make a significant contribution to prevention FASD in Australia.
- Health professionals, especially those who see antenatal clients, play an important role in health education by:
 - improving knowledge, attitudes, self-efficacy and individual capacity to change;
 - increasing access to and promoting use of the health services.

Slide 41: Module 1: Review

Purpose: to reflect on the learning objectives for Module 1.

Slide 42: Finishing up

Purpose: To close the session and answer any outstanding questions the participants might have.

Note: If this module is being presented on its own, complete the learning reflection, post-workshop survey and certificates of attendance (see below). If this module is being presented as a series, continue on to the next module.

Learning reflection

Ask participants to reflect on the learning goals they wrote in their Participant Workbooks at the beginning of the workshop.

Post-workshop survey

Evaluation is an important component of the training. At completion of the module, distribute the post-workshop survey (Appendix 7). Ask the participants to compare their post-workshop survey answers with those from the pre-workshop survey (Appendix 6). Participants do not need to reveal their scores but are encouraged to comment or personally reflect on any changes.

Certificates of attendance

Distribute the certificates of attendance (Appendix 5) and thank the participants for their attendance.



Module 1 References:

1. Adapted from PowerPoint presentation to Menzies Health Darwin by Nancy Poole Director, BC Centre Of Excellence For Women's Health Prevention.
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6. *Things to Avoid During Pregnancy: Teratogens*. Accessed January 2017 from <http://www.aboutkidshealth.ca/En/ResourceCentres/PregnancyBabies/Pregnancy/HealthCareinPregnancy/Pages/Things-to-Avoid-During-Pregnancy-Teratogens.aspx>
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10. National Health and Medical Research Council (2009). *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. Commonwealth of Australia. Canberra. Accessed January 2017 from https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf
11. Royal Australian College of General Practice (2014). *Supporting Smoking Cessation: A guide for health professionals*. Accessed January 2017 from <http://www.racgp.org.au/your-practice/guidelines/smoking-cessation/>

12. Australian Institute of Health and Welfare (2016). Australia's mothers and babies 2014. Accessed January 2017 from <http://www.aihw.gov.au/publication-detail/?id=60129557656>
13. Bates, C., Jarvis, M. and Connolly, G. (1999). Tobacco Additives: Cigarette engineering and nicotine addiction London; Action on Smoking and Health.
14. US Department of Health and Human Services. (2004). The health consequences of smoking: A report of the Surgeon General Atlanta; US Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
15. Zubrick, S., Lawrence, D., Silburn, S., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'Antoine, H., Read, A., Ishiguchi, P. and Doyle S. (2004). The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People. Perth: Telethon Institute for Child Health Research.
16. O'Leary, C., Nassar, N., Kurinczuk, J. and Bower, C. (2009). The effect of maternal alcohol consumption on fetal growth and preterm birth. BJOG: An International Journal of Obstetrics and Gynaecology 116: 390-400
17. Henderson, J., Gray, R. and Brocklehurst, P. (2007). Systematic review of the effects of low-moderate prenatal alcohol exposure on pregnancy outcomes. BJOG: An International Journal of Obstetrics and Gynaecology 114 (3): 243-252.
18. Fitzpatrick, J. and Carmichael-Olsen. (2015). The Lililwan Project: Neurodevelopmental outcomes and FASD in Remote Australian Aboriginal Children.
19. Alcohol and Pregnancy Project (2007). Alcohol and Pregnancy: Health Professionals Making a Difference. Perth: Telethon Institute for Child Health Research.
20. Hunter, E., Brady, M. and Hall, W. (2000). National Recommendations for the clinical management of alcohol-related problems in Indigenous Primary Care settings. Canberra: Commonwealth Department of Health and Aged Care.
21. Jacobson, J., Jacobson, S. and Sokol, R. (1996). Increased vulnerability to alcohol-related birth defects in the offspring of mothers over 30. Alcoholism: Clinical and Experimental Research 20 (2): 359-63.



Module 1 Further Reading and Additional Information:

Slide 3: Muggli, E., O'Leary, C., Donath, S., Orsini, F., Forster, D., Anderson, P., Lewis, S., Nagle, C., Craig, J., Elliott, E. and Halliday, J. (2016). "Did you ever drink more?" A detailed description of pregnant women's drinking patterns BMC Public Health. 16:683.

Slide 4: Telethon Kids Institute website accessed 30/11/2016
<http://alcoholpregnancy.telethonkids.org.au/about-fasd/what-is-fasd>

Slide 6: The Australian Guide to the Diagnosis of FASD and training modules can be accessed from
<http://alcoholpregnancy.telethonkids.org.au/australian-fasd-diagnostic-instrument/australian-guide-to-the-diagnosis-of-fasd/>

Slide 13: For further information on how the behaviours of children and young people with FASD can be misinterpreted
Drug Education Network (2011). Living with Fetal Alcohol Spectrum Disorder: a Guide for Parents and Caregivers. Accessed January 2017 from
<http://beta.den2.handbuiltcreative.com/wp-content/uploads/2011/08/Living-with-FASD.2011.pdf>

Slide 17: Transcript of Hidden Harm video

Section 1 (22min 50sec to 27min 50sec). Anne and Seth Russell.

DEB WHITMONT: Life has held few pleasures for Seth Russell and his mother, Anne. Seth Russell is 31. Until he was 17 and diagnosed with FASD by a doctor in Canada, he didn't know what was wrong with him.

Seth's school days hold little but bad memories.

SETH RUSSELL: I didn't learn anything at school. I remember a primary teacher who used to, um, grab my arm so tight that he'd leave bruises and marks on me.

ANNE RUSSELL: Because he...

SETH RUSSELL: I don't know why. I can't remember why but it was probably 'cause I didn't understand something and...

DEB WHITMONT: When Seth was born, his parents lived in a Queensland mining town. His mother, Anne, says she hates herself for what at the time was considered social drinking.

ANNE RUSSELL: Ah, we didn't, ah, drink any more or any less than anybody there at the time. Um, when I got pregnant, um, with Seth: ah, three to four drinks, ah, two to three or four times a week. And, um, those social, um, few drinks made



the difference between, um, Seth having a life that he should be leading right now and having the life that he currently does lead.

DEB WHITMONT: Anne Russell says, back in the '80s, her doctor told her there was no harm in having a few drinks in pregnancy. When she found herself with two uncontrollable children, she was told to go and take a course in parenting.

ANNE RUSSELL: Nothing seemed to make any difference: no punishment, no reward system, no o-, um, um... tough love, no- absolutely nothing worked. Um, it didn't matter if I took away a toy. It didn't matter if I said, "If you do this then I'll get you something." Nothing mattered.

They would, you know, jump on furniture, break furniture. I couldn't go out. Um, people, in fact, stopped coming around.

DEB WHITMONT: Life was equally miserable for her younger son, Seth.

SETH RUSSELL: I never knew when I was tired. I never knew I was getting tired. My brain would go a million miles an hour, constantly: 100 different things at a time. Always thinking, always running around. Um, I could never stop.

DEB WHITMONT: By his early teens, Seth was sleepless, frustrated and failing at school. He started getting into trouble, drinking and taking drugs.

ANNE RUSSELL: Um, I think he needed to have something that made his head slow down, made his mind slow. And because we didn't know what was wrong, he had a lot of stimulation. He had a lot of frustration at school 'cause he was always in trouble but he never, ever knew why. Every time the police siren, every time we saw the police go past, every time we heard an ambulance, it was Seth.

SETH RUSSELL: Um, I've had many people who were saying, "There's nothing wrong with you. Get over it." It's not the case. I look fine, I act fine. But nobody actually knows what goes on in my head. Things that, um, my brain does to me without me even wanting to. Makes life very difficult.

ANNE RUSSELL: And then when he started becoming suicidal, which was quite early in his school years, because his frustration at not being able to do what other children could do: a child suicidal at 10 is just not right.

SETH RUSSELL: I've been, ah, v- suicidal my whole life.

DEB WHITMONT: Do you still feel like that sometimes?

SETH RUSSELL: All the time, every day.

DEB WHITMONT: How do you stop it?

SETH RUSSELL: I don't think about it. Drugs. Drugs and alcohol.



DEB WHITMONT: Anne Russell believes that if Seth had been diagnosed sooner, she might have been able to help him avoid some of the pain of drugs and depression.

ANNE RUSSELL: Um, it just escalates from puberty on. It escalates, ah, without a diagnosis. Um, it can escalate until prison.

And prison and, or suicide are the two sort of end games, really, for, for people with FASD who haven't been diagnosed.

DEB WHITMONT: It's in Indigenous communities that FASD has been the most devastating.

So far, only one place in Australia has been brave enough to confront the extent of the problem. For the Fitzroy Valley, it was a matter of survival.

JUNE OSCAR, CEO, MARNINWARNTIKURA WOMEN'S RESOURCE CENTRE: We're a people that rely on an oral tradition, heritage. So our history, our languages, our ceremonies, our songs and dance requires us to have an ability to retain in memory all of these, ah, important things.

So if our children's brains are being damaged by alcohol, then it places at huge risk the survival of our cultures and our traditions.

(To Maureen Carter) So you're saying you could use this to...

DEB WHITMONT: Research in the Fitzroy Valley revealed one of the highest FASD rates in the world, with one in every five children now aged between 12 and 13 affected by foetal alcohol.

But even doing the study has begun to make a difference.

MAUREEN CARTER, CEO, NINDILINGARRI CULTURAL HEALTH SERVICES: Ah, there's a lot more awareness around, ah, the dangers of drinking during pregnancy. And a lot of our women now are abstaining from drinking alcohol.

DEB WHITMONT: There could be up to 300 children with FASD in the Fitzroy Valley - among them, 16-year-old Tristan Hand and his younger cousins, Quaden and Tylon.

GEOFF DAVIS, GRANDPARENT: Tristan must be the loveliest person in the world. Um, his, um disability sometimes means that he loses control of his emotions, so he can, he can, he can really lose it if he gets really anxious or something really upsets him.

(Footage of Tristan Hand riding his bicycle)

GEOFF DAVIS: Righto, show us your style, Tristan.



DEB WHITMONT: But in remote communities there are few services, little hope of a job and, so far, no strategies for the future for Tristan and hundreds of others like him.

MARMINGEE HAND, GRANDPARENT: You know, for this community, ah, one of the things that we really should be is having our, um, a strategy in place. We hope that people will understand that these children, um, are different. They are different from, um, other people and they've got needs and the, and, and we need to look after them in a certain way.

- End of transcript -

To find out more about Anne Russell's experiences and the support foundation she has established see the Russell Family Fetal Alcohol Disorders Association (rffada) <http://www.rffada.org/>

To find out more about the FASD projects by the Marninwarntikura Fitzroy Women's Resource Centre in the Fitzroy Valley <http://www.mwrc.com.au/>

Slide 25: Breastfeeding and alcohol consumption.

- The Australian Breastfeeding Association (ABA) has developed a brochure and a free app for Apple and Android devices, called 'Feed Safe'. Both provide an approximate time when the breastmilk is free of alcohol, based on body weight and number of standard drinks consumed.
<https://www.breastfeeding.asn.au/bf-info/safe-when-breastfeeding/alcohol-and-breastfeeding>
- There are some limitations for both the brochure and the app.
- The information in the brochure only provides information for women up to 86kg and up to 6 standard drinks. This is a limitation for larger women or those who have had more than 6 drinks.
- The app is more specific and requires you to enter your weight and height. You can also enter fractions of a drink (eg 1.5 drinks). A countdown timer starts once the relevant information has been entered.
- However both require women to know what a standard drink is and track how much they've been drinking. The app has a link to the NHMRC standard drinks guide.

Slide 35: We don't know...

Some common questions you may hear from participants include:

- *'what support is available for children and their families once a FASD diagnosis has been made?'*
This varies across Australia. There are support agencies for families and carers eg NOFASD and rffada (contact details are listed in the 'Helpful websites' section of this Facilitator Manual and the Participant Workbook).



- *'if FASD is a disability, are children eligible for government support?'*

At the time of finalising this training package (August 2017) FASD was not a recognised disability under the National Disability Insurance Agency in Australia. However, people with FASD can receive support determined by the level of impairment. Key experts in the field are advocating and lobbying for it to be recognised by the National Disability Insurance Agency in the future.

Slide 36: For more information on FASD projects by the Marninwarntikura Fitzroy Women's Resource Centre in the Fitzroy Valley <http://www.mwrc.com.au/>



Module 2: Brief Intervention and Motivational Interviewing

Aim: The aim of this session is to develop health professionals' skills and confidence to provide brief interventions and use motivational interviewing techniques with antenatal clients.

Note – If the training modules are being delivered individually (ie not in a series from Module 1 to 4), the Introduction slides should be delivered at the beginning of each training module.

Learning objectives:

- i. Increased confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking and substance misuse during pregnancy.
- ii. Increased knowledge of the AUDIT-C screening tool.

Resources:

- PowerPoint slides
- Participant Workbook
- Internet access, where possible
- Butchers paper, whiteboard and pens
- NSW Ministry of Health standard drinks chart (featured in the FPHPR package)
- Sets of glasses/cups of different sizes eg tumbler, highball, red, white and sparkling wine glasses, water jug
- Department of Veterans Affairs measure jug
- Pre- and post-workshop surveys (Appendix 6 and 7 of the Facilitator Manual)

Note: If this module is being presented as part of a two-day workshop present slides 1 onwards. If this module is being presented as a standalone module, present the Introduction session and proceed to slide 3. If not already completed, encourage participants to write down their learning goals for this module in their Participant Workbooks and complete the Pre-workshop survey (Appendix 6).

Slide 1: Module 2 Brief Intervention and Motivational Interviewing

Slide 2: Review Module 1 What is FASD?

Purpose: to review the content from Module 1.

- Read over the learning objectives with participants.

Slide 3: Module 2 Learning objectives

Purpose: to provide an overview of the learning objectives for Module 2.

- Read over the learning objectives with participants.



Slide 4: Australian Guidelines to Reduce Health Risks from Drinking Alcohol (1)

Purpose: to review the current Australian Guidelines on alcohol consumption for the general population.

- These guidelines were revised in 2009.
- The guidelines are now the same for both men and women, no more than 2 standard drinks a day and no more than 4 standard drinks on a single occasion¹.
- 1. No more than two standard drinks a day reduces the risk of long term disease or injury.
 - As alcohol consumption increases, the lifetime risk of death from alcohol-related disease or injury also increases.
 - For both men and women, the lifetime risk of death from alcohol related disease is about 0.4 in 100 when two drinks per day are consumed. When 3 drinks per day are consumed, this triples to more than 1 in 100.
- 2. No more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury.
 - Having four drinks on a single occasion more than doubles the relative risk of an injury in the six hours afterwards.
- 3. Not drinking is the safest option for young people under 18 years of age.
 - Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
 - For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible.

Slide 5: Australian Guidelines to Reduce Health Risks from Drinking Alcohol (2)

Purpose: to review the current Australian Guidelines on alcohol consumption for women who are pregnant or breastfeeding.

- Previous guidelines gave the impression that drinking during pregnancy carried no increased risk and that women should only ‘consider’ not drinking during pregnancy.
- Now the clear message is that “for women who are pregnant, planning a pregnancy or breastfeeding, not drinking is the safest option”.¹
- Despite the new guidelines in 2009 it is still a widely held belief that low levels of drinking during pregnancy are ok. Along with our Australian social norm around drinking, this has understandably led to confusion among women who are pregnant or planning to become pregnant.



Slide 6: Many factors influence women's behaviour during pregnancy

Purpose: to provide an overview of some of the cultural aspects that may influence women's choices to consume alcohol during pregnancy.

- When designing and implementing initiatives aimed at reducing FASD in Aboriginal and Torres Strait Islander communities, there are a range of factors that will influence the effectiveness of these efforts.²
- There are many reasons why women do drink during pregnancy and there are many reasons women do not drink during pregnancy.
- As health professionals it is important to be aware of these factors and to consider the client's emotional state when tailoring services and support systems to meet her specific needs.
- The image presented in this slide may be used to facilitate a discussion with antenatal clients around the client's current needs². This image may also aid health professionals and their pregnant clients to explore the woman's positive support networks and any services that may be offered to them.

Slide 7: Individual level influencers

Slide 8: Organisational level influencers

Slide 9: Community level influencers

Slide 10: Public policy influencers

Purpose: to discuss the varied and complex factors that can contribute to an individual's consumption of alcohol, and additional issues that are relevant during pregnancy.

Note, further information is provided in the Further Reading and Additional Information section for Module 2. This content will also be reviewed again in Module 4 (slide 7).

- Read over each slide with participants.
- For each slide ask the group to contribute additional examples.
- What are some factors that you think might influence a woman's decision to consume (or not consume) alcohol during pregnancy? Consider individual, interpersonal, organisational, community, policy as well as cultural and historical factors.

Slide 11: Current practices

Purpose: to encourage participants to reflect on how they currently support clients to consider behaviour change.

- As a group discuss the questions on the slide.



Slide 12: Why brief interventions?

Purpose: to introduce brief interventions to support behaviour change.

- Brief interventions are informal and opportunistic, evidenced-based approaches to assist clients to make positive changes when they are motivated and ready to change.
- Brief interventions can take between 5 and 20 minutes, and may occur over multiple sessions.
- The ongoing follow-up involved in antenatal care provides an ideal setting for brief interventions. Women are also more motivated to consider positive behaviour changes during pregnancy.

Slide 13: Brief interventions for healthy pregnancies

Purpose: to provide an overview of brief interventions with antenatal clients.

