FASD Prevention & Health Promotion Resources Training

for health professionals working with Aboriginal and Torres Strait Islander communities

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Participant Workbook

September 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.

Title: FASD Prevention & Health Promotion Resources Training: Participant Workbook

Preferred citation:

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Acknowledgements

The Fetal Alcohol Spectrum Disorder (FASD) Prevention and Health Promotion Resources Package was developed by:

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

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 expertise has been integral to the development of this training package.

The Project Team would especially like to thank the staff, management and board members from New Directions Mothers and Babies Services across Australia who participated in the piloting of this training package and provided valuable feedback.

Funding

The project partners gratefully acknowledge the funding received from the Australian Government Department of Health (2015-2017) for the development of the FASD Prevention and Health Promotion Resources Package.

Contents

Introduction

Welcome to the Fetal Alcohol Spectrum Disorder (FASD) Prevention & Health Promotion Resources Participant Workbook. This workbook and the associated training workshop were developed as part of the FASD Prevention & Health Promotion Resources Project.

The FASD Prevention and Health Promotion Resources Project

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 Resource 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 originated in 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 FASD Prevention and Health Promotion Resources 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.

Training aims and overview

The training is made up of five modules that can be delivered individually in separate sessions or together as a two-day workshop. This Participant Workbook contains the slides and handouts from all five modules.

Introduction: FASD Prevention and Health Promotion Resources Training Package
Module 1: What is Fetal ASD?
Module 2: Brief Intervention and Motivational Interviewing
Module 3: Monitoring and Evaluating
Module 4: Sharing Health Information.

The overall aim of the training 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).

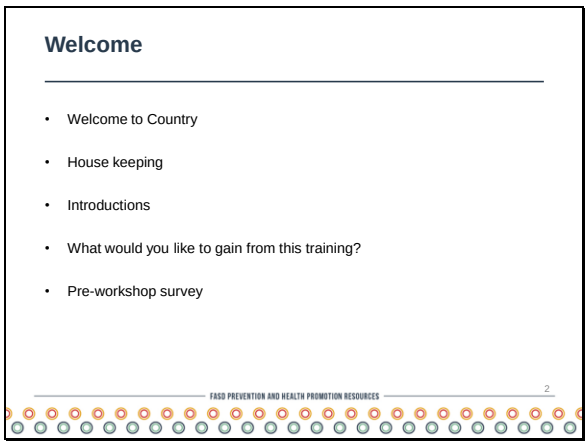
Certificate of Attendance

Each participant will receive a Certificate of Attendance at completion of the workshop. The certificate will list the amount of contact hours the participant completed. Participants should keep the certificate and their workbook as evidence of their attendance. This participant workbook may be used towards continuing professional development.

Introduction Module

My learning goals for this workshop

Goal



Overview

Introduction

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

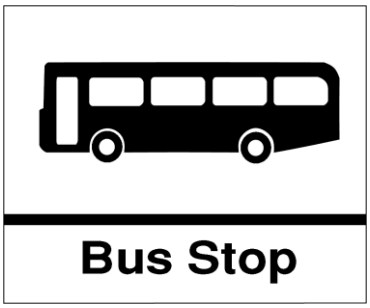
Training aims

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



Looking after yourself

Some of the content in this training may cause you distress.

Please feel free to take time out if you need to.

See the Helpful Websites section of your Participant Workbook for the contact details of support agencies eg NOFASD Australia and the Russell Family Fetal Alcohol Disorders Association.

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[1].

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 expertise has been integral to the development of this training package.

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- Telethon Kids Institute (TKI)

The project partners gratefully acknowledge the funding received from the Australian Government Department of Health (2015-2017) for the development of the FASD Prevention and Health Promotion Resources Package.

Additional notes

Introduction Module 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 Module Further Reading and Additional Information:

Selected national initiatives addressing FASD in Australia since 2012.

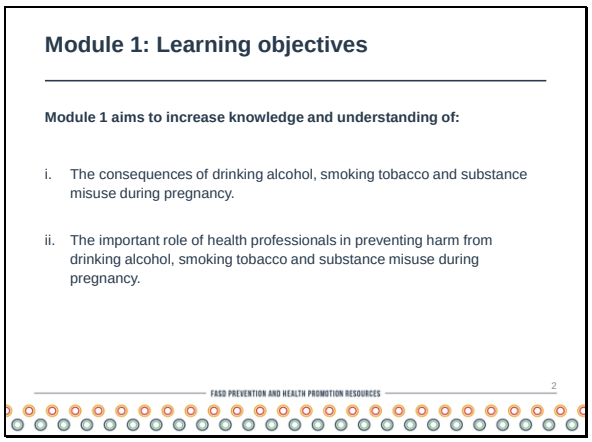
- 2012 – Final report from the House of Representatives Standing Committee into FASD was tabled in parliament, titled "FASD the hidden harm – Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders".
- 2013 – In response to the national inquiry, the Commonwealth Government 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?

My learning goals for this workshop

Goal



"…Relax, its not a big deal…"

How much alcohol is a safe to drink while you're pregnant?

Do you have to think twice about alcohol before you're pregnant?

What advice do women receive about drinking while pregnant?
Where do they get this advice from?

Are there mixed messages about alcohol during pregnancy?

Why might some women drink (or smoke or take drugs) while they are pregnant?

What is FASD?

How would you explain FASD to your clients or community members?

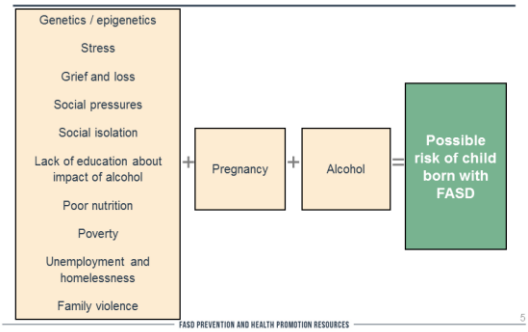
Fetal – baby in the belly

Alcohol – any grog, even low alcohol content

Spectrum – broad range, like a rainbow

Disorders – messed up, disarray

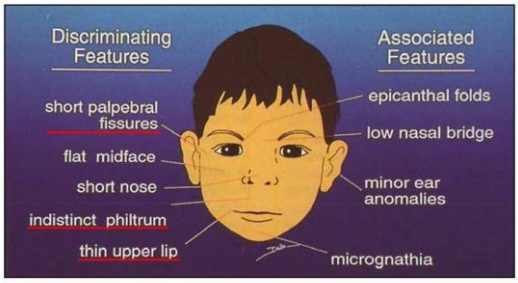
There is no 'safe' level[1]



Australian diagnostic criteria for FASD[2]

	FASD with 3 sentinel facial features	FASD with less than 3 sentinel facial features
Prenatal alcohol exposure	Confirmed or unknown	Confirmed
Neurodevelopmental domains - brain structure - motor skills - cognition - language - academic achievement - memory - attention - executive function - affect regulation - adaptive behaviour, social skills or communication	Severe impairment in at least 3 neurodevelopmental domains	Severe impairment in at least 3 neurodevelopmental domains
Sentinel facial features	Presence of at least 3 facial features	Presence of 0, 1 or 2 facial features

Sentinel facial features[3]



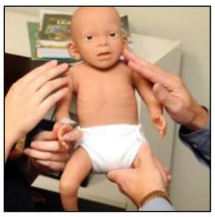
FASD: The invisible harm[2]

Neurodevelopmental conditions result in problems with:

- communication skills
- memory
- learning ability
- visual and spatial skills
- intelligence
- motor skills

Children may have Central Nervous System deficits without the physical features of FASD

FASD: The visible harm



Simulator doll – baby affected by FASD

- Small gestational size
- Small head, widely set eyes
- Low nasal bridge
- Bigger, lower ears
- Shorter nose and smaller chin
- Flattened mid-face
- Curved fingers and joints.

Reproduced with permission from www.virtualparenting.com.au

FASD PREVENTION AND HEALTH PROMOTION RESOURCES 9

FASD: Signs and symptoms[4]

Infants 0-3 years

- Irritable, hypersensitive to light etc
- Poor sucking reflex
- Delayed sitting, crawling, walking, talking
- Jitteriness/tremors, low muscle tone
- Attachment and bonding issues

Pre-school 4-5 years

- Hyperactive, attention deficits
- Temper tantrums, disobedience
- Language, motor skills problems
- Lack of physical boundaries
- Toilet training delays

FASD PREVENTION AND HEALTH PROMOTION RESOURCES 10

FASD: Signs and symptoms[4]

Adolescence 12-17 years

- Poor judgement, lack of abstract thinking
- Limited daily living skills and social supports
- Trouble perceiving social cues
- Restless, easily distracted
- Problems with handling money, concept of time
- Naivety & gullibility
- Problems learning from experience
- Issues with the law, truancy, substance abuse

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FASD: Signs and symptoms[4]

Adults 18+ years

- Depression, suicidal thoughts
- Social and sexual exploitation (unplanned parenthood)
- Unpredictable behaviour
- Withdrawn, isolated
- Homelessness
- Substance abuse, mental illness
- Violence and abuse
- Arrest, incarceration

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Effects of disabilities caused by FASD[5]

Primary disability	Secondary condition	Defensive behaviours
Learning and memory difficulties	Trouble with authorities, lying, defiance	Making things up to fill in the blanks
Impulsiveness	Destructive behaviour, stealing	Anger, frustration, aggression
Difficulty linking actions and consequences	Incarceration	Running away, avoidance, depression
Social skills and relationship issues	Inappropriate sexual behaviour	Isolation, attempt to buy friends, poor self-concept
Hyperactivity	Disrupted school experience, drug use	Anxiety, fear at being constantly overwhelmed

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Protective factors[5]

Some factors may reduce the impact of FASD and the development of secondary conditions:

- A diagnosis by 6 years of age
- Links with support agencies
- Living in a stable environment
- Never experiencing family violence

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Effects of FASD throughout life