- Brief interventions should provide information on the consequences of risky behaviour during pregnancy, assessment of readiness for behaviour change, problem solving and exploration of referral options to assist with behaviour changes.⁴
- Some key skills for brief interventions are listed on the slide. These processes serve a number of purposes including:
 - helping to build rapport
 - helping assess how the client feels
 - assessing readiness for change

Slide 14: Motivational interviewing

Purpose: to introduce motivational interviewing.

- Motivational interviewing is a client-focused, therapeutic approach that acknowledges the client as the expert on themselves.
- The health professional works with the client collaboratively to increase their autonomy while avoiding taking a confrontational or authoritative approach.
- Motivational interviewing is based on the following key principles^{5,6}:
 - Expressing empathy through active listening and reflecting back to the individual what you understand to be their current thoughts and feelings.
 - Developing discrepancies by drawing attention to times when the individual was different to their current situation and exploring with them what was different then.
 - Rolling with resistance by gently suggesting new perspectives and options to the individual.
 - Supporting self-efficacy by encouraging and supporting the individual's self-motivation and any small movements towards the individual's desired change.



Slide 15: Motivational interviewing techniques

Purpose: To provide an overview of motivational interviewing techniques.

- OARS is a strategy for active listening and to assist the client to identify their own motivations for change⁷
 - Open ended questions. Invite others to “tell their story” in their own words.
 - Affirmations. Statements that recognise client strengths and acknowledge behaviours in the direction of positive change, no matter how big or small. Affirmations build confidence in the client’s ability to change. To be effective, affirmations must be genuine.
 - Reflective listening. Used to engaging others in relationships, building trust, and fostering motivation to change, includes an interest in what the person has to say and respect for the their inner wisdom.
 - Summarising statements. Summarising helps to ensure that there is clear communication, and can provide a stepping stone towards change. Can be used at any time, but particularly useful during transitions in the conversation, eg after the client has told a story, or the appointment is ending.
- A summary of motivational interviewing is provided in Appendix 2 of the Participant Workbook.

Slide 16: How do you feel about brief intervention and motivational interviewing?



Interactive Activity – Readiness Rulers⁸

Purpose: to demonstrate the use of a ‘Readiness Ruler’ to determine confidence and importance in making a change.

Time: allow 10 minutes

Resources:

- Butchers paper or whiteboard and pens

Instructions:

- Refer participants to the ‘Readiness Rulers’ in their Participant Workbook, Appendix 2 (also included in the Further reading section for Slide 16).
 1. How important do you think it is to do brief interventions & motivational interviewing around alcohol consumption during pregnancy?
 2. How confident do you feel to do brief interventions & motivational interviewing?
- Ask the participants to think about these questions and to rate where they currently along a scale from 0 to 10, with 0 being not at all important/confident and 10 being extremely important/confident.

- Ask for 1 or 2 volunteers to discuss their rating of importance or confidence with the rest of the group.
 1. Why did you rate yourself where you did?
 2. Why did you not rate yourself a 0? (if applicable)
 3. What do you need to increase your rating?
- These rulers can be a useful tool to engage clients to think about how *important* the change is to them and how *confident* they feel to be able to make the change.
- These rulers are particularly useful with youth and males, as they are quantifiable and interactive eg it can be effective to sit down together with a client and make (and even decorate) these rulers to start the conversation,

Slide 17: The 5A's approach

Purpose: to introduce the 5A's approach to behaviour change conversations.

- The 5A's is an evidence-based framework to guide behaviour change conversations,⁹ eg for alcohol, tobacco and substance misuse during pregnancy as well as contraception options and family planning.
- **ASK** all women about their alcohol, tobacco and other drug use as part of their general health check. For women who are pregnant or planning pregnancy, assess their alcohol consumption on their first visit and regularly thereafter.
- **ASSESS** and record the level of risk from alcohol consumption, smoking tobacco and substance misuse using validated screening tools (discussed in more detail in Module 3: Monitoring and Evaluating). It is important to assess how many standard drinks are being consumed. Many people aren't aware of what a standard drink is, activities that can aid with this conversation will be explored later on in this module.
- **ADVISE** all women, regardless of whether or not they are drinking alcohol that there is no safe level of alcohol that can be consumed during pregnancy, therefore no alcohol is the safest choice for women who are pregnant or trying to become pregnant.
- **ASSIST** women to stop or reduce their risky behaviours by encouraging women to set their own goals for change. Provide positive reinforcement to those who have made attempts or have already made healthier choices, and remind them of the reasons to continue with this for the remainder of their pregnancy.
- **ARRANGE** for further support for women who would benefit from specialist help to reduce or to abstain from alcohol, tobacco or other drugs. Referrals may be internal or to an external specialist or support group.



Slide 18: 5A's video



Interactive Activity – 5A's video

Purpose: To discuss the good and not-so-good aspects of the brief intervention and motivational interviewing techniques demonstrated in the video.

Time: allow 10 minutes

Resources:

- Internet access, where possible
- Video link embedded in PowerPoint slide
- NSW Ministry of Health standard drinks chart (within the FPHPR package)

Background:

The '*Women Want to Know*' project was developed by the Foundation for Alcohol Research and Education (FARE) in collaboration with leading health professional bodies across Australia and is supported by funding from the Australian Government Department of Health.⁹

The video can be accessed from

<http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/wwtk>

Instructions:

- Play the video embedded in slide 18. If the internet is not available, read through the transcript included in the Further Reading section for slide 18.
- After watching the video or reading the transcript open up group discussion about brief intervention and motivational interviewing techniques.
- Prompt questions:
 - How did you feel the demonstration went?
 - What were some of the negative aspects of the video?
 - What were some of the positive aspects of the video?

Note: The doctor in the video referred to a standard drinks chart to aid the conversation. This resource was developed by the NSW Ministry of Health and is available in the FPHPR package, titled "standard drinks guide". Copies of this chart may be ordered for free from <http://yourroom.com.au/aboriginal-resources/>.

Slide 19: Ask

Purpose: to encourage the participants to explore different opportunities for asking women about alcohol, smoking, substance misuse and contraception and to determine any concerns they may have in doing this.

- Ask participants to think about the questions on this slide and write responses in their Participant Workbook, or discuss with a colleague.

Slides 20-21: Barriers to asking about risky behaviours in pregnancy

Purpose: to provide examples of some concerns raised by other health professionals when asking antenatal clients about alcohol consumption, smoking or substance misuse.

- All pregnant women should be asked about their alcohol consumption and provided with information about FASD. Presenting this information up-front will minimise the woman's feelings of being judged or singled out.
- Link the concerns raised by the participants to the list on this slide. Write a few of the most common issues on the whiteboard.
- Discuss why these are common concerns, and how they could be reduced. How would you overcome this issue in your health service? What supports or other services do you have access to at your health service that might assist you with this?

Slides 22-23: Assess – Alcohol consumption

Purpose: To explain why screening tools are important.

Why do we use screening tools to measure alcohol consumption?

- Standardised way of identifying risk.
- Reliable way to assess risk for a range of people.
- Can be good for tracking progress over time.
- Can be referred to later on to assist with FASD diagnosis.
- In research, makes comparing across services easier.
- Refer participants to Appendix 3 of the Participant Workbook and briefly go through the AUDIT-C questions⁹.
- Ask participants if they have seen or used the AUDIT-C before and if so, to share their experience.
- Note that the AUDIT-C tool produced for the Women Want to Know Campaign⁹ (in Appendix 3 of the Participant Workbook) is designed for use by health professionals to assess current levels of alcohol consumption and then use this information as part of a brief intervention conversation. The AUDIT-C tool on slide 23 is from the Australian FASD Diagnostic Assessment Form¹⁰. It would probably be completed retrospectively, and has a slightly different way of interpreting the score, to inform a FASD diagnosis.



Slide 24: Assess – Standard drinks

Purpose: to introduce an activity that may be used with clients to assess number of standard drinks.

The Australian standard drink measure contains 10g of alcohol (equivalent to 12.5mls of pure alcohol). For example⁹

- 100ml glass of red wine at 13% alc vol = 1 standard drink.
- 100ml glass of white wine at 11.5% alc vol = 0.9 of a standard drink.
- 375ml bottle or can of full strength beer at 4.8% alc vol = 1.4 standard drinks.
- 30ml nip of high strength spirit at 40% alc vol = 1 standard drink.
- 330ml bottle of full strength ready-to-drink 5% alc vol = 1.2 standard drinks.

Note: Both standard drinks activities described below may be presented if time permits. If time does not permit, choose the activity that will have the most practical use to the participants.



Interactive Activity – estimating standard drinks

Purpose: To demonstrate that standard drinks are difficult to gauge and that this may lead to some clients underestimating the number of standard drinks they consume.

Time: allow 15 minutes

Resources:

- Jugs of water
- Variety of glassware (you may be able to ask the training venue to provide some of these glasses) eg
 - Champagne glass
 - White wine glass
 - Red wine glass
 - Beer glass
 - Spirits glass
- Measuring jug – order through the Department of Veterans Affairs

Instructions:

- Break the participants into groups of 2-3 people, with a jug of water, measuring jug and set of glassware for group.
- Ask participants to estimate a standard drink and pour this into each of the different types of glasses eg pour a standard drink of red wine (water) into the red wine glass.
- Once the participants have guessed a standard drink for each glass, ask them pour the water into the measuring jug. This will allow them to compare their estimate with a measured standard drink.

- This activity usually raises awareness that people often over-pour their drinks. This makes it hard to track how much alcohol is being consumed. It also means that clients may underestimate how many standard drinks they consume, which could affect the results of the AUDIT-C.



Interactive Activity – Standard drinks quiz

Purpose: to demonstrate another way to raise awareness of standard drink measurements using a range of popular alcoholic drinks.

Time: allow 10 minutes

Resources:

- Standard drinks quiz (Appendix 1 in the Participant Workbook)

Instructions:

- Break the participants into groups of 2-3 people
- Ask participants to connect the picture of the alcoholic beverage to the number of standard drinks
- This activity can be useful in raising clients' awareness of the number of standard drinks contained within their favourite alcoholic beverages. Knowledge of number of standard drinks makes it easier to track how much alcohol they consume, which could affect the results of the AUDIT-C.

Slide 25: Assess – Stage of change

Purpose: to introduce the Stages of Change model¹¹.

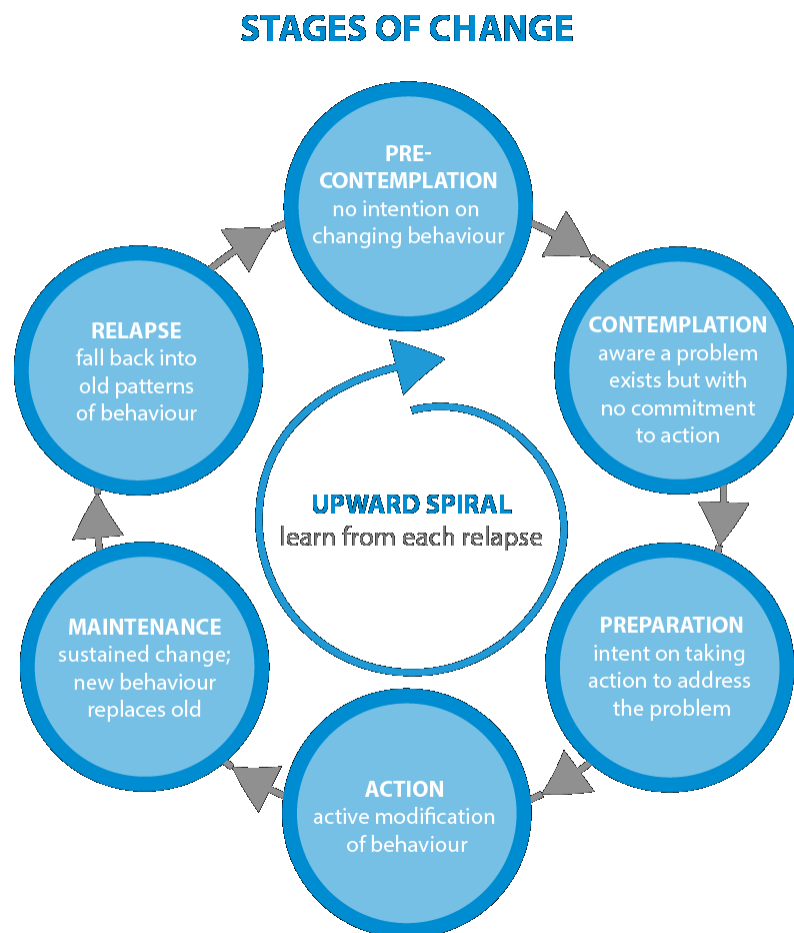


Image source: The Homeless Hub¹²

- **Pre-contemplation** – at this stage people are not thinking seriously about changing and tend to defend their current behaviour patterns. They may not see their behaviour as a problem due to the benefits of their risky behaviour outweighing any costs or adverse consequences.
- **Contemplation** – people in this stage are able to consider the possibility of quitting or reducing their use but feel ambivalent about taking the next step. On one hand they may still enjoy parts of their risky behaviour, while on the other hand they're starting to experience some adverse consequences (including personal, psychological, physical, legal, social or family problems).
- **Preparation** – people in this stage have usually made a recent attempt to change their behaviour in the last year. The 'cons' of continuing have now outweighed the 'pros' and they are less ambivalent about taking the next step. They believe that change is necessary and that the time for change is imminent. They are usually taking some small

steps towards changing their behaviour, however some people at this stage still decide not to do anything about their behaviour.

- **Action** – people in this stage are actively changing their behaviour and making great steps towards significant change, however, they are at greatest risk of lapse or relapse.
- **Maintenance** – people in this stage are able to successfully avoid any temptations to return to their previous risky behaviour. They have learned to anticipate and handle temptations and are able to employ new ways of coping. They may have a temporary slip (lapse), but don't tend to see this as a failure.
- **Lapse/relapse** – Lapse and relapse are an inevitable process of change. A lapse is a slip up with a quick return to action or maintenance whereas a relapse is a return to the original risky behaviour. Both lapse and relapse are important for learning and helping the person to become stronger in their resolve to change. Alternatively relapses can be a trigger for giving up in the quest for change. The key to recovering from a relapse is to review the change attempt up to that point, identify personal strengths and weaknesses, and develop a plan to resolve those weaknesses to solve similar problems the next time they occur.

Slide 26: Assess – Readiness for change

Purpose: to re-introduce the 'Readiness Rulers' for behaviour change.

- The key elements that are necessary for an individual to decide to change and successfully change are:
 - The want and need for change
 - The feeling that they can change
 - The feeling that now is the right time to change
- Instilling the importance of change by providing information on the risks associated with FASD and encouraging the individual to identify pros and cons of their current behaviour as well as promoting the positives of making the change.
- Increasing confidence that change can occur by supporting the individual through the provision of relevant information, support systems and services to allow them to make their desired change.
- Creating a change plan – explored in Slide 32.
- The 'Readiness Rulers' (see Further Reading for slide 16) can be a useful tool to explore the clients feelings about change – how *important* the change is to them and how *confident* they feel to be able to make the change.

Slides 27-28: Advise – What are the guidelines?

Purpose: to briefly review the current recommendations for consuming alcohol for women who are pregnant or breastfeeding.¹



Slide 29: Advise – Stage of change and actions

Purpose: to provide examples of tailoring advice to individuals at different stages of change.

- **Pre-contemplation** – the client is usually happy with their behaviour and does not see a need to change. Provide brief advice on the guidelines and offer advice on harm minimisation strategies.
- **Contemplation** – at this stage the individual will identify reasons to make a change versus risks for staying the same. Help to increase their confidence and encourage them to identify positive reasons for change.
- **Preparation** – the individual will likely be taking steps towards changing. Work with the client to set suitable goals and encourage their successes towards change. Ask the individual what they've already tried and what has been successful for them in the past.
- **Action** – in this stage the client has been doing the healthy behaviour for between 1 to 6 months. It's important to continue to encourage and celebrate the individual's successes towards changing. Help them to consider strategies to cope with potential barriers.
- **Maintenance** – the client has been doing the healthy behaviour for at least 6 months. Continue to support the client by identifying potential temptations and forming strategies for relapse prevention. Help the individual to identify support systems close to them that may be used to keep them on track.
- **Lapse/relapse** – This is either a one-off or longer-term regression back to the 'old' unhealthy behaviour. Help the client to return to the 'preparation' stage. Let the client know this is very common, and discuss learnings from the experience to the same situation in the future. Point out ways in which the individual was successful previously to encourage them to try again.

Slide 30: Assist – Decisional balance

Purpose: to introduce ways to strengthen a client's commitment to change as part of motivational interviewing.

- Identifying pros and cons for making change or staying the same (also known as decisional balance). The aim is to provide the client with relevant information and explore her feelings about her substance use. The client, rather than the health professional, identifies the potential problem areas.
- Exploring worst-case scenario/best-case scenarios to encourage a pregnant woman to think about the future.⁶

Slide 31: Assist – Open-ended questions

Purpose: to provide examples of some open-ended questions that may be used to address alcohol consumption during pregnancy.

- Read over the slide with participants.
- Ask the group to contribute additional examples.



Slide 32: Assist – Create a change plan

Purpose: to provide an example of how to create a change plan with clients who are ready to change their behaviour.

- Writing a change plan will help to solidify their goals, why they want to reach them, and how they plan to do it.
- Health professionals should help their clients to develop a change plan however the plan should be primarily developed and driven by the client.
- An example change plan is outlined on the next slide¹³.