Without support, people with FASD may have poorer outcomes

0 - 7 years	8 - 11 years	12 - 17 years	18 + years
Delayed development Stigmatised as 'problem child' Repeated punishment	Truancy Labelled 'delinquent' Mental illness Disrupted schooling	Juvenile detention Depression, suicide Couch surfing Drop out of school Inappropriate sexual behaviour	Incarcerated Homeless Centrelink/Welfare Addiction Supported by parents Suicide

No blame, no shame

A woman may drink because:

- She does not know she is pregnant
- She does not know of the risk of harm to the fetus
- To cope with life's problems (unfavourable social and health conditions)
- It is a social norm
- She feels pressure due to paternal alcohol use

No blame, no shame, no judgement

Many women simply may not know they are pregnant or may not be aware of the harm that alcohol consumption can cause

Hidden Harm

http://www.abc.net.au/4corners/stories/2015/11/02/4341366.htm

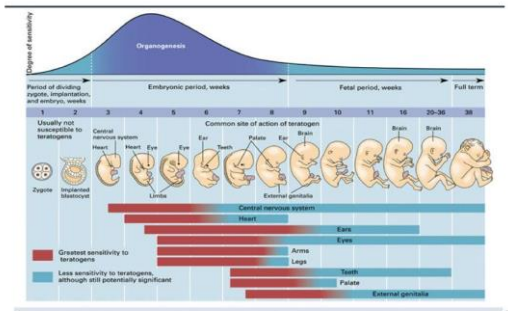
Teratogens[6]

Teratogen (te-*rat*-o-gen): a substance that causes birth defects

Examples of birth defects:

- Brain damage
- Central nervous system damage (brain and spinal cord)
- Low birth weight, premature birth,
- Physical damage, such as growth deficiencies and organ defects

Effects of teratogens during pregnancy



Effects of teratogens[7]

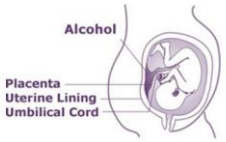
Effect	Cannabis	Ice	Tobacco	Alcohol
Growth restriction	X	X	X	X
Low birth weight	X	X	X	X
Physical problems			X	X
Behavioural problems		X		X
Mental illness	X	X	X	X
Small head circumference				X
Learning disabilities	X	X		X
Neonatal withdrawal	X	X	X	X
Sleep cycle disturbance	X	X	X	X

Alcohol and unplanned pregnancies[8]

- 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, indicating many will be exposed to alcohol prior to pregnancy awareness.

Transmission of alcohol to the fetus[9]

- Alcohol reaches the embryo and fetus through the mother's blood.
- Alcohol crosses the placenta very easily and enters the fetal bloodstream. It then passes into all developing tissues.
- Alcohol can impair the growth of organs that are developing at the time the alcohol is consumed.
- The fetus can not metabolise alcohol, so the alcohol concentration stays higher for longer, until it is cleared from the mother's bloodstream.
- Babies of women over 30 years are more at risk, due to age-related slowing of metabolism[21].



Australian Guidelines to Reduce Health Risks from Drinking Alcohol[10]

Guideline 4.

Pregnancy and Breastfeeding

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.

A. For women who are pregnant or planning a pregnancy, not drinking is the safest option.

B. For women who are breastfeeding, not drinking is the safest option

Australian Guidelines to Reduce Health Risks from Drinking Alcohol[10]

ADVICE FOR WOMEN WHO ARE PREGNANT OR PLANNING A PREGNANCY

- Not drinking alcohol is the safest option.
- The risk of harm to the fetus is highest when there is high, frequent, maternal alcohol intake.
- The risk of harm to the fetus is likely to be low if a woman has consumed only small amounts of alcohol before she knew she was pregnant or during pregnancy.
- The level of risk to the individual fetus is influenced by maternal and fetal characteristics and is hard to predict.

Australian Guidelines to Reduce Health Risks from Drinking Alcohol[10]

ADVICE FOR BREASTFEEDING MOTHERS

- Not drinking alcohol is the safest option.
- Women should avoid alcohol in the first month after delivery until breastfeeding is well established.
- After that:
  - alcohol intake should be limited to no more than two standard drinks a day
  - women should avoid drinking immediately before breastfeeding
  - women who wish to drink alcohol could consider expressing milk in advance.

Tobacco and pregnancy[11]

Smoking tobacco increases risk of:

- Ectopic pregnancy
- Miscarriage
- Placental complications
- Low birth weight
- Premature delivery
- SIDS
- Cleft lip, cleft palate
- Childhood cancers

Tobacco and pregnancy[12]

- 11% of women who gave birth in 2014 smoked during pregnancy.
- Of these, 22% quit during their pregnancy.
- Some women were more likely to smoke:
  - 32% of women aged less than 20 years smoked (compared with 6% aged 35-39 years)
  - 20%-34% of women in very remote/remote areas smoked (compared with 8% in major cities)
  - 44% of Indigenous women smoked (compared with 12% of non-Indigenous mothers)

What is in a cigarette?[13,14]

- **4000+ harmful chemicals**
- **69 chemicals are known to cause cancer (carcinogens)**
- **Nicotine – poisonous drug that makes people addicted to smoking**
- **Carbon Monoxide – poisonous gas produced during the burning of tobacco (also found in car exhaust fumes)**
- **Tar – sticky brown mixture of chemicals that stains fingers, teeth and lungs. Includes a number of cancer causing substances**

Myths – Tobacco and pregnancy

- Smoking during pregnancy is not harmful
- Roll-your-own tobacco is not as bad
- Smoking cigarettes is better (or worse) than smoking marijuana.
- If you are exposed to a lot of smoke from other people you may as well keep smoking.
- Smoking light cigarettes will not harm the unborn baby.
- Smaller baby = easier labour.
- It's worse to give up when you're pregnant, because the baby will 'stress for a smoke'

Supporting Smoking Cessation: A guide for health professionals[11]

The only safe level of smoking in pregnancy is not smoking at all.

Any level of nicotine or tobacco smoke exposure increases the risk of adverse effects

The greatest gain in health benefits comes from quitting rather than cutting down.

Supporting Smoking Cessation: A guide for health professionals[11]

Recommended smoking cessation treatment

- Pregnant women should be encouraged to stop smoking completely.
- They should be offered intense support and proactive telephone counselling.
- Self-help material can supplement advice and support.
- If these interventions are not successful, health professionals should consider NRT, after clear explanation of the risks involved.
- Those who do quit should be supported to stay non-smokers long-term.

Nicotine Replacement Therapy (NRT) and pregnancy[11]

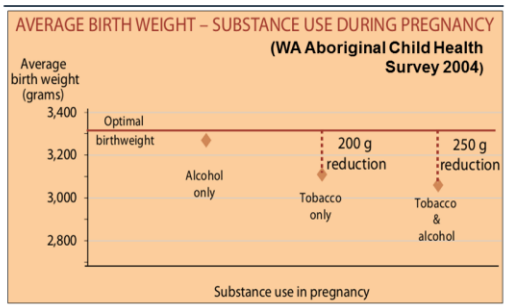
Pregnant women:

- Quitting should ideally be achieved without NRT.
- Gum, lozenge, sub-lingual tablet (under the tongue) or inhaler may be used.
- The risks of patches should be discussed before use.

Breastfeeding women:

- Use intermittent forms of NRT
- Breastfeed before use

Combined substance use and pregnancy[15]



We do know that…

- 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, based on their level of impairment.

We don't know…[16,17]

How many Australian children and adults have FASD

Why?

- Women may not seek assistance and/or fully disclose drinking behaviour during pregnancy due to stigma, fear of children being removed from their care and feelings of shame.
- A lack of understanding about FASD among the medical profession.
- A lack of routine screening of women about their alcohol use during pregnancy and pre-conception.
- Until May 2016 there was no agreed diagnostic criteria and clinical guidelines.

Estimating FASD prevalence in Australia

'Lililwan Study'

Aboriginal leaders in Fitzroy Valley conducted the only FASD prevalence study in Australia – by community, for community[18]

- The survey of 108 babies born in the area between 2002 and 2003.
- Estimated prevalence for FASD is 120 per 1,000 children aged seven to nine years.
- In comparison, overseas prevalence estimate is 1-3 per 1,000 births in the general population.
- Marninwarntikura Fitzroy Women's Resource Centre www.mwrc.com.au/

Key messages - Alcohol and pregnancy[10]

ADVICE FOR WOMEN WHO ARE PREGNANT OR PLANNING A PREGNANCY

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Key messages - Alcohol and breastfeeding[10]

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- Those who do quit should be supported to stay non-smokers long-term.

The role of health professionals[19,20]

You have the ability to make a difference

- Health professionals are well positioned to make a difference in alcohol use among women before and during their pregnancy
  - Women expect advice from health professionals
  - Private interactions with a level of trust
  - Have detailed knowledge of health issues
  - Personalised advice, rather than general
- Health professionals provide external authority to support women in changing drinking behaviours

Module 1: Review

Module 1 aimed to increase knowledge and understanding of:

i. The consequences of drinking alcohol, smoking tobacco and substance misuse during pregnancy.

ii. The important role of health professionals in preventing harm from drinking alcohol, smoking tobacco and substance misuse during pregnancy.

Additional notes

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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3. Streissguth, A. (1994). A Long-Term Perspective of FAS. Alcohol Health and Research World, 18(1) 74-81.

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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

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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 https://alcoholpregnancy.telethonkids.org.au/alcohol-pregnancy-and-breastfeeding/about-fasd/

Slide 6: The Australian Guide to the Diagnosis of FASD and training modules can be accessed from https://alcoholpregnancy.telethonkids.org.au/alcohol-pregnancy-and-breastfeeding/diagnosing-fasd/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?'*

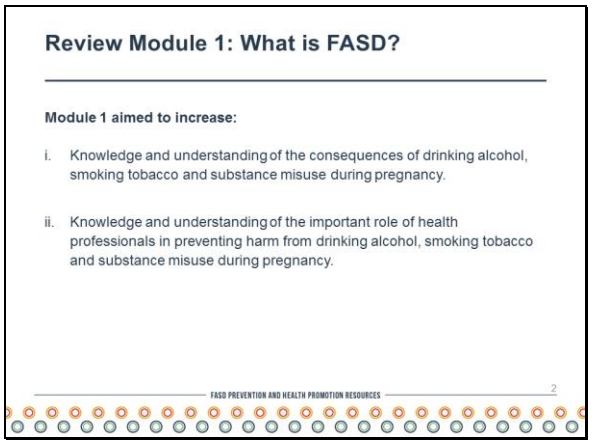
  At the time of finalising this training package (August 2017) FASD was not a recognised disability under the National Disability Insurance Agency in Australia. However, people with FASD can receive support determined by the level of impairment. Key experts in the field are advocating and lobbying for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

My learning goals for this workshop

Goal



Module 2: Learning objectives

Module 2 aims to increase:

i. Confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking, and substance misuse during pregnancy.

ii. Knowledge of the AUDIT-C screening tool.