Slide 33: Assist – Sample change plan

Goal: (select one or create own)

- I will drink no more than ___ drink(s) on any day and no more than ___ drink(s) per week (refer to current guidelines).
- I will stop drinking.

Timing: I will start on this date...

Reasons: My most important reasons to make these changes are...

Strategies: I will use these strategies...

People: The people who can help me are (names and how they can help)...

Signs of success: I will know my plan is working if...

Possible roadblocks: Some things that might interfere—and how I'll handle them...

Roadblocks I've experienced and how I've handled them...



Slide 34-35: Arrange



Interactive Activity – local support services

Purpose: to help the participants explore different services and referral pathways that are available to them that they can offer to their clients.

Time: allow 15 minutes

Resources: Appendix 5, Participant Workbook

Instructions:

- Break the participants into 4 groups, each group will address one of the following topics:
 - contraception
 - smoking cessation
 - alcohol consumption
 - substance misuse
- Consider the questions on the slide and identify services they could refer clients to within their area. Use Appendix 5, Participant Workbook for recording notes.
- Invite the participants to share their ideas with the rest of the group.

Slide 36-38: Brief intervention example – Smoking

Purpose: To provide an example of different ways to respond depending on the client's stage in the change cycle.

- When working through the different stages of the change cycle with your clients, it's important to:
 - Try supportive counselling first.
 - Suggest practical ways to reduce the behaviour eg lower dose, intermittent nicotine through lozenges, inhalers or gum.
 - Provide key information relating to the chosen solution eg if the client has chosen to try patches to quit smoking, advise them that they will need to remove the patch at night time.
 - Continue to reinforce how they have been able to make positive changes.

Slide 39: Module 2: Review

Purpose: to reflect on the learning objectives for Module 2.

Slide 40: Finishing up

Purpose: To close the session and answer any outstanding questions the participants might have.

Note: If this module is being presented on its own, complete the learning reflection, post-workshop survey and certificates of attendance (see below). If this module is being presented as a series, continue on to the next module.

Learning reflection

Ask participants to reflect on the learning goals they wrote in their Participant Workbooks at the beginning of the workshop.

Post-workshop survey

Evaluation is an important component of the training. At completion of the module, distribute the post-workshop survey (Appendix 7). Ask the participants to compare their post-workshop survey answers with those from the pre-workshop survey (Appendix 6). Participants do not need to reveal their scores but are encouraged to comment or personally reflect on any changes.

Certificates of attendance

Distribute the certificates of attendance (Appendix 5) and thank the participants for their attendance.



Module 2 References:

1. National Health and Medical Research Council (2009). Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Commonwealth of Australia. Canberra. Accessed January 2017 from https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf
2. Hayes, L. (2012). Aboriginal woman, alcohol and the road to fetal alcohol spectrum disorder. *Medical Journal of Australia*, 197(1): p. 21-23.
3. Victorian Department of Human Services. (2009). Alcohol beverage advertising in mainstream Australian media 2005 to 2007: expenditure and exposure.
4. The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn. East Melbourne, Vic: RACGP, 2016.
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7. Substance Abuse and Mental Health Services Administration. (2007). *Motivational Interviewing: The basics*, OARS. Accessed January 2017 from <http://homelesshub.ca/resource/motivational-interviewing-open-questions-affirmation-reflective-listening-and-summary>
8. Humeniuk, R., Henry-Edwards, S., Ali, R., Poznyak, V., Monteiro, M. (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. World Health Organisation, Geneva Switzerland.
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10. Bower, C., Elliott, EJ., on behalf of the Steering Group (2016). Report to the Australian Government Department of Health: "Australian Guide to the diagnosis of Fetal Alcohol Spectrum Disorder (FASD)".
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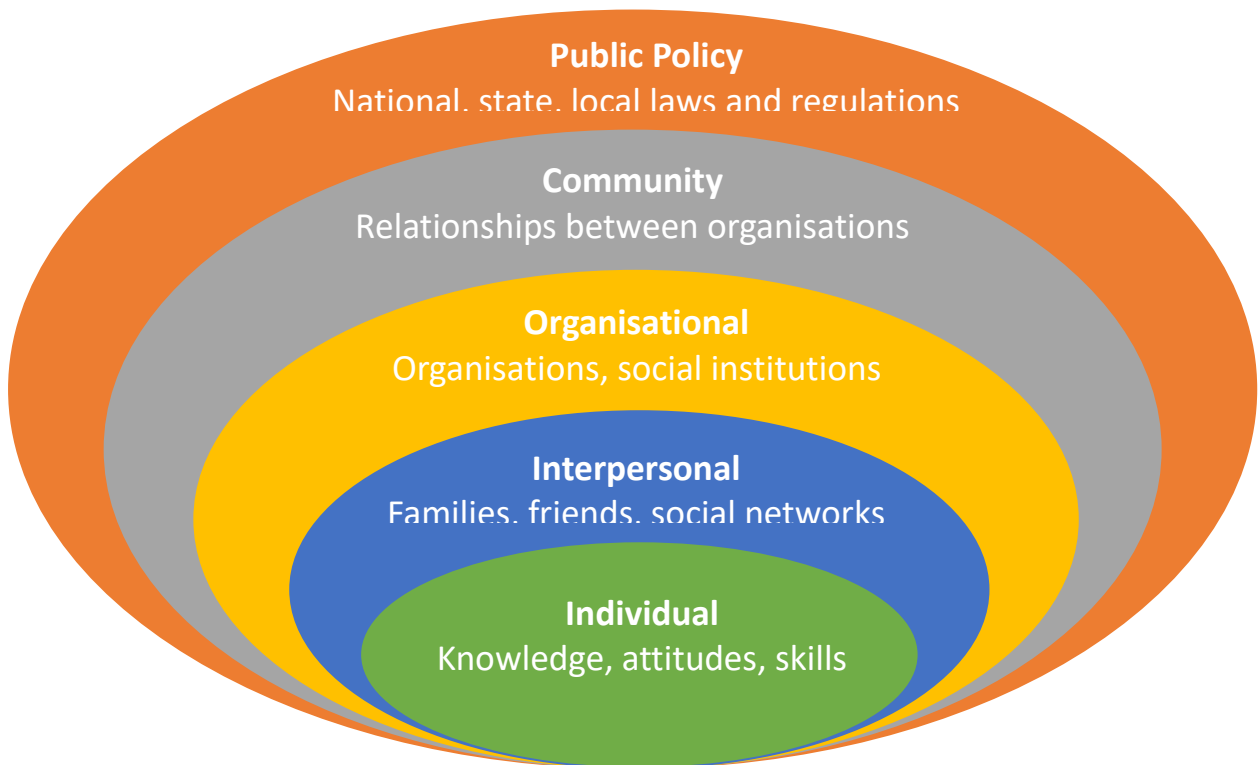


12. The Homeless Hub (2016). Theories to Support the Work: Stages of Change. Accessed January 2017 from <http://homelesshub.ca/toolkit/subchapter/stages-change>
13. US Department of Health and Human Services. Rethink Drinking. Planning for Change. Accessed January 2017 from <https://www.rethinkingdrinking.niaaa.nih.gov/Thinking-about-a-change/Its-up-to-you/Planning-For-Change.aspx>



Module 2 Further Reading and Additional Information:

Slide 7-10: Introducing the Socio-Ecological Model to explain influences on behaviour acting at different levels.



The Socio-Ecological Model, pictured above and described in the table below, is also discussed in Module 4, Slide 7. This model identifies key factors that may either assist or hinder behaviour change.

Table 1: Descriptions of the socio-ecological model levels

| SEM Level | Description |
|----------------------|--|
| Individual | Characteristics of an individual that influence behaviour change, including knowledge, attitudes, behaviour, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic/caste identity, sexual orientation, socio-economic status, financial resources, values, goals, expectations, literacy, stigma, and others. |
| Interpersonal | Formal (and informal) social networks and social support systems that can influence individual behaviours, including family, friends, peers, co-workers, religious networks, customs or traditions. |
| Community | Relationships among organizations, institutions, and informational networks within defined boundaries, including the built environment (eg parks), village associations, community leaders, businesses, and transportation. |

| | |
|------------------------------------|--|
| Organisational | Organisations or social institutions with rules and regulations for operations that affect how, or how well, for example services are provided to an individual or group. |
| Policy/Enabling Environment | Local, state, national and global laws and policies, including policies regarding the allocation of resources for maternal, newborn, and child health and access to healthcare services, restrictive policies (eg high fees or taxes for health services), or lack of policies that require warning labels on alcoholic beverages. |

Slide 12: Further information on brief interventions.

The Central Australian Rural Practitioners Association. CARPA Standard Treatment Manual: 4. Chronic Disease – Brief Interventions. 2014. Accessed January 2017 from http://www.remotephmanuals.com.au/publication/stm/Brief_interventions.html

Slide 16: Readiness Rulers⁸

How important is it to change your behaviour if you decided to?

On a scale of 0 to 10, where 0 is not at all important and 10 is extremely important, how would you rate yourself?

| Not at all | | | Neutral | | | | Extremely | | | |
|------------|---|---|---------|---|---|---|-----------|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

How confident do you feel to change your behaviour if you decided to?

On a scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, how would you rate yourself?

| Not at all | | | Neutral | | | | Extremely | | | |
|------------|---|---|---------|---|---|---|-----------|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

- Why are you at a _____ and not a 0?
- What would it take for you to move from a _____ to a (higher number)?



Slide18: Transcript for the 5A's video

A pregnant woman enters a health service where she is greeted at the door by her Doctor and shown through to the Doctor's room.

Doctor: Ok look so we've covered smoking and nutrition and now I'd like to talk about something that I discuss with all of my pregnant patients and that's alcohol.

ASK

Doctor: How much would you say you drink?

Patient: Well I drank a bit before I found out I was pregnant umm but just wine with dinner.

Doctor: Ok, has that changed since you found out that you're pregnant?

Patient: Ah not really umm but I've never been a big drinker.

ASSESS

Doctor: Ok. Just so I've got a better idea of what your drinking patterns are like, how often would you say you drink?

Patient: Ah 3 or 4 nights a week, wine with dinner.

Doctor: And how much would you have? What I'm going to do is I'm going to show you here a chart of all of what a standard drink is.

Patient: Well I usually drink wine so I guess about a bottle between us.

Doctor: Between you and your husband?

Patient: (nods)

Doctor: Ok. Would you share it equally? Would one of you drink more?

Patient: (Shaking head) yeah no I drink less than my husband. I don't really want to drink much at the moment but I just find it helps me relax.

Doctor: Ok. What have you heard about alcohol in pregnancy?

Patient: Everything in moderation (laughs). Umm I know that, I've heard that you're not supposed to go and get wasted and I'm definitely not doing that. Umm it's just a glass or two with dinner and I drank during my pregnancy with Tim so I'm not overly worried about it.

ADVISE

Doctor: Look moderation is good for most things, but when you're pregnant it's safest not to have any alcohol at all.

Patient: No alcohol at all!?

Doctor: (continues looking down, taking notes).



Patient: But I drank when I was pregnant with Tim and he's fine.

Doctor: Look I'm sure he is, but when you were pregnant with Tim it was 4 years ago. The guidelines have now since changed, there's actually no safe level of alcohol when you're pregnant. And also every pregnancy is different so what might've been ok in your first pregnancy, may not be so ok now (looks down at her clipboard).

Patient: (Very distressed) are you saying that I've hurt my baby? Because I've been drinking as I normally would. If it's so bad then why hasn't anyone told me sooner?

Doctor: I'm not saying that you've hurt your baby, and no one is suggesting that and I'm really sorry that no one has been clear with you beforehand. But the important thing is now that you're aware, that you stop drinking any alcohol, that you start looking after your health, that you maintain your nutrition, reduce your stress and relax. All of the decisions that you make from now on are going to be really important for your health and the health of your baby.

Patient: Well that's going to be really hard because a glass wine, it helps me relax.

ASSIST

Doctor: You've mentioned relaxing a few times. Umm is there something that's causing you to feel not relaxed?

Patient: Well it would be great if my husband helped out more. Umm came home earlier, helped put Tim to bed. Umm maybe if he gave up drinking too.

Doctor: Do you think that's something he'd be willing to do?

Patient: I don't know umm but we can chat about it. So what do I say to those people who say that a glass of wine on occasion is no big deal?

Doctor: Is it going to be hard for you to be around those people?

Patient: Yes! Because my friends, they just say doctors, they tell you that to make you feel guilty. I don't know what to say to that.

Doctor: Look I can understand. In those situations it's probably best just to say that there are new guidelines, you want to do what is healthiest for your baby, and umm you want to give your baby and yourself the best start. How does that sound?

Patient: (Nodding) Yeah that sounds ok, umm I can try it.

Doctor: Ok good. Now look I'm going to give you some information that will explain the reasoning behind these new guidelines and also some tips that might make you feel more confident about stopping drinking.

ARRANGE

Doctor: Don't forget that anytime you can come back in and discuss it and perhaps bring your husband as well and we can go through all of this together.



Patient: Yeah that might be really helpful (nods). I'll think about that.

Voice over: It's important to open with a question like "what do you know about" or "how do you feel about drinking alcohol in pregnancy?" These open questions allow the woman the opportunity to talk about her knowledge and feelings. It also allows the health professional to know where to guide the conversation in terms of advice. Rather than tell the woman the health consequences of alcohol consumption, this approach known as motivational interviewing aims to find out the patients level of knowledge and provide the relevant information. There is no assumption that if she just had the correct information she would change. So it's good to make some general statements such as "a lot of women receive mixed messages about alcohol and pregnancy". This helps the woman realise that they're not alone and that it's completely normal for a health professional to bring up alcohol.

- End of transcript -



Module 3: Monitoring and Evaluating

Aim: The aim of this session is to highlight the importance of monitoring and evaluating FASD prevention activities, and to explain the link between screening for antenatal alcohol use and FASD diagnosis.

Note – If the training modules are being delivered individually (ie not in a series from Module 1 to 4), the Introduction slides should be delivered at the beginning of each training module.

Learning Objectives:

- Increased awareness of the importance of monitoring and evaluating FASD prevention and health promotion strategies.
- Increased knowledge of appropriate indicators to monitor and evaluate FASD prevention and health promotion strategies.
- Increased understanding of the link between antenatal screening records and The Australian FASD Diagnostic Assessment Form.

Resources:

- PowerPoint slides
- Participant Workbooks
- Internet access, where possible
- Butchers paper, whiteboard and pens
- Pre- and post-workshop surveys (Appendix 6 and 7 of the Facilitator Manual)

Note: If this module is being presented as part of a two-day workshop present Slides 1 onwards. If this module is being presented as a standalone module, present the Introduction session and proceed to Slide 4. If not already completed, encourage participants to write down their learning goals for this module in their Participant Workbooks and complete the Pre-workshop survey (Appendix 6).

Slide 1: Module 3 Monitoring and Evaluating

Slide 2: Review Module 1 What is FASD?

Purpose: to review the content from Module 1.

- Read over the learning objectives with participants.

Slide 3: Review Module 2 Brief Intervention and Motivational Interviewing

Purpose: to review the content from Module 2.

- Read over the learning objectives with participants.



Slide 4: Module 3 Learning objectives

Purpose: to provide an overview of the learning objectives for module 3.

- Read over the learning objectives with participants.

Slide 5: Monitoring vs evaluating

Purpose: to describe the difference between monitoring and evaluating a program.

Monitoring¹

- Is routine tracking of the key elements of program or project performance
- Allows you to document the 'story' of your program or 'journey' of the people involved in your program.
- It helps to identify areas for improvement and areas that are working well.
- This information can be collected in many ways eg record-keeping, regular reporting, surveillance systems or satisfaction surveys.
- Monitoring can be reported as numbers (quantitative) or stories (qualitative). Both are equally important, the stories help to give context to the numbers.
- For example you might track attendance at community education sessions and find that young men are not attending, even though they are one of your target groups. Knowing this, you might decide to find out why they aren't attending and then develop specific strategies to encourage them to attend.

Evaluating¹

- In contrast to monitoring, evaluation occurs at specific time-points during a program, usually at the end.
- Evaluation measures the outcomes that have occurred as a result of the program eg increases in knowledge as a result of a staff training session.
- Evaluation helps to determine whether a program was successful or unsuccessful, and the value of a program.

Both monitoring and evaluating¹

- Can be reported as numbers (quantitative) or stories (qualitative). Both are equally important, the stories help to give context to the numbers.
- A plan for monitoring and evaluation should be built into the design of a program from the beginning, not added as an afterthought at the end.
- Be mindful that monitoring and evaluation both require resources. Carefully select only the most useful and meaningful information to collect. This will avoid spending time and effort collecting information that is not relevant to the aims of your work.
- Many external influences can impact on the success of your programs. Therefore it may be useful to collect information on other factors that might affect your outcomes eg



whether unexpected levels of staff turnover affected your ability to deliver antenatal clinics as usual.

Slide 6: What type of information can we monitor?

Purpose: to describe the various elements of a program that can be monitored

- Inputs – the things that are needed for a program to achieve its goals eg staff time, money or specific equipment.¹
- Outputs – the things that were achieved, or completed, as a result of the inputs into the program eg increases in the number of antenatal clients receiving screening for alcohol and tobacco use, episodes of care.¹
- Outcomes – the short-term effects, or outcomes of the program eg increased numbers of brief interventions conducted with antenatal clients for tobacco cessation. Can also be used to look at trends, how are we going this year compared with last year?¹

Things to consider when designing methods to monitor program implementation:

- The information collected should always have a purpose, it should be collected and recorded accurately.
- May need to consider where this information can be recorded as part of an existing process and location (eg an online patient record system) or whether a new process will need to be developed.
- Staff may need training in data collection and recording information accurately.