Australian Guidelines to Reduce Health Risks from Drinking Alcohol[1]

General population

1. No more than 2 standard drinks a day reduces risk of long term disease or injury
2. No more than 4 standard drinks on a single occasion to reduce risk of alcohol-related injury
3. Not drinking is the safest option for young people under 18 years of age

Australian Guidelines to Reduce Health Risks from Drinking Alcohol[1]

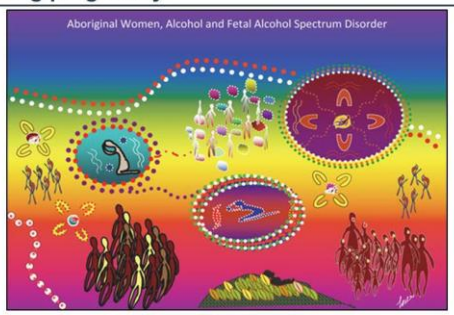
4. Pregnancy and Breastfeeding

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.

A. For women who are pregnant or planning a pregnancy, not drinking is the safest option.

B. For women who are breastfeeding, not drinking is the safest option

Many factors influence women's behaviour during pregnancy[2]



Individual level influencers

- Genetic predisposition for addictive behaviours
- Environment of alcohol use or abuse
- Knowledge of the effects of alcohol on the fetus, and FASD
- Stressors and coping mechanisms
- Age and previous pregnancies
- Other examples?

Organisational level influencers

- Role of beverage/alcohol industry in awareness
- Availability of health facilities and practitioners
- Accessibility to bars and other locations that sell alcohol
- Other examples?

Alcohol companies in Australia spend an estimated $125 million a year on alcohol advertising on direct television, radio, outdoor, and print media alone[3]

Community level influencers

Cultural norms related to use of alcohol in Australia

Other examples?

Public policy influencers

- Funding for programs/services to raise awareness of the impact of drinking during pregnancy
- Funding for support services
  eg alcohol rehabilitation, mental health programs
- Regulations related to selling/access of alcohol products and the definition of alcoholic beverage
  eg taxes, availability
- Other examples?

Current practices

Group discussion

- How do you engage your clients in a conversation about their lifestyle, health concerns and behaviour change?
- When do you usually do this?
- Do you use any resources to guide these conversations with your clients?

Why brief interventions?

Good evidence

- As good as Cognitive Behavioural Therapy in decreasing alcohol and drug use

Many health issues

- Alcohol consumption during pregnancy
- Smoking cessation
- Unsafe sex

Best practice

- Honours a client's right to determine what happens to them
- Recommended in current national prevention and treatment guidelines:
  - Supporting smoking cessation: A guide for health professionals (RACGP, 2014)
  - Guidelines for preventive activities in General Practice 9th ed (RACGP, 2016)
  - CARPA Standard Treatment Manual 6th ed (CARPA, 2014)

Brief interventions for a healthy pregnancy

Who should be offered brief interventions?

- Women of child-bearing age as part of pre-conception care[4]
- Women consuming risky amounts of alcohol *(2+ standard drinks/day or 4+ standard drinks on a single occasion)* or smoking or using drugs
- Antenatal clients, at every visit

How?

- Listen to the client's story in their own words
- Avoid judging or blaming
- Provide information on the risks and consequences of drinking behaviour
- Use Motivational Interviewing techniques

Motivational Interviewing

- **The client is the expert on themselves**
- **Role of the health professional**[5,6]
  - Express empathy
  - Develop discrepancy between current behaviour and goals/values
  - Roll with resistance to avoid argument, confrontation
  - Encourage confidence in ability to change

Motivational interviewing	vs.	Authoritative approach
Facilitator	vs.	Expert
Collaboration	vs.	Confrontation
Autonomy	vs.	Authority

Motivational interviewing techniques

Tips for active listening (OARS)[7]

Open ended questions "Tell me about…"

Affirm what they are saying

"I can see that staying off the smokes last week was really hard. Good on you for staying strong"

Reflect back what they have said to you

"So, it sounds like you don't think your drinking is an issue, but your sister is worried about you"

Summarise to ensure you are both on the same track

"Let me see if I understand so far…"

How do you feel about brief interventions and motivational interviewing?

Group discussion – Readiness Rulers[8]

How important do you think it is to use brief interventions & motivational interviewing with antenatal clients?

How confident do you feel to use brief interventions & motivational interviewing with antenatal clients?