Slide 7: Why do we monitor?

Purpose: to highlight different reasons for monitoring within primary health services.

- Different groups will be interested in the results for different reasons.
- Importantly, without this information we cannot make good decisions about whether programs are being effective, or whether they need to be changed or stopped, or continued.
- Collecting data can help to make your work 'visible' to the community and to decision makers.
- Without it we don't know what impact we are having on our community's health and wellbeing.



Slide 8: Accountability to community

Purpose: to discuss ways in which health services can be accountable to community and why this is important.

- Ask participants to share examples of how their health service engages with their community. Prompt questions:
 - How is feedback on your programs or service provision provided to your community?
 - How could your community contribute to monitoring and evaluation?
- Annual reports are an example of being accountable to community
 - Data from annual reports can tell an important story for community and for health service staff, especially if staff are involved in data interpretation, as they usually know the background and context within the community and health service.
 - Ask the group – What happens to your annual reports? Do you have an opportunity to discuss information within your team, within your health service, or with your clients? Or do they sit on a bookshelf?

Slide 9: Accountability to managers, board members

Purpose: to discuss ways health services are accountable to their board members or managers and why this is important.

- Monthly or quarterly internal reports.
- Presentations to board members.
- Are there other ways in which you report to your managers or boards?
- What are some of the benefits of regular internal reports?
 - Can enable two-way communication with board members and managers.
 - Helps develop links across teams within organisations, especially important in large organisations or those with many clinic locations.
 - Can help to identify programs that are working well, boards and executive managers can advocate for additional funding.



Slide 10: Accountability to funders

Purpose: to discuss data that is already collected by the Australian Government and how this can be used by health services.

- The data in these reports are collected by health services as part of funding agreements.^{2,3}
- What might be some uses for national data?
 - Can compare local statistics with national statistics (with caution, need to ensure it's a valid comparison ie the same things are being compared).
 - Use national statistics to highlight local areas of greater need, for example if writing funding applications.
 - Can see improvements (or not) over time eg some decreases in smoking rates.

Slide 11: Data for national reports

Purpose: to encourage participants to think about what data their health service is already collecting.

- Online Services Report (OSR) pictured on the left on the previous slide³
 - When? collected and reported annually
 - Who? all organisations that receive Australian Government funding to provide health services to Aboriginal and Torres Strait Islander people, both community controlled and government funded services.
- Indigenous Primary Health Care National Key Performance Indicators (nKPIs)²
 - When? collected and reported every 6 months. There are 24 nKPIs, a selection are shown on the slide.
 - Who? all Aboriginal and Torres Strait Islander primary healthcare organisations funded by the Department of Health.
 - How? Data is collected via OCHREStreams (the Commonwealth Department of Health's web-based reporting tool).
 - The purpose of nKPIs is to improve the delivery of primary health-care services by supporting continuous quality improvement (CQI) activity among service providers.
 - The nKPIs allow comparisons of trends over time, organisations can also compare with national, state and regional data.
- Both reports can be used for reporting back to community and to guide decision making at the local health service level.
- These national data sets show the importance of accurate record keeping and data entry in client records systems.



Slide 12: What data are we already collecting?

Purpose: to describe the various elements of a program that can be monitored and highlight the types of data that are already being collected within clinics.

- This slide provides some examples from the OSR and the nKPIs, and categorises them as inputs, outputs and outcomes.
- Remember from our earlier slide
 - Inputs – the things that are needed for a program to achieve its goals. Most of the OSR data fits here.
 - Outputs – the things that were achieved as a result of the inputs into the program some OSR data and some nKPIs.
 - Outcomes – the short term effects of the program. Most nKPIs fit here.
- When we can access these three types of information together we get a better understanding of the whole clinic.
- However it can sometimes take a while to see progress in outcomes when we also need to see changes in inputs then outputs.
- Note there is a nKPI to track the smoking status of women who gave birth. However there is no nKPI for alcohol exposed pregnancies. These nKPIs are reported only for services receiving funds to provide health services to Aboriginal and Torres Strait Islander people. Ideally data on alcohol exposed pregnancy and smoking, would be collected in the national perinatal dataset. This would capture information from all health services and would provide a national picture of FASD risk for the first time.
- The next three slides show examples of inputs, outputs and outcomes from a health service.



Slide 13: What can be monitored – inputs



Interactive Activity – Interpreting graphs (1)

Purpose: to show examples of inputs – staffing levels and Medicare income generated (in this example this is an input because it is a source of funding that goes back into the service).

Time: allow 5 minutes

Resources: none

Health services already collect a lot of data, discussing and interpreting the data provides great opportunities to have a closer look at the true story behind the numbers. Remember these aren't just numbers, each number is a person.

Instructions:

- Encourage participants to discuss the graph and pull together a story to explain the figures.
- There are no right and wrong answers, the aim is to show that looking at data doesn't have to be scary it can be interesting. It is a very useful process to gain an understanding of how the whole clinic is meeting the needs of the community.
- Looking at data over a number of years can show improvements (or gaps) in areas that may otherwise be hard to see.
- Data displayed over a few years is called 'trend data'.

Staff Breakdown graph.

- This service regularly looks at its staffing mix. What does it tell us?
 - Clinical staff mainly non-Indigenous
 - Non-clinical staff mostly Indigenous and also Team Leaders and Coordinators.
 - Likely that the 'first faces' you will see eg receptionists are Indigenous. This can make the health service more welcoming for clients and can improve the standing of the health service within the community.
 - Can the health service employ more clinical staff who are Indigenous?

Medicare Income graph.

- What does this graph tell us about Medicare income from 2011-12 to 2014-15.
 - Income has increased steadily over 4 financial years. What might be some reasons for this?
 - Have adult health checks (item number 715) increased?

Slide 14: What can be monitored – outputs



Interactive Activity – Interpreting graphs (2)

Purpose: to show examples of outputs – episodes of care.

Time: allow 5 minutes

Resources: none

Instructions:

Discuss each graph individually and encourage participants to pull together a story to explain the figures. There are no right and wrong answers.

Prompt questions:

- What do these graphs tell us about the episodes of care that occurred in 2013-14 and 2014-15?
 - There may have been new roles in the health service in 2013-14 ie Dietitian and Physiotherapist.
 - The Diabetes Educator also increased substantially in the 2nd year.
 - More funding may have been available to promote the health service.
 - Could have been a drive with community to promote and complete 715 health checks and GP Health Plans. This could have generated more referrals to allied health.
 - There may have been a change in management with a greater focus on health checks and allied health.
 - Some of the allied health staff (diabetes educator, dietitian, physiotherapist, Obstetrician & Gynaecologist) could have gained the trust of the local community.
 - Why did some services increase in 2013-14 and then drop off in 2014-15?
- It can also be useful to look at episodes of care by sex. Blue is for female and green is for male. What does this graph tell us?
 - Contacts with men are increasing, what can we do to keep increasing this?
 - Contacts with men could include opportunities to discuss FASD prevention and early intervention for alcohol and other drug use.

Wrap up:

- Capturing meaningful data is very important and looking at data can be fascinating.
- Staff within the service know the true story behind the numbers. There is great value in adding the true story and avoids making assumptions.
- When staff are involved in interpreting the data it raises opportunity for discussion, for planning, for review, for PDSA cycles (look at data, make a plan, evaluate as you go, identify what is or isn't working and determine what might we do differently next time).

Slide 15: What can be monitored – outcomes



Interactive Activity – Interpreting graphs (3)

Purpose: to show examples of outcomes – antenatal and child health data.

Time: allow 5 minutes

Resources: none

Instructions:

Discuss each graph individually and encourage participants to pull together a story to explain the figures. There are no right and wrong answers.

- The graph on the left provides the proportion of first antenatal visits occurring before 13 weeks and proportion of babies born with normal birth weight. The graph on the right shows longer term child health outcomes up to 5 years later.
- What can these graphs tell us?

Slide 16: Monitoring for improvement (1)

Purpose: to introduce the Plan, Do, Check, Act cycle for improvement.

- The Plan Do Check Act cycle is a fairly common model and some participants may already be familiar with it.
- It is also known as the Plan Do Study Act cycle, or PDCA, or PDSA.
- This diagram shows the steps in a cycle for improvement of programs or activities.
 - Plan: involves establishing the need for the program or activity. It should involve recording of baseline information that you can compare with later. In this stage it is important to be clear on the goals and objectives that you are trying to achieve. Don't forget to document your plan, including your resource requirements, timeframe, and how you will assess the success of your activities.
 - Do: in this stage you put your plans into action.
 - Check (or Study): this is the monitoring phase. If there are areas not working as planned you can modify some of your actions. It is important to document your results as you go.
 - Act (or Adjust): You may conduct a final evaluation. As a result of the information collected through both monitoring and evaluation you may reassess your activities and decide to modify them, before starting the cycle again.

- Documenting your plans, results and decisions at each stage allows you to justify your decisions to funding bodies and your community. If the program is successful you may be able to apply for additional funding.
- This process should be viewed as a positive opportunity for continual learning.

Slide 17: Monitoring for improvement (2)



Interactive Activity – Sharing experiences of Continuous Quality Improvement

Purpose: to encourage participants to reflect on their experiences of quality improvement, what was done well and what they would do differently in future. Inviting a couple of volunteers to share these stories will promote group learning.

Time: allow 15 minutes

Resources: none

Instructions:

- Ask the participants to pair up with someone else from their health service to think of a quality improvement activity they have been involved with.
- Reflect on this activity and answer the list of questions on the slide.
- Note that some participants may realise this is an area their health services does not consider routinely, or that they may not have easy access to data.
- After 5-6 minutes bring everyone back to the larger group and ask for 3-4 volunteers to share their stories with the group.

Wrap-up: After a few participants have shared their experiences, summarise any similar experiences from the group. Points to highlight could include:

- The wide variety of measures in maternal and child health and the variety of ways data can be collected and reported. Therefore it is necessary to only select the most relevant pieces of information for monitoring.
- Look for opportunities to link current work with FASD prevention, smoking, drug use in pregnancy, or effective use of contraception. Ask how is this addressed, and where is this recorded?
- Which other team members could also be involved with delivering and entering data on healthy pregnancies?

Slide 18: Record keeping

Purpose: to encourage participants to reflect on their current record keeping practice and systems.

- What systems do you currently use for record keeping in your health service?
- Ask participants to consider the questions from the slide and share their experiences with the group.

Slide 19: How can we capture information to monitor our program?

Purpose: to show a range of sources of information available to health services.

- There are many different sources of information available. Some examples are listed on the slide.
- We'll look at each of these in more detail in the next few slides.

Slide 20: Surveys

Purpose: to highlight the types of information you can obtain from surveys.

- Here is an example of a feedback survey. Note the type of questions relate to satisfaction with the health service provided.
- How might this sort of information help with monitoring or continuous quality improvement?
- Ask the group – Is anyone already using this type of information from surveys within their health services? If so, how is it being used? What sorts of changes have been made as a result?

Slide 21: National registries

Purpose: to highlight the types of information you can obtain from national registries.

Participant Information:

- Very valuable information on specific communities can be accessed from government websites eg
 - Myhealthycommunities provides information by Primary Health Network or local area, it can be used to build graphs and maps, and compare local and national level data.
- Refer also to State and Territory information sites, or local government websites.



Slide 22: Extracting data from medical records

Purpose: to highlight the types of information you can obtain from patient records information systems.

- Ask the group – Why do we record information in medical records?
- Write responses on a whiteboard or butchers paper.
- Ask participants to rank the responses from most important reason to least important.
- Ask participants why they have given these rankings.
- Highlight that entering data correctly, in its correct place, in a timely manner, helps to provide safe and quality patient care. It's about more than just populating indicators and reporting.

Slide 23: Monitoring for understanding

Purpose: to introduce an example of using a logic model.

Background:

This graph has been provided by Dr Jason Agostino and is based on work he conducted in the Cape York region.

- Ask participants to discuss what they see in the graph.
 - From 2000 to 2008 the proportion of underweight children in this health service decreased from close to 16% to about 5%.
 - The expected proportion of underweight children is about 2%.
 - Over 8 years, the proportion of underweight children decreased substantially.
 - What might be some reasons for this decrease?
- What would you have measured to help to explain this change?
 - Inputs
 - Outputs
 - Outcomes
- How do we know what we should measure in advance?

Slide 24: Logic models

Purpose: to provide an example of how to create a simple logic model.

- Using the previous slide as an example, we will develop a logic model to describe what is needed for a child to grow up a healthy weight. We will then use similar thinking to inform the design of FASD prevention activities.
- A logic model gives us a roadmap, or a logical pathway, to explain how our planned activities will bring about change in our community. They can be displayed a number of different ways, this is an example of a simple logic model⁴.



- Logic models are most effective when they are used at the planning stage of a program, as they help to define an issue, identify what is causing or contributing to the issue and specify the rationale behind the program.

Parts of a logic model:

- Inputs – the resources needed eg equipment, staffing, funding, in-kind support.
- Activities – the actions, or events, or processes you will implement during the program eg develop and distribute educational materials, conduct education group, run a social media campaign, change your patient record information system.
- Outputs – the direct result of conducting your ‘activities’ as you had planned eg how many people received educational materials, number of education groups and the number of people who attended from your target group.
- Outcomes – changes that are expected to occur as a result of your ‘activities’ eg changes in attitudes, knowledge, behaviour in those people who attended your education group.
- Impacts – changes that are expected to occur in the longer term, as a result of your ‘activities’, they are usually changes at the community or organisational level eg changes to policy or improved conditions or increased capacity.

How to develop a logic model:

- Start with the end in mind, be clear on long-term goals, or impacts, of the program.
- You may need involvement from team members, community or partners to develop a logic model.

Slide 25: Logic models – deciding what to measure (1)

Purpose: to work through an example of building a logic model as a group.

- Going back to the example on healthy weight in children lets work backwards and try to complete some of these boxes for outputs, activities and inputs.
- Ask participants to contribute their ideas to complete the following. Refer back to the descriptions in the previous slide.
 - Outcomes
 - Outputs
 - Activities
 - Inputs



Slide 26: Logic models – deciding what to measure (2)

Purpose: to work through an example of building a logic model as a group.

- Outcomes:
 - Immunisation
 - Alcohol consumption and smoking in mothers
 - Children born a healthy weight
- Outputs:
 - Number of visits per child
 - Group sessions (mums and bubs, cooking classes)
 - Number of 'health checks' performed
- Activities:
 - Find out why attendance at antenatal and postnatal visits is currently low and make changes to encourage higher attendance.
- Inputs:
 - Funding for maternal and child health
 - Staff (Aboriginal Health Workers, child health nurses, GPs)

Slide 27: Developing indicators

Purpose: to work through an example of creating indicators to evaluate a program.

- In order to be meaningful, indicators generally contain the following: population, change target, threshold and timeline⁵. So for each indicator ask:
 1. Who do you want to change?
Women in community X of child bearing age who attend antenatal clinics
 2. How many do we expect will succeed in changing?
100% of women (this would be ideal, is it realistic?)
 3. What sort of change are we looking for, how much change is enough?
Abstaining from alcohol use during pregnancy
 4. By when does this outcome need to happen?
Staff training complete in 2 months and audit antenatal records in 6 months



Slide 28: Creating a logic model and indicators for a FASD plan

Purpose: to draw together the information presented in this module, to create indicators to monitor and evaluate FASD prevention activities.

Note that if Module 4 is being presented after Module 3, more detail will be presented on designing goals, objectives and strategies and identifying target groups.

- In small groups, ask participants to work through the questions on the slide.
- Allow 15 minutes for this activity.
- To wrap up this activity, ask for volunteers to share their ideas.

The last section of this module relates back to data collection during antenatal visits for the purposes of informing possible future investigation of FASD.

Slide 29: Screening tools vs Diagnostic tools

Purpose: to highlight the difference between screening tools and diagnostic tools.

- Screening tools
 - Do not give a definite answer
 - Show increased risk
 - Results are used to decide on path of action eg referral to a specialist
 - Can be used to introduce a brief intervention for risk factors
- Diagnostic tools
 - Are very accurate
 - Can identify a condition
 - Some invasive diagnostic tests can carry increased risk which is why screening is conducted first
 - May require a multi-disciplinary team

Slide 30: Linking screening and diagnosis (1)

Purpose: to revise the criteria for a FASD diagnosis as specified in The Australian Guide to the Diagnosis of FASD⁶ (presented in Module 1, slide 6)

- The clinician/s completing the Australian FASD Diagnostic Assessment Form will refer to antenatal notes about alcohol consumption to complete the section on Maternal Alcohol Use.
- For potential future reference, it is important that discussions about alcohol are recorded in the client record.



Slide 31: Linking screening and diagnosis (2)

Purpose: to show participants the relevant sections of the Australian FASD Diagnostic Assessment Form⁶

- According to the Australian FASD Diagnostic Assessment Form evidence of confirmed prenatal alcohol exposure may come from various sources including:
 - Information reported by the birth mother about her alcohol consumption during the pregnancy, ideally using a validated tool;
 - Reports by others, including a relative, partner, household or community member who had direct observation of drinking during the index pregnancy; or
 - Documentation in child protection, medical, legal or other records of maternal alcohol consumption, alcohol-related disorders, and problems directly related to drinking during the index pregnancy, including alcohol-related injury and intoxication.
 - Therefore, the AUDIT-C, as a validated tool used during antenatal visits can become an important source of information.