The 5A's approach

5A's[9]	Techniques / tools
Ask – All antenatal clients about alcohol, smoking, other drugs	Embed into routine care for all clients
Assess - Level of risky behaviour, readiness for change	Screening tools to assess how many standard drinks, readiness for behaviour change
Advise - Provide information on risk factors	Current national guidelines Dependent on stage of readiness for change
Assist - Work with client to develop goals and targets	Motivational interviewing, OARS Dependent on stage of readiness for change
Arrange - Referral to other services, organise follow-up	Link with appropriate services in your area Record in client file

5A's video clip

Let's watch a health professional go through the 5A's with a pregnant client[9]:

https://www.youtube.com/watch?v=9q36z2v_vMk&feature=youtube

Ask

Group discussion

- When is it important to ask young women about:
  - Alcohol
  - Smoking
  - Drug use
  - Contraception
- What are the challenges in asking your antenatal clients about these behaviours?
- How can you feel more comfortable discussing these topics with your antenatal clients?

Barriers to asking about alcohol use in pregnancy

Health professionals may feel:

- Unsure how to ask, or are concerned about the response
- They lack time to raise the issue
- They lack knowledge about FASD
- It is not their role and are unprepared to give advice
- They lack skills in brief intervention and motivational interviewing
- That it is not relevant to the woman or is of low priority
- Unsure about conflicting recommendations
- Unsure of effective screening tools or referral services

Overcoming barriers

Group discussion

- Do it later in the consult when relationship built
- Normalise it "I ask everyone about how much they drink"
  "These questions are part of standard practice at this visit"
- Other suggestions?

Assess – Alcohol consumption

Why do we use alcohol consumption screening tools?

- Standardised way of identifying risk
- Reliable way to assess risk for a range of people
- Can be useful for tracking progress over time
- Can be used to assess risk and then start a brief intervention, if needed
- Can be referred to later on to assist with FASD diagnosis

Assess – Alcohol consumption using AUDIT-C[10]

AUDIT-C Reported alcohol use (if available)

1. How often did the birth mother have a drink containing alcohol during this pregnancy?

Unknown	Never [skip Q2+Q3]	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
☐	☐0	☐1	☐2	☐3	☐4

2. How many standard drinks did the birth mother have on a typical day when she was drinking during this pregnancy?

Unknown	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
☐	☐0	☐1	☐2	☐3	☐4

3. How often did the birth mother have 5 or more standard drinks on one occasion during this pregnancy?

Unknown	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
☐	☐0	☐1	☐2	☐3	☐4

AUDIT-C score during this pregnancy: (Q1+Q2+Q3)=_____ Scores= 0=no risk 1-4= confirmed use 5+= confirmed high-risk

Assess – Standard drinks

These are only an approximate number of standard drinks.
Always read the container for the exact number of standard drinks.

Assess – Stage of change

Whether a person is ready to change determines the support we offer

Stages of Change[10]

- Pre-contemplation — Not ready
- Contemplation — Unsure
- Preparation — Getting ready
- Action — Taking steps
- Maintenance — Sticking with the change
- Relapse — Learning from slip-ups

Assess – Readiness for change

What is needed for someone to change?

1. **They want to change**
   Your role: Instil the importance of change
2. **They feel they can change**
   Your role: Increase confidence they can change
3. **They feel now is the right time to prioritise action**
   Your role: Help create a change plan

Useful tool – Readiness Ruler

Advise – Australian Guidelines to Reduce Health Risks from Drinking Alcohol[1]

Guideline 4.

Pregnancy and Breastfeeding

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.

A. For women who are pregnant or planning a pregnancy, not drinking is the safest option.

B. For women who are breastfeeding, not drinking is the safest option

Advise – Alcohol and breastfeeding[1]

Time taken for alcohol to be cleared from breast milk (hours:minutes)

Maternal weight (kg)	Australian standard drinks						
	1	2	3	4	5	6	7
50	1:51	3:43	5:35	7:27	9:18	11:11	13:03
59	1:42	3:26	5:09	6:52	8:36	10:19	12:02
66	1:37	3:15	4:53	6:31	8:10	9:48	11:26
70	1:33	3:07	4:41	6:15	7:50	9:24	10:57

Time is calculated from the beginning of drinking

Feedsafe app – calculates time until alcohol has cleared from breast milk

Advise – Stage of change and actions

Pre-contemplation	Provide advice about harm minimisation Offer support when ready to change in the future
Contemplation	Identify positive reasons to change and risks of not changing Increase confidence to change
Preparation	Set goals together Take steps towards change
Action	Encourage and celebrate the change
Maintenance	Support the change Help identify strategies to prevent relapse
Relapse	Help get back to 'getting ready' or 'changing' without becoming demoralised

Assist – Decisional balance

Pre-contemplation, Contemplation or Preparation

Assist your client to identify:

Good and bad things about changing	What makes it hard to change
vs	vs
Good and bad things about staying the same	What would make it easy to change

FASD PREVENTION AND HEALTH PROMOTION RESOURCES 30

Assist – Open-ended questions

Pre-contemplation, Contemplation or Preparation

Help clients think about change and feel more motivated:

- How do you feel about your alcohol use?
- What are some of the good things about your alcohol use?
- What worries you about your alcohol use?
- What might be some benefits of you stopping or reducing the amount of alcohol that you drink?

FASD PREVENTION AND HEALTH PROMOTION RESOURCES 31

Assist – Create a change plan

Preparation, Action and Maintenance

Strengthen commitment to change by[13]:

- Ensuring the client drives the change plan
- Assisting the client to set their own goals
- Having the client identify support people in their lives
- Discussing what support is available from your health service, or other local organisations

FASD PREVENTION AND HEALTH PROMOTION RESOURCES 32

Arrange

Arrange a follow-up visit to check-in with the client's progress

- Ideally follow-up within 1-2 weeks
- Arrange a referral, if needed
  - another staff member or program within your clinic
  - a specialist or clinic
  - a local program

Arrange

Group discussion

What support services does your health service offer?

- Are these meeting community need or are new services needed?
- What can other staff at your service provide?
- What visiting services do you have?
- What external services are there to support clients?
- Are these culturally appropriate, accessible, affordable?

Brief intervention example – Smoking

ASK – about smoking eg "I can see you still have that cough, can we talk about your smoking?"

ASSESS – the client's smoking status and their readiness to change

Brief intervention example – Smoking

PRE-CONTEMPLATION Woman comes in with chest infection	**ADVISE** – that smoking may have contributed to their infection and it's best to quit **ASSIST** – provide a brochure with quit information **ARRANGE** – follow-up at next appointment
CONTEMPLATION Client comes in for a fluvax, knows they should stop smoking but aren't ready	**ADVISE** – every cigarette is harmful, I'm available when ready to talk about quitting **ASSIST** – client to explore the benefits of quitting and difficulties they're experiencing **ARRANGE** – follow-up at next appointment
PREPARATION Client comes in for first antenatal check, wants to stop quitting but feels will need help	**ASSIST** – in creating a change plan, identify challenges and how they can deal with them **ARRANGE** – Nicotine replacement (if needed) and referral to support services eg QuitLine

Brief intervention example – Smoking

ACTION Client comes in for second antenatal check, has been using NRT successfully	**ADVISE** – baby's health is benefitting. **ASSIST** – celebrate their achievements. Revisit their change plan, discuss their challenges and how they can overcome these. ARRANGE – follow-up at next visit.
MAINTENANCE Client comes in for glucose tolerance test, is off the smokes and NRT	**ADVISE** - **ASSIST** – Celebrate! Reinforce that this is the best thing they can do for their health. Talk about what's been difficult and how they've dealt with it. **ARRANGE** – follow-up at next visit.
RELAPSE Client comes in for baby check, you notice they're smoking again	**ADVISE** – this is a normal part of the process. **ASSIST** – them to see how they quit before and that they can do it again. Offer support for when they are ready to quit again. **ARRANGE** - follow-up at next visit or QuitLine

Module 2: Review

Module 2 aimed to increase:

i. Confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking and substance misuse during pregnancy.

ii. Knowledge of the AUDIT-C screening tool.

Additional notes

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.

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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.

9. Foundation for Alcohol Research and Education. (2014). Women want to know – 5A's. Accessed January 2017 from http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/5a

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)".

11. Prochaska J, DiClemente C. Towards a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviours: processes of change. New York: Pergamon, 1986.

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.
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 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.remotephcmanuals.com.au/publication/stm/Brief_interventions.html

Slide16: Readiness Rulers[8]

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 its' 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.

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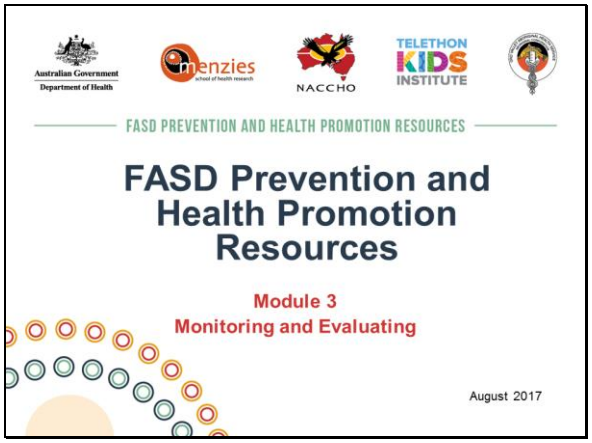
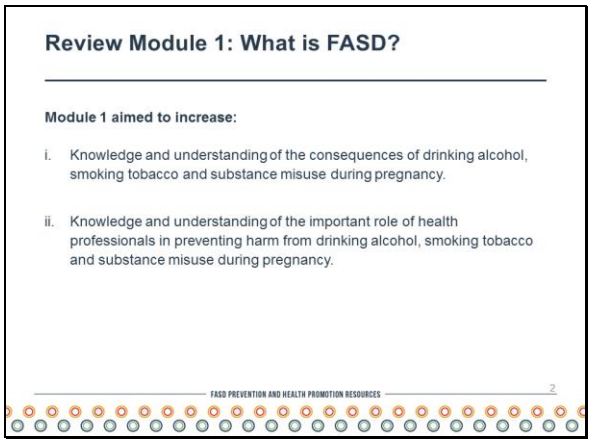
Module 3: Monitoring and Evaluating

My learning goals for this workshop

Goal





Review Module 2: Brief interventions and motivational interviewing

Module 2 aimed to increase:

i. Confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking and substance misuse during pregnancy.

ii. Knowledge of the AUDIT-C screening tool.