Assessing the reliability of evidence:

- If recalled information from different informants is in direct conflict (ie confirmed absence and confirmed presence) and reliable information on exposure is not available, alcohol exposure should be recorded as unknown.
- The reliability of information on prenatal alcohol exposure may reflect the timing of pregnancy awareness.
- A history of alcohol dependence without evidence of consumption during the index pregnancy is not sufficient to indicate confirmed exposure but should raise suspicion of risk.

Slide 32: Australian FASD Diagnostic Assessment Form (1)

Purpose: to show the sections of the Australian FASD Diagnostic Assessment Form directly related to maternal alcohol use.

- The next four slides show only the section of the form related to Maternal Alcohol Use. It is split over four slides due to the size of form.
- Remember this information would usually be completed based on historical antenatal records.
- There is space to record whether the mother modified drinking behaviour once she found out she was pregnant.

Slide 33: Australian FASD Diagnostic Assessment Form (2)

- This is the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C), with scoring and assessment of risk⁶.



Slide 34: Australian FASD Diagnostic Assessment Form (3)

- This section is a record of previous problems from maternal alcohol misuse or dependency⁶.

Slide 35: Australian FASD Diagnostic Assessment Form (4)

- This section uses the information from the previous three sections to summarise the risk due to alcohol exposure.
- This summary, along with thorough investigation of other antenatal exposures and physical and developmental assessments are combined to determine a FASD diagnosis⁶.

Slide 36: Reflection

Purpose: to encourage reflection and discussion on what health services and staff might need to do differently to record information on alcohol exposed pregnancies, and record strategies such as brief interventions.

- Ask the group – Now that we have just had a detailed look at the Maternal Alcohol Use section of the Australian FASD Diagnostic Assessment Form, what might you do differently in recording your antenatal visits?”
- Some suggestions could include:
 1. The importance of asking about alcohol use in pregnancy, recording responses and providing a brief intervention or referral if needed.
 2. Arrange meetings after this training with relevant staff in health service to make changes to patient records systems so there is a dedicated space to
 - (1) record AUDIT-C at multiple points during pregnancy
 - (2) record of brief intervention
 - (3) record follow-up referrals or actions.
 3. Share with other staff within the health service the importance of educating women in communities, aunts and grandmothers, men, all females of child-bearing age, to give the real story on prevention messages to pregnant women.
 4. Provide more health promotion and education for prevention eg incorporate into existing group sessions, distribute health education resources (refer to the FASD Prevention and Health Promotion Resources Package).
 5. When doing postnatal checks, be more specific about what you are describing in the infant or child when writing referrals eg observations of behaviour, growth.

Slide 37: Module 3: Review

Purpose: to reflect on the learning objectives for Module 3.



Slide 38: Finishing up

Purpose: To close the session and answer any outstanding questions the participants might have.

Note: If this module is being presented on its own, complete the learning reflection, post-workshop survey and certificates of attendance (see below). If this module is being presented as a series, continue on to the next module.

Learning reflection

Ask participants to reflect on the learning goals they wrote in their Participant Workbooks at the beginning of the workshop.

Post-workshop survey

Evaluation is an important component of the training. At completion of the module, distribute the post-workshop survey (Appendix 7). Ask the participants to compare their post-workshop survey answers with those from the pre-workshop survey (Appendix 6). Participants do not need to reveal their scores but are encouraged to comment or personally reflect on any changes.

Certificates of attendance

Distribute the certificates of attendance (Appendix 5) and thank the participants for their attendance.



Module 3 References:

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4. W.K. Kellogg Foundation (2004). Logic Model Development Guide. Michigan, USA. Accessed January 2017 from <https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide>
5. Centre for Theory of Change. TOC Background. Accessed January 2017 from <http://www.theoryofchange.org/what-is-theory-of-change/toc-background/>
6. Bower C, Elliott EJ 2016, on behalf of the Steering Group. Report to the Australian Government Department of Health: “Australian Guide to the diagnosis of Fetal Alcohol Spectrum Disorder (FASD)”.



Module 3 Further Reading and Additional Information:

Slide 24: Logic Models

- A logic model gives us a roadmap, or a logical pathway, to explain how our planned activities will bring about change in our community. They can be displayed a number of different ways, this is an example of a simple logic model⁴.
- Logic models are most effective when they are used at the planning stage of a program, as they help to define an issue, identify what is causing or contributing to the issue and specify the rationale behind the program.

Parts of a logic model:

- Inputs – the resources needed eg equipment, staffing, funding, in-kind support.
- Activities – the actions, or events, or processes you will implement during the program eg develop and distribute educational materials, conduct education group, run a social media campaign, change your patient record information system.
- Outputs – the direct result of conducting your ‘activities’ as you had planned eg how many people received educational materials, number of education groups and the number of people who attended from your target group.
- Outcomes – changes that are expected to occur as a result of your ‘activities’ eg changes in attitudes, knowledge, behaviour in those people who attended your education group.
- Impacts – changes that are expected to occur in the longer term, as a result of your ‘activities’, they are usually changes at the community or organisational level eg changes to policy or improved conditions or increased capacity.

How to develop a logic model:

- Start with the end in mind, be clear on long-term goals, or impacts, of the program.
- You may need involvement from team members, community or partners to develop a logic model.

Slide 27: Developing indicators

- In order to be meaningful, indicators generally contain the following: population, change target, threshold and timeline⁵.
- For each indicator ask:
 1. Who do you want to change?
 2. How many do we expect will succeed in changing?
 3. What sort of change are we looking for, how much change is enough?
 4. When does this outcome expected to happen?



Module 4: Sharing Health Information

Aim: the aim of this session is to introduce health professionals to the FASD Prevention and Health Promotion Resources package and develop their skills to plan and evaluate FASD prevention strategies.

Note – If the training modules are being delivered individually (ie not in a series from Module 1 to 4), the Introduction slides should be delivered at the beginning of each training module.

Learning Objectives:

- i. Increased knowledge of health promotion and health education strategies for FASD prevention.
- ii. Increased awareness of the FASD Prevention and Health Promotion Resources Package.
- iii. Increased skills to plan, implement and evaluate FASD health education and health promotion strategies for a range of target groups, within health services.

Resources:

- PowerPoint slides
- Participant Workbooks
- Computer and internet access for participants, where possible (or FPHPR Package saved on USBs for participants)
- Butchers paper, whiteboard and pens
- FASD Education Program Plan template (Appendix 4 of the Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 of the Participant Workbook)
- Pre- and post-workshop surveys (Appendix 6 and 7 of the Facilitator Manual)

Note: If this module is being presented as part of a two-day workshop present slides 1 onwards. If this module is being presented as a standalone module, present the Introduction session and proceed to slide 4. If not already completed, encourage participants to write down their learning goals for this module in their Participant Workbooks and complete the Pre-workshop survey (Appendix 6).

Slide 1: Module Four Sharing Health Information

Slide 2: Review Module 1: What is FASD?

Purpose: to review the content from Module 1.

- Read over the learning objectives with participants.



Slide 3: Review Module 2: Brief interventions and motivational interviewing

Purpose: to review the content from Module 2.

- Read over the learning objectives with participants.

Slide 4: Review Module 3: Monitoring and evaluating

Purpose: to review the content from Module 3.

- Read over the learning objectives with participants.

Slide 5: Module 4 Learning objectives

Purpose: to provide an overview of the learning objectives for module 4.

Module 4 aims to increase:

- i. Knowledge of health promotion, health education and approaches.
- ii. Awareness of strategies to share health information, specifically the use of the FASD Prevention and Health Promotion Resources Package for FASD education with a range of audiences.
- iii. Knowledge and skills to plan, implement and evaluate FASD health education and health promotion activities for use at your health service.

Slide 6: Health Promotion

Purpose: to briefly introduce the key concepts of health promotion.

- A whole of community approach involves linking primary health services with other agencies whilst engaging community members in the process.
- Some examples of potential partnering agencies include Traditional Owners group/s, schools, Primary Health Networks, NGOs, other government services, employment programs or alcohol and other drug services.

Slide 7: Many factors influence health in pregnancy

Purpose: to introduce the Socio-Ecological Model to explain the complex factors that influence behaviour change.

- This slide shows the socio-ecological model (SEM)¹. The individual is at the centre surrounded by four layers of factors that influence health and well-being.
- For each of the five population groups targeted through this package, there will be factors that influence their behaviour on each of the levels outlined in the SEM model.
- In this module we will discuss ways to share health information with the target groups at each of the SEM levels.
 - Individual level influencers eg knowledge, attitudes, gender, stigma, self-efficacy



- Interpersonal level influencers eg family, friends, customs, traditions
- Community level influencers eg built and natural environment, transport
- Organisation level influencers eg social institutions' rules that determine service delivery
- Public policy level influencers eg local state, national, global laws, tax systems
- For more detail on the SEM see the Further Reading and Additional Information section.
- Ask the group – What health promotion activities are you currently doing at some of these levels?

Slide 8: Cultural considerations – Aboriginal and Torres Strait Islander communities

Purpose: to highlight specific considerations when developing health promotion strategies with Aboriginal and Torres Strait Islander people.

- Programs aimed at changing an individual's risky behaviour should acknowledge the way in which the individual is inextricably tied to the culture in which they exist.
- For further information refer to Further Reading and Additional Information section for Slide 8. This diagram show the complex and interconnecting nature of factors that can lead to long-term alcohol misuse².
- It is important to consider:
 - Whether you have permission to enter certain settings to discuss the risks of consuming alcohol during pregnancy.
 - Whether home visits are appropriate in your community.
 - Whether it is appropriate for a female to be talking to men's groups about certain topics in your community.
 - The importance of women's relationships with others in the community, particularly elders and men.
 - Cultural diversity within your community as well as the communities of the services that clients are referred to.
 - Potential challenges with numerous languages and dialects of the clients.
 - The individual's socioeconomic circumstances.
 - Ease of accessibility of your services to clients within your community.

Slide 9: Health promotion continuum (1)

Purpose: to discuss the range of health promotion activities and discover how participants are currently delivering health promotion activities.

Health promotion approaches range from³:

- **Medical focus** – Improves physiological risk factors (eg high blood pressure, early cancer detection and immunisation)
- **Behavioural focus** – Improves behavioural risk factors (eg smoking, poor nutrition, physical inactivity and stress management)



- **Socio-environmental focus** – Targets the determinants of health in the environment in which we live, work, learn and play. Conditions such as poverty and pollution, and looks at psycho-social factors eg poor social connections, lack of job prospects, disempowerment.
- Health promotion strategies can occur along a continuum, from focusing on individual health (health professionals screening for risk factors; individual advice) to population health (healthy communities and environments; settings such as schools, hospitals).³
- These strategies can be grouped into 5 broad categories based on their target audience and intent:
 1. Screening, individual risk assessment and immunisation
 2. Health information and social marketing
 3. Health education and skill development
 4. Community action
 5. Creating healthy settings and supportive environments
- The SEM showed us that there are a wide variety of influencers on health and well-being, operating at a personal level through to national (and even global) levels. Therefore effective health promotion aims to use a combination of initiatives operating at several levels
- For example, a community-based health promotion program to reduce alcohol related harm might combine the following strategies:
 1. Screening questions and brief intervention about alcohol consumption at the health service.
 2. Local media public service announcements about the negative health and social effects of harmful levels of drinking.
 3. Small group education sessions and skill development in schools and sports clubs.
 4. Community action groups lobbying the liquor licensing body and liquor outlets, leading to changes in local regulations to reduce the hours alcohol can be purchased (supportive environment).
 5. Changes in local policy to restrict sale alcohol sales per person at takeaway liquor outlets (settings, supportive environment).
- Planning and implementing these strategies would need a local partnership with all interested stakeholders, agreeing on the overall goals and objectives.
- Ask the group – Is your health service involved in any health promotion activities? What are they? Are any partners involved?
- As a group, decide where the participants’ examples fit along the continuum.

Slide 10: Health promotion continuum (2)

Purpose: To outline the continuum of health promotion activities.

- This slide has the same headings as the previous slide, and focuses on health education and information sharing (red box).^{3, 12}



Slide 11: Health promotion vs health education

Purpose: to discuss the difference between health promotion and health education.

- Ask the group – what is the difference between health promotion and health education?
- **Health education** is an important part of health promotion that involves raising an individual's awareness of the risks associated with their behaviour and providing them with the necessary information to enable him or her to decide to change. However, this approach can create a great deal of resistance and a “don't tell me what to do” mentality from the individual that is being given the information.
- **Health promotion** is much broader than just education and also focuses on creating an environmental that is conducive to healthy behaviour changes by incorporating educational, cultural, socio-political determinants of health.

Slide 12: Health promotion and social media

Purpose: to provide some examples of media campaigns developed in rural communities to prevent FASD.

- These two videos were developed by the Indigenous Hip Hop Program (IHHP) in collaboration with local communities in Tennant Creek and Broome.
- The IHHP develops a variety of music videos aimed at raising awareness of a topic, in Indigenous Australian communities.
- They usually work with Indigenous youth to build on their strengths, develop their skills and attitudes to support community development.
- For more information on the IHHP go to <https://indigenoushipop.com/>
- OVAHS (Kununurra, WA) has used a similar audio-visual campaign to spread awareness of FASD. The videos went to air during local cinema advertising and in their health services waiting rooms.

Slide 13: Health education is not about telling people what to do

Purpose: to reiterate that an authoritative or expert frame of mind is ineffective in health education.

- A common mistake with health education is the belief that telling an individual what they should do and how to do it will change their behaviours, also known as an “expert-driven” approach, however this approach will not be effective⁶.
- When sharing health information it is important to be mindful to:
 - Have relaxed and open body language paired with non-clinical wording is the most engaging approach
 - Not overload people with new information – be realistic about what information can be shared in the time available.
 - Not underestimate your audience.



- Not underestimate what you can learn from you audience.
- Decide on the best person/people to share the information with the particular audience.
- Think about language and the most appropriate way to explain things clearly. Share information in people’s first language when possible.
- Think about how to ask questions in a way which invites people to respond, to share their knowledge, concerns and ideas.

Slide 14: The aims of health education

Purpose: to discuss the aims of sharing health information with each of the target groups.

- The aim of health education is typically to help the individual achieve positive, well informed changes in their health behaviours. This is generally achieved by:
 - encouraging people to adopt and sustain health promoting life styles and practices
 - promoting the proper use of the health services available to them
 - arousing interest in new knowledge, improve skills and change attitudes to make rational decisions to solve their own problems
 - stimulating individual and community self-reliance and participation to achieve health development through individual and community involvement

Slide 15: Opportunities for health education

Purpose: To provide a visual overview of the various activities that sit under the individual, group and mass approach to health education.

Individual approach examples:

- Providing brochures, posters and audio-visuals in the waiting room of your health service.
- OVAHS have made a jigsaw puzzle using the different parts of the brain as a way to help explain the impact that alcohol can have on brain development in utero.

Group approach examples:

- OVAHS links in with other services in their community that have similar KPI’s to them and have coordinated monthly presentations.
- OVAHS have set up ‘condom trees’ throughout their community. These containers are fixed to trees and regularly filled with condoms by health service staff.

Mass approach examples:

- The ‘Women Want to Know’ and ‘Alcohol – think again’ campaigns are both examples of mass media campaigns.
- Mary G’s video and radio segments (Mary G is a (WA based comedian).
- International FASD Day, 9th of September



- Ask the group – Has anyone been doing any activities similar to these within their community?

Slide 16: Approaches to health education – Individuals

Purpose: To encourage participants to think of ways they could share health information on an individual level.

The best times or places to share health information with individuals may be:

- As part of your day-to-day work practice.
- At the time when the individual most want to hear it, are ready to hear it, or need to hear it.
- As soon as possible after a relevant event while an issue is fresh in the individuals mind.

Some examples of ways of sharing health information with individuals may be:

- Through brief interventions (discussed in Module 2) when you
 - Do health assessments
 - Do well women’s and well men’s checks
 - Do maternal and child health checks
 - Take a client’s health history
 - Give back test results
 - Give treatment or referral
- Using resources that support information sharing (see the FPHPR package).
- Story telling including:
 - Family, relationships, community, and culture
 - Health related practices, beliefs, attitudes, knowledge, values and life experience
 - What has worked well, or not been successful, in the community before
 - Statistics, scientific test results or knowledge, beliefs, attitudes, values and life experience
 - Health stories from other communities
- Using paintings or performing arts – theatre, video, dance music, song.
- Using case studies.
- Reports for the community.
- Reaching rural communities through radio.

Slide 17: Approaches to health promotion and health education – Groups

Purpose: to encourage participants to think of ways they could share health information within a group situation.

The best times or places to share health information with a group may be:

- At the time when the group or community most want to hear it, are ready to hear it, or need to hear it.
- As soon as possible after a relevant event while an issue is fresh in people’s minds.



- When you can link information sharing to a community event such as school activities, sports days, cultural activities.
- During health days or health weeks.
- When people invite you to men's or women's places.

Some examples of ways of sharing health information with groups may be:

- Through brief interventions (discussed in Module 2) when you:
 - Organise community stalls
 - Engage with specific activity groups eg local sporting teams
- Using resources that support information sharing (see FPHPR package).
- Story telling including:
 - Family, relationships, community, and culture
 - Health related practices, beliefs, attitudes, knowledge, values and life experience
 - What has worked well, or not been successful, in the community before
 - Statistics, scientific test results or knowledge, beliefs, attitudes, values and life experience
 - Health stories from other communities
- Using paintings or performing arts – theatre, video, dance music, song.
- Using case studies.
- Reports for the community.
- Reaching rural communities through radio.

Slide 18: Approaches to health promotion and health education – General public

Purpose: to encourage participants to think of ways they could share health information to the general public through a mass media approaches.

- The purpose of providing information at a community level is two-fold: first, to demystify an issue and second, to raise awareness.
- It is useful to consider having two equally important components: statistics and stories. All statistics are built up from stories, and effective information programs incorporate the story approach. Before practitioners ask 'What do people need?' or 'What are their problems and how can they be addressed?' they need to firstly ask 'What do people know?' and secondly 'What do people value?'

Some examples of ways of sharing health information to the general population:

- Radio.
- TV.
- Social media.

Ask the group – What types of health education activities is your health service currently conducting in your community?



Slide 19: The River of Health

Purpose: to describe the complexities of health

The text on the slide is very small so a copy of The River of Health⁸ has been provided below.

One day an Aboriginal Health Worker went to the river to go fishing.

While she was there she saw a person in the river who was in trouble. The person in the river didn't know how to swim.

The health worker jumped into the water, pulled her out and gave her first aid.

Then another person came down the river needing help, so she jumped in and saved him as well.

The same thing happened again and again and when the health worker thought about it, she thought the story was a little bit the same as her job in the community.

The river was the same as an illness, which makes people sick, and she had to give them treatment to make them well, just like when she was pulling people out of the river to save them from drowning,

Just then a little boy who had been watching this, tapped her on the shoulder and said to her maybe it would be easier to go further up the river and find out why people were falling in and, if possible, to stop this from happening.

When she listened to him, she thought again about her job as a health worker. She thought that if she could prevent many of her people from getting sick, then she wouldn't have to fix them up with treatment all the time.

In her heart she knew that many people would still fall into the river so she thought she should teach people to look after themselves and their families when they got sick.

When she went to work at the health centre she told the other health workers that she had been thinking about the three parts of community health work: PREVENTION, INTERVENTION AND TREATMENT.

They talked about how the 'River of Illness' can become the 'River of Health'.

- End of transcript -



Slide 20: Historical perspective – Swimming the River



Interactive Activity – Swimming the River⁹

Purpose: to show a video explaining the impact of post-colonisation policies on the health and quality of life of Aboriginal and Torres Strait Islander peoples.

Time: allow 15 minutes

Resources:

- Internet access, where possible.
- Weblink embedded in slide 20. If the internet is not available, ask workshop participants to read the transcript (see Further Reading slide 20).
- The 'Swimming the River' video provides an overview of the complex factors influencing Aboriginal and Torres Strait Islander people's health and wellbeing.
- After the video facilitate a discussion on people's reaction to the story and the way it is told.

Slide 21: FASD Prevention and Health Promotion Resources Package

Purpose: to introduce the participants to the resource package and provide an overview of its development.

Background information: The overall FASD Prevention and Health Promotion Resources (FPHPR) Package includes several documents: these training materials and a directory of current, culturally appropriate resources for health professionals and communities. The resources included in the Package provide information on alcohol, tobacco and other drug use during pregnancy as well as contraception and family planning options. While the intended audience for the Package includes health professionals working with Aboriginal and Torres Strait Islander communities, the content is also relevant to those working with other communities.

The initial online search was conducted in 2015 and was repeated in 2017. Key words were used to search several platforms: 1) the Australian Indigenous HealthInfoNet, 2) relevant organisational websites, 3) grey literature databases, 4) Google search engines and 5) consultation with experts in relevant fields. The inclusion criteria outlined below were used to identify current and culturally appropriate resources for inclusion in the FPHPR Package. Following the updated search in 2017, all copyright owners of the eligible resources were contacted to seek permission to include their resources in the FPHPR Package.

Slides 22-24: Using the FPHPR Directory to search for resources



Interactive Activity – How do you use the FPHPR Directory to find and access resources?

Purpose: To provide the participants with an opportunity to explore the Resource Directory

Time: Allow 15 minutes

Resources:

- The FPHPR Directory (available online or saved on USBs for participants).
- Internet access, where possible.

Instructions:

- Provide an overview of the types of resources included in the FPHPR Package for each of the five population groups.
- Demonstrate how to use the Resource Directory to search for resources.
- The following information relates to slides 23 and 24.

The FPHPR included in the Resources Directory are categorised by their purpose (first column) and the population groups (first row) for whom they are intended. Choose your population group of interest (eg pregnant women) and the type of resource (its purpose eg educating and raising awareness of FASD and alcohol consumption during pregnancy). Select the 'click here' hyperlink to be taken to a table displaying all of the available resources for your search. An x indicates that no resources are included for this category.

Table 1: Contents page of the FPHPR Package Bibliography with red arrows showing an example search.

| Resource Purpose | Population Group | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| | Pregnant women | Women of childbearing age | Grandmothers and Aunties | Men | Health professionals |
| Educating and raising awareness of: | | | | | |
| - FASD and alcohol consumption during pregnancy | Click here | Click here | Click here | Click here | Click here |
| - Tobacco use during pregnancy | Click here | Click here | Click here | Click here | Click here |
| - Drug use during pregnancy | Click here | Click here | Click here | Click here | Click here |
| - Family planning and contraception options | Click here | Click here | X | Click here | Click here |
| Planning evidence-based interventions: | | | | | |
| - One-on-one sessions | X | X | X | X | Click here |
| - Health promotion programs | X | X | X | X | Click here |
| Frameworks for evaluating interventions | X | X | X | X | Click here |
| Encouraging behavioural change: | | | | | |
| - Brief interventions or motivational interviewing | X | X | X | X | Click here |
| - How to support women | X | X | X | Click here | Click here |
| - Screening tools and guides | X | X | X | X | Click here |
| Addressing barriers to FASD prevention | Click here | Click here | Click here | Click here | Click here |



If you searched for resources designed for ‘educating and raising awareness of FASD and alcohol consumption during pregnancy’ developed for pregnant women, you would be taken to Table 2. Each resource is listed by author, title and year produced, the type of resource (audiovisual, brochure, poster etc), the population group it was designed for and where it was developed (location). The comments section provides a description of the resource, whether it was developed specifically for Aboriginal and Torres Strait Islander people, and access and cost details.

Table 2 (example) – Resources for educating and raising awareness of FASD and alcohol consumption during pregnancy, for pregnant women

| Author | Title and year | Material type | Target population | Details | Location |
|---------------------------------------|--|----------------------|---|--|-----------------|
| Brisbane Indigenous Media Association | <i>Stayin' strong: drugs and alcohol</i> (2015) | Audio visual – video | All | <p><u>Free online:</u> http://www.bimaprojects.org.au/tag/drugs-and-alcohol/</p> <p><u>Focus:</u> Specific for Aboriginal and Torres Strait Islander people</p> <p><u>Summary:</u> <i>Stayin' strong: drugs and alcohol</i> is a series of podcasts aimed at informing Aboriginal and Torres Strait Islander people about the impact of alcohol and other drugs on their health and the positive outcomes that can be gained through abstaining from harmful substance use, including ice and volatile substances.</p> <p>Podcasts of particular relevance to this package include:</p> <ul style="list-style-type: none"> - Alcohol and healthy pregnancy - <i>Foetal</i> Alcohol Spectrum Disorder <p>The resources can be used by psychiatrists and other healthcare professionals, researchers, or those aiming to address their own alcohol and other drug use.</p> | Australia – QLD |
| Queensland Department of Health | <i>Growing strong - Alcohol, tobacco and other drugs during pregnancy and breastfeeding</i> (2012) | Booklet | Pregnant women, women of childbearing age, and men. | <p><u>Free to download:</u> http://www.healthinfontet.ecu.edu.au/uploads/resources/17641_17641_2012.pdf</p> <p><u>Focus:</u> Specific for Aboriginal and Torres Strait Islander people</p> <p><u>Summary:</u> This resource is part of the <i>Growing strong: feeding you and your baby</i> set of resources from Queensland Health. The booklet discusses why alcohol, tobacco and other drugs (legal and illegal) should be avoided during a woman's pregnancy and the breastfeeding of her baby. It outlines the health risks to both the mother and developing baby. In addition, it highlights the harmful effect of family and friends smoking</p> | Australia – QLD |

Slide 25: Planning health promotion programs

Purpose: To outline the key elements of planning a health promotion program.

The remainder of the session will focus on planning your own FASD education program plan. In small groups you be given a scenario to work on, and you will complete a template provided in Appendix 4 of your Participant Workbook. This activity will draw together information from all of the training modules.

The main steps are:¹⁰

1. Identify your target **group** – **who** are the ‘primary’ and ‘secondary’ target groups.
2. Develop **goals** and **objectives** – including **what** needs to change, **how** much change needs to occur and **when**.
3. Develop **strategies** achieve the goals and objectives – including specifics of **what** will be done and **where**.
4. Allocate **resources** to the strategies – funding, staffing, equipment.
5. Develop a program **evaluation**

Slide 26: Identify your target group

Purpose: to demonstrate how to identify your target group/s for your FASD plan.

- A health promotion program will often have both ‘primary’ and ‘secondary’ target groups¹⁰. The ‘primary’ group is the individual or sub-group that you are hoping to see a change in. For the purposes of learning activity you will be given a scenario where the primary target group will be either 1) pregnant women, 2) women of childbearing age, 3) men, 4) grandmothers and Aunties or 5) health professionals.
- The ‘secondary’ target group are individuals, networks, organisations, or communities that influence the primary audience’s choices and behaviours. Secondary audiences can reduce the likelihood of the primary audience achieving the desired change and therefore should be accounted for in your health promotion program.
- Factors to consider for each population group when designing your program.

Pregnant women may be:

- Unaware that they are pregnant.
- Unable to share their pregnancy news with friends, family or their community.
- Wrongly informed of alcohol consumption during pregnancy.
- Experiencing a lack of social support.
- Unable to completely abstain during pregnancy.

Women of childbearing age may be:

- Unaware of contraception options and their effective use.
- Unable to be open about their sexual activity.



- Wrongly informed of alcohol consumption during pregnancy.
- Experiencing a lack of social support.

Men may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Unaware of contraception options and their effective use.
- Unable to be open about their sexual activity.
- Unaware of their important role in supporting women.
- Creating unsupportive environments for women.

Grandmothers and Aunties may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Passing on misconceptions and myths eg “I drank during pregnancy and my children were fine”.
- Unaware of their important role in supporting women.
- Creating unsupportive environments for women.

Health Professionals may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Passing on misconceptions and myths eg “Drinking red wine is very good to decrease stress during pregnancy”.
- Unaware of their important role in supporting women.



Interactive Activity – Identifying the target audience

Purpose: to build participants’ skills and confidence in identifying their target audience for a FASD Education Program Plan.

Time: allow 10 minutes

Resources:

- FASD Education Plan template (Appendix 4 Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 Participant Workbook)

Instructions:

Appendix 6 of the Participant Workbook contains various scenarios. In small groups, complete the FASD Education Plan template (Appendix 4) using your scenario.

Use the information from this session to identify your primary and secondary target groups. Complete the ‘identify your target audience’ section of the program plan.

Consider:

- Who are they? (eg pregnant women; women of childbearing age; father-to-be; elders/grannies/Aunties; health professionals)

- Where do they live, how are they connected? (eg by a sporting activity)
- What might influence their behaviour? (consider enablers and blockers discussed in Module 2)

Slide 27: Goals: What are you trying to achieve?

Purpose: to demonstrate how to design goals and objectives.

Goal is a statement about the broad, long-term change your project is working toward. It refers to what you ultimately want to achieve, or your destination.

Objectives are statements about more specific and immediate changes you want in order to progress towards your goal. The changes might be in skill levels, attitudes, knowledge, processes, awareness or behavior.

Goals should be¹¹:

- Clearly defined.
- Focus on one thing at a time.
- Are able to be measured in some way.
- Focus on the **change** you are wanting rather than the doing of activities.
- Are realistic and achievable.

Objectives should be **SMART**¹⁰:

- **Specific** (clear and precise).
- **Measurable** (able to be evaluated, data readily available and accessible).
- **Appropriate** (aligned with stakeholder expectations, theory and other evidence).
- **Realistic** (reasonable considering the resources and other circumstances).
- **Time-limited**.

When developing the goals and objectives of your program plan, think about¹¹:

1. **What** you would like to see different/changed at the end of the program (changes should be significant, feasible, and within your capabilities)?
2. **How** much change is realistically achievable?
3. **What** is it going to do to achieve this change?
4. **Who** will have been affected?
5. **How** will they have been affected?



Goals and objectives checklist¹¹:

- Is your goal written in a way that identifies the broad, long-term change you want to achieve?
- Does your goal include what, who, how and where?
- Is it written as clearly and concisely as possible and can be clearly understood by someone unfamiliar with the program?
- Do your objectives focus on one thing at a time?
- Do your objectives refer to change?
- Do your objectives relate to your goal?



Interactive Activity – Developing goals and objectives

Purpose: to build participants' skills and confidence in identifying their target audience for a FASD Education Program Plan.

Time: allow 15 minutes

Resources:

- FASD Education Plan template (Appendix 4 Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 Participant Workbook)

Instructions:

Continue with your FASD Education Program Plan and scenario to develop your program goals and objectives.

Consider:

- What needs to change? (consider the blockers discussed in Module 2)
- What is measurable? (eg how much? by when?)

Slide 28: Strategies – How will you do it?

Purpose: to help participants clarify their key strategies and messages.

Strategies are statements about how you will meet the goals and objectives.

Activities are what you are going to do to achieve these strategies and communicate your key messages.¹¹

Strategies should be:¹¹

- Appropriate for the community.
- Directly relevant to the change you are seeking ie. your goals and objectives.



- Realistic in terms of number of strategies undertaken, time, resources and skills available.
- Supported by relevant stakeholder.
- Either proven to be successful in similar circumstances or are innovative.

Strategies checklist:¹¹

- Are your strategies related to your objectives?
- Do they focus on the activities of your program?
- Are they realistic, eg. number of strategies, time resources & skills?
- Are they considered appropriate by the workers and community members involved?

Key messages should be:¹⁰

- Clear and concise.
- Reflective of the programs overall goals.
- Motivational.
- Specific to a target audience.

To develop your key messages, consider:¹⁰

- What you want to say to your audience.
- What you want your audience to know.
- What do want your audience to do.

Activities should be:¹⁰

- Practical and appropriate for the community and target audience.
- Realistic in terms of the time, resources and skills available.

To identify the appropriate activities for each strategy, consider:¹⁰

- What actions will contribute to achieving your goal?
- What outcomes (results) do you expect?
- What can you measure to see if the goals have been achieved and within what timeframe?

Once you have outlined clear strategies with key messages and appropriate activities, you will need to allocate the resources required to achieve each of the activities. To identify the relevant resources, consider:

- What resources are available within your health service, or partners.
- Any resourcing gaps that may need addressing.
- Exploring ways to address any resourcing gaps (ie collaborating with other services in your area, seeking additional funding, in-house resource development using the FASD PosterMaker).





Interactive Activity – developing strategies and key messages

Purpose: to build participants' skills and confidence in developing strategies and key messages for a FASD Education Program Plan.

Time: allow 15 minutes

Resources:

- Internet access, where possible
- FASD Education Plan template (Appendix 4 Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 Participant Workbook)
- FASD Prevention and Health Promotion Resource Package (available online or saved on a USB)

Instructions:

Continue with your FASD Education Program Plan and scenario to develop your program's key messages. Once you have identified your key messages move on to develop a set of strategies for each of your programs goals and objectives. Next identify a set of activities that you will use to carry out these strategies and present your key messages. Use the FASD Prevention and Health Promotion Resource Package to allocate resources that will help you to carry out your activities.

Consider:

- What is it that you want to tell your audiences?
- What do you want them to know or do as a result of your project?
- What actions contribute to the programs goals?
- How will you do this? (eg by [time frame] we will hold [number] of [activities])

Slide 29: Evaluation: How will you know you've made a difference?

Purpose: to demonstrate how to design an evaluation plan.

Module 3 explored data collection tools, processes and the importance of continuous quality improvement to evaluate a program's success and changes. These are important elements to include in your FASD Education Program Plan so you're able to measure the changes made by the program and evaluate its impact towards the overall goals and objectives.

- An evaluation plan is a short summary of what needs to be evaluated, what information needs to be collected (indicators), and how you are intending to collect this information.
- Some indicators involve collecting information along the way and enable you to make improvements throughout the program (monitoring). Other indicators involve collecting information at the end of the project (evaluation).



- Each of the program objectives should have at least one indicator and some may have multiple. A range of indicators that measure a combination of short-, medium- and long-term change is suggested.¹¹

To develop indicators, consider:¹¹

- What is an appropriate timeframe for observing a result?
- Is the measure available at that time?
- Are the sources of data required to assess this result accessible?
- Are the providers of the measure reliable, responsive, and timely?
- Do you have the resources for any direct costs, eg fees or licenses?
- Do you have the expertise to analyse or otherwise manage the data provided?

Process Indicators measure how well the program activities and strategies are going and often fall into the following three main groups:¹¹

1. Implementation (what has been done)
 - a. Workshop outlines
 - b. Procedures developed
 - c. Copies of media coverage
2. Reach & scope (who & how many have been involved)
 - a. Number of participants
 - b. Proportion of ethnic groups, age groups etc
 - c. Workers and organisations involved
3. Quality (how well things have been done)
 - a. Proportion of participants who report they are satisfied with materials or information produced, or the service provided
 - b. Certain standards of quality have been met

Impact/Outcome Indicators provide a sign of how well you have achieved the changes you were hoping for as a result of your project. They are about measuring change, the extent to which you have achieved your objectives and your longer term goal.

Indicators of impact relate to your objectives, and indicators of outcome relate to your goal.¹¹

Indicators should be assessed on their:¹¹

- Reliability – the extent to which the indicator will give consistent, accurate measurement over time.
- Validity – the extent to which the indicator measures what you set out to measure.





Interactive Activity – Developing key indicators

Purpose: to build participants' skills and confidence in developing key indicators for a FASD Education Program Plan.

Time: allow 15 minutes

Resources:

- FASD Education Plan template (Appendix 4 Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 Participant Workbook)

Instructions:

Continue with your FASD Education Program Plan and scenario to identify key indicators to show any changes made by your program

Consider:

- How would you measure change in your objectives?
- What data/indicators do you currently have available that measure this change?
- What limitations does this data/indicator have?
- If there is no data currently available, what do you need to change to create data/indicators for this objective?



Interactive Activity – Developing evaluation strategies

Purpose: to build participants' skills and confidence in developing evaluation strategies for a FASD Education Program Plan.

Time: allow 15 minutes

Resources:

- FASD Education Plan template (Appendix 4 Participant Workbook)
- FASD Education Program Scenarios (Appendix 6 Participant Workbook)

Instructions:

Continue with your FASD Education Program Plan and scenario to identify evaluation strategies for your program

1. List the things you will do, for example:
 - a. review what you did and write a report,
 - b. ask the people in your target audience to answer some questions, or
 - c. Have another person external to your program evaluate your program.

2. How will you do this? For example:
 - a. what things will you need to do?
 - b. who will be responsible for doing this?
 - c. how much money and time is needed to do this?
3. What will you do with this information? For example:
 - a. write a report for the agency that provided your funding,
 - b. use the information to make changes to the program and run it again,
 - c. give the information to another organisation that is going to run this program again
 - d. share the information with your community.

Slide 30: Finalise your plan

Consider the following questions to ensure your plan is complete:¹⁰

- Does the program include broad goals?
- Are your objectives SMART (specific, measurable, appropriate, realistic, and time-limited)?
- Have you identified a few major strategies to advance the goals and objectives?
- Have you chosen the best activities to advance the strategy? Are these activities appropriate to the audience?
- Have you identified relevant resources (people, funds, materials) for each activity and strategy?
- Does your plan have at least one indicator for each objective?
- Are the indicators reliable, valid and accessible?



Interactive Activity – sharing your FASD Education Plan

Purpose: To offer the participants an opportunity to review and share their FASD Education Program Plan.

Time: allow 30 minutes

Instructions: Ask each group to share the program they developed with the larger group.

Slide 31: Module 4: Review

Purpose: to reflect on the learning objectives for Module 4.

Slide 32: Finishing up

Purpose: To close the session and answer any outstanding questions the participants might have.

Note: If this module is being presented on its own, complete the learning reflection, post-workshop survey and certificates of attendance (see below). If this module is being presented as a series, continue on to the next module.

Learning reflection

Ask participants to reflect on the learning goals they wrote in their Participant Workbooks at the beginning of the workshop.

Post-workshop survey

Evaluation is an important component of the training. At completion of the module, distribute the post-workshop survey (Appendix 7). Ask the participants to compare their post-workshop survey answers with those from the pre-workshop survey (Appendix 6). Participants do not need to reveal their scores but are encouraged to comment or personally reflect on any changes.

Certificates of attendance

Distribute the certificates of attendance (Appendix 5) and thank the participants for their attendance.



Module 4 References:

1. UNICEF (n.d.). Module 1: Understanding the Social Ecological Model (SEM) and Communication for Development (C4D).
2. Hayes, L., D'Antoine, H. and Carter, M. (2014). Addressing fetal alcohol spectrum disorder in Aboriginal communities. In *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Dudgeon, P., Milroy, H. and Walker, R. eds. Commonwealth of Australia: Canberra, Australia. p. 373-382.
3. Victorian Department of Human Services (2003). *Integrated Health Promotion Toolkit*. Melbourne: Victoria.
4. World Health Organisation (1998). *Health Promotion Glossary*. Geneva, Switzerland.
5. Green, L. & Kreuter, M. (2005). *Health Program Planning: An Educational and Ecological Approach*. New York: McGraw-Hill.
6. Egger, G., Spark, R. & Donovan R. (2005). *Health promotion, strategies and methods*. Sydney: McGraw-Hill
7. Weeramanthri, T. (1996). Knowledge, language and mortality: communicating health information in Aboriginal communities in the Northern Territory. *Australian Journal of Primary Health*, 2(2): p. 3-11.
8. Northern Territory Department of Health and Aged Care (1989). *Aboriginal health promotion training manual*. Darwin, Northern Territory.
9. Wunan Foundation (2013). *Swimming the river*. Accessed February 2017 from <https://youtu.be/OP9FRacTji0>
10. Ontario Agency for Health Protection and Promotion (Public Health Ontario). *Planning Health Promotion Programs: Introductory Workbook*. 4th ed. 2015, Toronto, ON: Queen's Printer for Ontario.
11. Murray, C., et al. *Planning and Evaluation Wizard: Step-by-step project planning and report writing for primary health care*. Accessed February 2017 from http://www.flinders.edu.au/medicine/sites/pew/pew_home.cfm
12. World Health Organisation (1986). *Ottawa Charter for Health Promotion*. Ottawa: Canada.



Module 4 Further Reading and Additional Information:

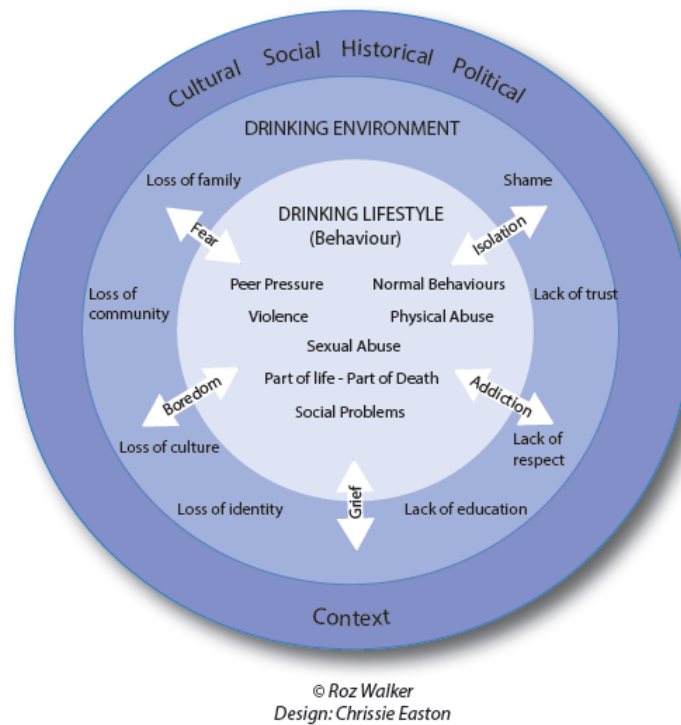
Slide 7 Descriptions of the socio-ecological model levels.

| SEM Level | Description |
|------------------------------------|--|
| Individual | Characteristics of an individual that influence behaviour change, including knowledge, attitudes, behaviour, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic/caste identity, sexual orientation, socio-economic status, financial resources, values, goals, expectations, literacy, stigma, and others. |
| Interpersonal | Formal (and informal) social networks and social support systems that can influence individual behaviours, including family, friends, peers, co-workers, religious networks, customs or traditions. |
| Community | Relationships among organizations, institutions, and informational networks within defined boundaries, including the built environment (eg parks), village associations, community leaders, businesses, and transportation. |
| Organizational | Organizations or social institutions with rules and regulations for operations that affect how, or how well, for example services are provided to an individual or group. |
| Policy/Enabling Environment | Local, state, national and global laws and policies, including policies regarding the allocation of resources for maternal, newborn, and child health and access to healthcare services, restrictive policies (eg high fees or taxes for health services), or lack of policies that require warning labels on alcoholic beverages. |



Slide 8 Hayes, L. (2012). Aboriginal woman, alcohol and the road to fetal alcohol spectrum disorder. *Medical Journal of Australia*. 197(1):21-23.

The diagram below² has been used to outline the interconnecting factors that create a drinking cycle that can lead to alcohol consumption being an acceptable part of life.



Slide 20: Transcript for Historical perspective: Swimming the River.

G'day, I'm Ian Trust, the Executive Chair of Wunan Foundation, a not-for-profit organisation based in Kununurra in the East Kimberly region in Western Australia.

I'd like to share with you a metaphor that I've developed to explain the key issues facing my people, the Aboriginal people of East Kimberly. It's titled – Swimming the River.

The way I see it is like this, for most of the past 70,000 years, if you were Aboriginal you had to cross a harsh and unrelenting desert. In this harsh environment we not only survived but prospered and this was long before we had mining royalties and government services.

The key to our survival of course was a close knit community where everyone cared about the wellbeing of each other, where everyone contributed to the survival of your community. If you were a child you learned from the day you were born how to survive in this harsh environment and the rules which maintained your community. Elder's enforced strict norms and values and a sense of responsibility towards each other, our children and our old people. These things were embedded in our culture. A couple of hundred years ago the first

settlers arrived and our world was turned upside down. Our people no longer roamed free anymore and new skills were needed to succeed in this new world. Now instead of the desert, there were new barriers to our survival that we needed to navigate. Now we had to learn to swim a river and where you learn to swim this river is at places they call schools.

These schools are set up to teach you to read and write and other important skills so you can swim the river. And the reason we must learn to swim the river is because all of the opportunities in this new world are on the other side of the river.

These opportunities include things such as jobs, houses, and business opportunities. All of which contribute to a better life. Many of our families have learned to adapt to this new world and understand the importance of their children learning how to swim from an early age. These families support their children, walking alongside them all the way to the bank of the river to make sure they know how to swim.

Even when these children go all the way through school, they don't swim straight across the river. But they make it to the other side because they've learnt one of the most important skills, how to adapt.

Unfortunately in the East Kimberly, we estimate that only 40% of our families walk alongside the kids all the way to the river bank. The other 60% of our families don't understand the importance of parents walking alongside their children. Because of a lack of parental support, the children from these families are in and out of the education system and by the time they leave school they haven't acquired the skills they need to swim the river. In most cases they don't make it to the other side to access the opportunities there.

This river is a dangerous place to be. There's a strong current and it's called welfare and those without the skills or the motivation to cross the river get swept along in the grip of the current. The reason why the river is dangerous is because downstream in the river lives a couple of big crocodiles. These crocodiles are drugs and alcohol.

History has shown us in the last 40 years in the East Kimberly, the longer you stay in the river the chances are you'll end up in the jaws of one of those crocodiles. Unfortunately for many of my people that is exactly what has happened.

Of course some of the people who have ended up in the mouths of crocodiles have gone on to be parents. In turn, many of them have not walked alongside their children to the river bank and so the cycle passes from one generation to the next. In some families it has been going on for at least four generations.

The by-product of this tragedy for many families who have been swept down the river has been poor health and living conditions, homelessness, domestic violence, mental illnesses, Fetal Alcohol Syndrome Disorder in children, and suicide. Many of them have lost their culture and language and have ended up in prison.



The difference between those families that have learnt to swim the river and those who haven't is dependent upon three things. These are: having access to opportunities in education, employment and housing; having the ability to access these opportunities; and having a level of responsibility to bring the other two together. In the East Kimberly there are plenty of opportunities and our people have lots of ability but the thing that is missing is individual and family responsibility. That's what can help people move forward and help us rebuild our culture.

A key question to ponder is – why have we not broken the dysfunctional cycle that results in many of our people ending up in the mouths of crocodiles? The answer, I think, is low expectation from the government and from the community at large. The assumption is, these people do not have the ability to swim the river. As a result a lot of money goes into pulling people out of the mouths of crocodiles, rather than ensuring they learn to swim the river. The other part of the answer is that people know that the solutions will require some tough decisions in areas such as welfare reform, and holding parents responsible for their children's wellbeing. But the bottom line is that without these tough decisions, nothing will change.

- End of transcript -

Slide 25: Planning health promotion programs

The main steps are:¹⁰

1. Identify your target **group** – **who** are the 'primary' and 'secondary' target groups.
2. Develop **goals** and **objectives** – including **what** needs to change, **how** much change needs to occur and **when**.
3. Develop **strategies** achieve the goals and objectives – including specifics of **what** will be done and **where**.
4. Allocate **resources** to the strategies – funding, staffing, equipment.
5. Develop a program **evaluation**

Slide 26: Identify your target group

- A health promotion program will often have both 'primary' and 'secondary' target groups¹⁰. The 'primary' group is the individual or sub-group that you are hoping to see a change in. For the purposes of learning activity you will be given a scenario where the primary target group will be either 1) pregnant women, 2) women of childbearing age, 3) men, 4) grandmothers and Aunties or 5) health professionals.



- The ‘secondary’ target group are individuals, networks, organisations, or communities that influence the primary audience’s choices and behaviours. Secondary audiences can reduce the likelihood of the primary audience achieving the desired change and therefore should be accounted for in your health promotion program.
- Factors to consider for each population group when designing your program.

Pregnant women may be:

- Unaware that they are pregnant.
- Unable to share their pregnancy news with friends, family or their community.
- Wrongly informed of alcohol consumption during pregnancy.
- Experiencing a lack of social support.
- Unable to completely abstain during pregnancy.

Women of childbearing age may be:

- Unaware of contraception options and their effective use.
- Unable to be open about their sexual activity.
- Wrongly informed of alcohol consumption during pregnancy.
- Experiencing a lack of social support.

Men may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Unaware of contraception options and their effective use.
- Unable to be open about their sexual activity.
- Unaware of their important role in supporting women.
- Creating unsupportive environments for women.

Grandmothers and Aunties may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Passing on misconceptions and myths eg “I drank during pregnancy and my children were fine”.
- Unaware of their important role in supporting women.
- Creating unsupportive environments for women.

Health Professionals may be:

- Wrongly informed of alcohol consumption during pregnancy.
- Passing on misconceptions and myths eg “Drinking red wine is very good to decrease stress during pregnancy”.
- Unaware of their important role in supporting women.

Slide 27: Goals: What are you trying to achieve?

Goal is a statement about the broad, long-term change your project is working toward. It refers to what you ultimately want to achieve, or your destination.



Objectives are statements about more specific and immediate changes you want in order to progress towards your goal. The changes might be in skill levels, attitudes, knowledge, processes, awareness or behavior.

Goals should be¹¹:

- Clearly defined.
- Focus on one thing at a time.
- Are able to be measured in some way.
- Focus on the **change** you are wanting rather than the doing of activities.
- Are realistic and achievable.

Objectives should be **SMART**¹⁰:

- **Specific** (clear and precise).
- **Measurable** (able to be evaluated, data readily available and accessible).
- **Appropriate** (aligned with stakeholder expectations, theory and other evidence).
- **Realistic** (reasonable considering the resources and other circumstances).
- **Time-limited**.

When developing the goals and objectives of your program plan, think about¹¹:

6. **What** you would like to see different/changed at the end of the program (changes should be significant, feasible, and within your capabilities)?
7. **How** much change is realistically achievable?
8. **What** is it going to do to achieve this change?
9. **Who** will have been affected?
10. **How** will they have been affected?

Goals and objectives checklist¹¹:

- Is your goal written in a way that identifies the broad, long-term change you want to achieve?
- Does your goal include what, who, how and where?
- Is it written as clearly and concisely as possible and can be clearly understood by someone unfamiliar with the program?
- Do your objectives focus on one thing at a time?
- Do your objectives refer to change?
- Do your objectives relate to your goal?

Slide 28: Strategies – How will you do it?

Strategies are statements about how you will meet the goals and objectives.



Activities are what you are going to do to achieve these strategies and communicate your key messages.¹¹

Strategies should be:¹¹

- Appropriate for the community.
- Directly relevant to the change you are seeking ie. your goals and objectives.
- Realistic in terms of number of strategies undertaken, time, resources and skills available.
- Supported by relevant stakeholder.
- Either proven to be successful in similar circumstances or are innovative.

Strategies checklist:¹¹

- Are your strategies related to your objectives?
- Do they focus on the activities of your program?
- Are they realistic, eg. number of strategies, time resources & skills?
- Are they considered appropriate by the workers and community members involved?

Key messages should be:¹⁰

- Clear and concise.
- Reflective of the programs overall goals.
- Motivational.
- Specific to a target audience.

To develop your key messages, consider:¹⁰

- What you want to say to your audience.
- What you want your audience to know.
- What do want your audience to do.

Activities should be:¹⁰

- Practical and appropriate for the community and target audience.
- Realistic in terms of the time, resources and skills available.

To identify the appropriate activities for each strategy, consider:¹⁰

- What actions will contribute to achieving your goal?
- What outcomes (results) do you expect?
- What can you measure to see if the goals have been achieved and within what timeframe?

Once you have outlined clear strategies with key messages and appropriate activities, you will need to allocate the resources required to achieve each of the activities. To identify the relevant resources, consider:



- What resources are available within your health service, or partners.
- Any resourcing gaps that may need addressing.
- Exploring ways to address any resourcing gaps (ie collaborating with other services in your area, seeking additional funding, in-house resource development using the FASD PosterMaker).

Slide 29: Evaluation: How will you know you've made a difference?

Module 3 explored data collection tools, processes and the importance of continuous quality improvement to evaluate a program's success and changes. These are important elements to include in your FASD Education Program Plan so you're able to measure the changes made by the program and evaluate its impact towards the overall goals and objectives.

- An evaluation plan is a short summary of what needs to be evaluated, what information needs to be collected (indicators), and how you are intending to collect this information.
- Some indicators involve collecting information along the way and enable you to make improvements throughout the program (monitoring). Other indicators involve collecting information at the end of the project (evaluation).
- Each of the program objectives should have at least one indicator and some may have multiple. A range of indicators that measure a combination of short-, medium- and long-term change is suggested.¹¹

To develop indicators, consider:¹¹

- What is an appropriate timeframe for observing a result?
- Is the measure available at that time?
- Are the sources of data required to assess this result accessible?
- Are the providers of the measure reliable, responsive, and timely?
- Do you have the resources for any direct costs, eg fees or licenses?
- Do you have the expertise to analyse or otherwise manage the data provided?

Process Indicators measure how well the program activities and strategies are going and often fall into the following three main groups:¹¹

4. Implementation (what has been done)
 - a. Workshop outlines
 - b. Procedures developed
 - c. Copies of media coverage
5. Reach & scope (who & how many people have been involved)
 - a. Number of participants
 - b. Proportion of age groups, men and women etc
 - c. Workers and organisations involved



6. Quality (how well things have been done)
 - a. Proportion of participants who report they are satisfied with materials or information produced, or the service provided
 - b. Certain standards of quality have been met

Impact/Outcome Indicators provide a sign of how well you have achieved the changes you were hoping for as a result of your project. They are about measuring change, the extent to which you have achieved your objectives and your longer term goal.

Indicators of impact relate to your objectives, and indicators of outcome relate to your goal.¹¹

Indicators should be assessed on their:¹¹

- Reliability – the extent to which the indicator will give consistent, accurate measurement over time.
- Validity – the extent to which the indicator measures what you set out to measure.

Slide 30: Finalise your plan

Consider the following questions to ensure your plan is complete:¹⁰

- Does the program include broad goals?
- Are your objectives SMART (specific, measurable, appropriate, realistic, and time-limited)?
- Have you identified a few major strategies to advance the goals and objectives?
- Have you chosen the best activities to advance the strategy? Are these activities appropriate to the audience?
- Have you identified relevant resources (people, funds, materials) for each activity and strategy?
- Does your plan have at least one indicator for each objective?
- Are the indicators reliable, valid and accessible?



Helpful websites

This is a list of websites for further information on FASD.

1. Telethon Kids Institute – Alcohol and Pregnancy & FASD

<https://alcoholpregnancy.telethonkids.org.au/>

This is the website for the 'Reducing the Effects of Antenatal Alcohol on Child Health Centre for Research Excellence (CRE)'. It's a good starting point to find information on the CRE, the Australian Guide to the Diagnosis of FASD, and other related resources. The resources section includes resources for Aboriginal and Torres Strait Islander communities.

2. Health/InfoNet Australian Indigenous Alcohol and Other Drugs Knowledge Centre – FASD Portal

<http://aodknowledgecentre.net.au/aodkc/alcohol/fasd>

The Health/InfoNet is a useful site for information about all areas of Indigenous health. The Australian Indigenous Alcohol and Other Drugs Knowledge Centre FASD portal aims to provide a central collection of policies and strategies, publications, resources and training materials supporting prevention and management of FASD in Aboriginal and Torres Strait Islander communities. This website is designed for people working, studying or interested in addressing the harms of alcohol use in pregnancy.

3. NOFASD Australia

https://canceraustralia.gov.au/sites/default/files/publications/national-aboriginal-and-torres-strait-islander-cancer-framework/pdf/2015_atSI_framework_1.pdf

NOFASD Australia aims to prevent alcohol exposed pregnancies in Australia and improve quality of life for those living with FASD by providing a strong and effective voice for individuals and families living with FASD. The site includes several resources directed at preventing FASD and assisting families and individuals living with a FASD diagnosis.

4. Russell Family Fetal Alcohol Disorders Association

<http://www.rffada.org/>

The Russell Family Fetal Alcohol Disorders Association (rffada) is a national not-for-profit health promotion charity dedicated to the prevention of FASD and ensuring parents, carers, and individuals affected by this disorder have access to diagnostic services, support and multidisciplinary management planning in Australia. On this site you will find a range of support resources and information on support groups for families.

Appendix 1: Two Day Training Agenda – sample

See over page

FASD Prevention and Health Promotion Resources Training Agenda

| DAY 1 | |
|-------------|---|
| Time | Session Topics |
| 0830 | Introduction |
| 0900 | Module One: What is FASD? |
| 1030 – 1045 | Morning tea |
| 1045 | Module One: What is FASD? Continued... |
| 1215 -1300 | Lunch |
| 1300 | Module Two: Brief Intervention and Motivational Interviewing |
| 1430 – 1445 | Afternoon Tea |
| 1445 | Module Two: Brief Intervention and Motivational Interviewing Continued... |
| 1615 | Day 1 reflection and wrap up |
| 1630 | Finish |

| DAY 2 | |
|-------------|--|
| Time | Session Topics |
| 0830 | Brief review of Day 1 Module Three: Monitoring and Evaluating |
| 1000 – 1030 | Morning tea |
| 1030 | Module Three: Monitoring and Evaluating Continued... |
| 1200 -1230 | Lunch |
| 1230 | Module Four: Sharing Health Information |
| 1400 – 1430 | Afternoon Tea |
| 1430 | Module Four: Sharing Health Information Continued... |
| 1600 | Wrap up and Conclusion |
| 1630 | Finish |

Appendix 2: Pre-workshop Checklist for Facilitators – sample

| Registrations and travel requirements | Time frame | Completed |
|--|---------------|-----------|
| - Develop list of potential participants | 6 weeks prior | |
| - Confirm final numbers | 4 weeks prior | |
| - Book flights and accommodation, if applicable | 3 weeks prior | |
| - Send participants the training agenda | 2 week prior | |
| - Organise pre-training run through with facilitators, if applicable | 1 week prior | |
| - Organise Welcome to Country | 2 weeks prior | |
| Venue and catering | Time frame | Completed |
| - Book training venue | 4 weeks prior | |
| - Book catering (consider any dietary requirements) | 3 weeks prior | |
| - Organise equipment eg whiteboard, projector, projector leads, and laptop | 2 weeks prior | |
| Training materials and resources | Time frame | Completed |
| - Print documents and handouts (refer to packing list) | 2 weeks prior | |
| - Order stationary if needed (refer to packing list) | 3 weeks prior | |
| - Finalise agenda | 2 week prior | |
| - Create name tags (participants, facilitators) | 2 week prior | |
| - Print training certificates | 2 weeks prior | |
| - Save PowerPoint slides, FPHPR folders and Directory on a USB (one per participant) | 1 week prior | |

Appendix 3: Packing List for Facilitators – sample

| Participant packs: | | # required | Packed |
|-----------------------|-----------------------|------------|--------|
| Agenda | 1 per participant +2 | | |
| Participant Workbooks | 1 per participant + 2 | | |
| Participant handouts | 1 per participant + 2 | | |

| Housekeeping: | | # required | Packed |
|---|--|------------|--------|
| Sign-in Sheet (see Appendix 4) | 1 | | |
| Name tags | 1 per participant and facilitator | | |
| FPHPR Training Certificate of Attendance (see Appendix 5) | 1 per participant | | |
| Pre-workshop survey (see Appendix 6) | 1 per participant + 2 | | |
| Post-workshop survey (see Appendix 7) | 1 per participant + 2 | | |
| Facilitator Reflection Form (see Appendix 8) | 1 per facilitator | | |
| Resources or equipment required for the interactive activities in each module being delivered | See the information provided at the beginning of each module for details | | |

| Stationary: | | # required | Packed |
|--------------------|-------------|------------|--------|
| Butchers paper | 1 full pack | | |
| Pens | 4 | | |
| Blu-tac | 1 pack | | |
| Whiteboard Markers | 1 pack | | |
| Post-it notes | 5 stacks | | |

| Multimedia: | | # required | Packed |
|----------------------------------|-------------|------------|--------|
| PowerPoint files for each module | | | |
| Internet access (where possible) | | | |
| Computer access | | | |
| Laptop | If required | | |
| Projector | If required | | |
| Powerboards and extension leads | If required | | |
| Projector | If required | | |

Appendix 4: Training Sign-in Sheet – sample

See over page

Appendix 5: Certificate of Attendance – sample

See over page



This to certify that

has successfully completed [contact hours] of

FASD Prevention & Health Promotion Resources Training

Facilitator's signature:

Date:

Facilitator's Name:

Appendix 6: Pre-workshop Survey

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FASD Prevention & Health Promotion Resources Training

Pre-workshop Survey

Your responses will help to evaluate the training workshops and to continue to improve their content and format.

Workshop date: _____

Location: _____

1. What is your current position? (*select one*)

1. Aboriginal or Torres Strait Islander Health Worker/Practitioner
2. Aboriginal or Torres Strait Islander Maternal and Infant Health Worker/Practitioner
3. Aboriginal or Torres Strait Islander Liaison Officer
4. Child and Family Health Nurse / Nurse
5. FASD Officer
6. Manager, Maternal and Child Health Unit
7. Midwife
8. Other (Please specify) _____

2. Do you identify as being of Aboriginal and/or Torres Strait Islander origin?

- | | |
|---|--------------------------------|
| 1. Yes, Aboriginal | 3. Yes, Torres Strait Islander |
| 2. Yes, Aboriginal and Torres Strait Islander | 4. No |

3. Please indicate your gender

1. Female
2. Male
3. Other

4. How long have you been working in your current role?

1. Less than 6 months
2. 6 months – 2 years
3. More than 2 years

10. Do you feel you have enough time to... *(circle one number on each line)*

| | Yes | No |
|---|-----|----|
| 1. Advise pregnant women about alcohol consumption during pregnancy | 1 | 2 |
| 2. Explain to pregnant women the effects on the fetus and child of consumption during pregnancy | 1 | 2 |
| 3. Assess alcohol consumption during pregnancy | 1 | 2 |
| 4. Conduct brief intervention for alcohol consumption during pregnancy | 1 | 2 |

Questions 11 and 12 ask about your attitudes towards alcohol consumption during pregnancy.

11. To what extent do you agree that asking every pregnant woman about whether they have consumed alcohol during pregnancy... *(circle one number on each line)*

| | Strongly disagree | Disagree | Agree | Strongly agree |
|---|-------------------|----------|-------|----------------|
| 1. Will identify women who need support to stop consuming alcohol during pregnancy | 1 | 2 | 3 | 4 |
| 2. Will enable changes in behaviour and improved health outcomes for the mother and child | 1 | 2 | 3 | 4 |
| 3. Will uncover complex problems that are difficult for health professionals to address | 1 | 2 | 3 | 4 |
| 4. Will lead to some women feeling judged | 1 | 2 | 3 | 4 |
| 5. Will cause anxiety and guilt among women who have consumed alcohol during pregnancy | 1 | 2 | 3 | 4 |
| 6. Will distress or anger pregnant women | 1 | 2 | 3 | 4 |
| 7. Will threaten my relationship with pregnant women | 1 | 2 | 3 | 4 |

12. To what extent do you agree that... (circle one number on each line)

| | Strongly disagree | Disagree | Agree | Strongly agree |
|---|-------------------|----------|-------|----------------|
| 1. Information about the effect alcohol may have on the fetus should be readily available to women of child-bearing age | 1 | 2 | 3 | 4 |
| 2. Pregnant women should completely abstain from consuming alcohol | 1 | 2 | 3 | 4 |
| 3. Pregnant women expect to receive information about the consequences of alcohol consumption at antenatal visits | 1 | 2 | 3 | 4 |
| 4. Women planning to become pregnant in the near future should abstain from consuming alcohol | 1 | 2 | 3 | 4 |
| 5. Infrequent consumption of one standard drink of alcohol during pregnant is not harmful to the mother or fetus | 1 | 2 | 3 | 4 |

Questions 13 asks about your knowledge of conditions caused by and effects associated with alcohol consumption during pregnancy.

13. Which of the following effects on the fetus and child are associated with alcohol consumption during pregnancy? (select all that apply)

- | | |
|---|--|
| 1. Delayed development | 8. Disrupted school experience |
| 2. Alcohol and/or other drug dependence | 9. Attention Deficit Hyperactivity Disorder (ADHD) |
| 3. Behavioural problems | 10. Learning disabilities |
| 4. Lowered intelligence | 11. Long term emotional disorders |
| 5. Preterm birth | 12. Spontaneous abortion |
| 6. Neonatal abstinence syndrome | 13. Seizures |
| 7. Structural brain damage | 14. Legal problems |
| | 15. Not sure |

Thank you for completing this survey, please return the survey to the facilitator.

Appendix 7: Post-workshop Survey

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FASD Prevention & Health Promotion Resources Training

Post-workshop Survey

Your responses will help to evaluate the training workshops and to continue to improve their content and format.

Workshop date: _____

Location: _____

1. When you return to your health service how confident would you feel to...
(circle one number on each line)

| | Not at all confident | Somewhat confident | Fairly confident | Very confident |
|---|----------------------|--------------------|------------------|----------------|
| 1. Advise pregnant women about alcohol consumption during pregnancy | 1 | 2 | 3 | 4 |
| 2. Explain to pregnant women the effects on the fetus and child of consumption during pregnancy | 1 | 2 | 3 | 4 |
| 3. Assess alcohol consumption during pregnancy | 1 | 2 | 3 | 4 |
| 4. Conduct brief intervention for alcohol consumption during pregnancy | 1 | 2 | 3 | 4 |

2. When you return to your health service, do you feel like you would have enough time to...
(circle one number on each line)

| | Yes | No |
|---|-----|----|
| 1. Advise pregnant women about alcohol consumption during pregnancy | 1 | 2 |
| 2. Explain to pregnant women the effects on the fetus and child of consumption during pregnancy | 1 | 2 |
| 3. Assess alcohol consumption during pregnancy | 1 | 2 |
| 4. Conduct brief intervention for alcohol consumption during pregnancy | 1 | 2 |

3. To what extent do you agree that asking every pregnant woman about whether they have consumed alcohol during pregnancy will... (circle one number on each line)

| | Strongly disagree | Disagree | Agree | Strongly agree |
|--|-------------------|----------|-------|----------------|
| 1. Identify women who need support to stop consuming alcohol during pregnancy | 1 | 2 | 3 | 4 |
| 2. Enable changes in behaviour and improved health outcomes for the mother and child | 1 | 2 | 3 | 4 |
| 3. Uncover complex problems that are difficult for health professionals to address | 1 | 2 | 3 | 4 |
| 4. Lead to some women feeling judged | 1 | 2 | 3 | 4 |
| 5. Cause anxiety and guilt among women who have consumed alcohol during pregnancy | 1 | 2 | 3 | 4 |
| 6. Distress or anger pregnant women | 1 | 2 | 3 | 4 |
| 7. Threaten my relationship with pregnant women | 1 | 2 | 3 | 4 |

4. To what extent do you agree that... (circle one number on each line)

| | Strongly disagree | Disagree | Agree | Strongly agree |
|---|-------------------|----------|-------|----------------|
| 1. Information about the effect alcohol may have on the fetus should be readily available to women of child-bearing age | 1 | 2 | 3 | 4 |
| 2. Pregnant women should completely abstain from consuming alcohol | 1 | 2 | 3 | 4 |
| 3. Pregnant women expect to receive information about the consequences of alcohol consumption at antenatal visits | 1 | 2 | 3 | 4 |
| 4. Women planning to become pregnant in the near future should abstain from consuming alcohol | 1 | 2 | 3 | 4 |
| 5. Infrequent consumption of one standard drink of alcohol during pregnancy is not harmful to the mother or fetus | 1 | 2 | 3 | 4 |

5. Which of the following effects on the fetus and child are associated with alcohol consumption during pregnancy? *(select all that apply)*

- | | |
|---|--|
| 1. Delayed development | 8. Disrupted school experience |
| 2. Alcohol and/or other drug dependence | 9. Attention Deficit Hyperactivity Disorder (ADHD) |
| 3. Behavioural problems | 10. Learning disabilities |
| 4. Lowered intelligence | 11. Long term emotional disorders |
| 5. Preterm birth | 12. Spontaneous abortion |
| 6. Neonatal abstinence syndrome | 13. Seizures |
| 7. Structural brain damage | 14. Legal problems |
| | 15. Not sure |

The following questions ask for your feedback on the delivery of the workshop

6. The workshop provided... *(circle one number on each line)*

| | Strongly disagree | Disagree | Agree | Strongly agree |
|---|-------------------|----------|-------|----------------|
| 1. A culturally safe space | 1 | 2 | 3 | 4 |
| 2. Opportunities for networking with other health professionals | 1 | 2 | 3 | 4 |
| 3. Information about resources to prevent FASD and how to access them | 1 | 2 | 3 | 4 |

7. Would you like to make any other comments or suggestions about the training?

Thank you for completing this survey, please return the survey to the facilitator

Appendix 8: Facilitator Reflection Form

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Facilitator Reflection Form

Facilitator Name: _____

Organisation: _____

Date: _____

Venue: _____

Format: _____

It's important for the training facilitator to reflect on how they felt the training went for both them, and their participants.

1. Please reflect on what happened at the training, from the beginning to the end.

2. How do you feel the training went for you?

3. How do you feel the training went for your participants?



Please describe the most and least helpful aspects of the training.

4. Most helpful aspects

5. Least helpful aspects

6. What have you learnt from this training?

7. From your reflections, what would you do differently next time?

8. Is any follow-up required? If so, what are your next steps?