Module 3: Learning objectives

Module 3 aims to increase:

i. Awareness of the importance of monitoring and evaluating FASD prevention and health promotion strategies.

ii. Knowledge of appropriate indicators to monitor and evaluate FASD prevention and health promotion strategies.

iii. Understanding of the link between antenatal screening records and The Australian FASD Diagnostic Assessment Form.

Monitoring vs evaluating[1]

Monitoring	Evaluating
Conducted while program is running	Conducted at the end of a program
Continuous collection of information	Collects information at specific time-points, usually at the end
Usually completed by people within the organisation	Usually completed by people external to the organisation
Example: tracking attendance rates at community education sessions	Example: auditing antenatal client records

What type of information can we monitor?[1]

Inputs	Outputs	Outcomes
What is needed for the program to work	*What we are doing to improve outcomes*	*Evidence of improved care for our patients and community*
Funding Staff Resources or clinic equipment Practice accreditation Clinic equipment	Number of – patients seen – group sessions held – screening assessments Description of advocacy activities undertaken	Risk factors – BMI, smoking Coverage of interventions – Pap smears, Immunisations

Why do we monitor?

For accountability

- To community
- To your managers, or Board
- To funders

To improve

- Continuous Quality Improvement

To understand

- Our own interest
- Research

Accountability to community

Examples:

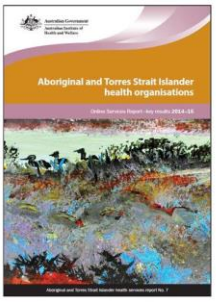
- Health service annual reports.
- Surveys with community members.
- Remember to share this information back to your clients and community.
- Other examples?

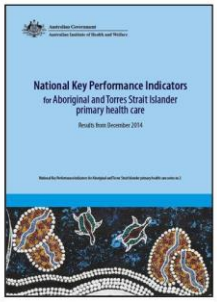
Accountability to managers, board members

Examples:

- Monthly or quarterly internal reports.
- Presentations to Board.
- Other examples?

Accountability to funders[2,3]





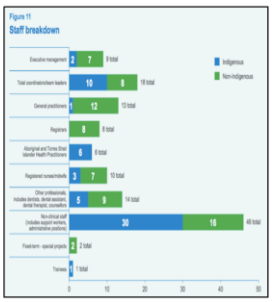
Data for national reports

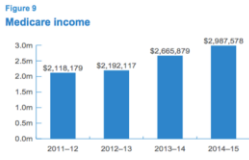
Online Services Report (annual)	nKPIs (six monthly)
Staff numbers: Aboriginal health workers, Aboriginal health practitioners, midwives, nurses	First antenatal visit in first 13 weeks
Clients and client contacts For each type of staff	Health checks 0-4 year olds
Total number of antenatal visits	Smoking status recorded Alcohol consumption recorded
Group sessions: Antenatal classes, Mums and bubs, Parenting classes	Smoking status result Alcohol consumption result
	Smoking status of women who gave birth
	Birth weight result

What data are we already collecting?

Inputs	Outputs	Outcomes
What is needed for the program to work	*What we are doing to improve outcomes*	*Evidence of improved care for our patients and community*
Most of the Online Services Report (OSR)	Most nKPIs Some OSR eg – patients seen – groups sessions	Some nKPIs eg – smoking status of women who gave birth – alcohol consumption result – birth weight result

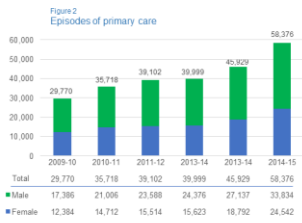
What can be monitored – Inputs



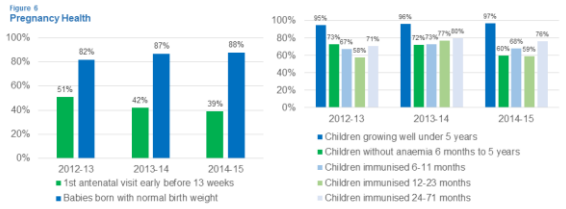


What can be monitored – Outputs

Specialist	2012–13	2013–14	2014–15
Cardiac Educator	152	5	74
Diabetes Educator	143	873	862
Dietitian	0	53	211
Obstetrician and gynaecologist	20	90	122
Ophthalmologist	27	84	24
Optometrist	152	325	253
Paediatrician	56	150	89
Sonographer	14	0	33
Physiotherapist	0	34	239
Specialist Medical Practitioner	380	499	357
Total	**944**	**2113**	**2264**



What can be monitored – Outcomes



Monitoring for improvement

Monitoring for improvement

Group discussion

Think of a continuous quality improvement activity that you have been part of in maternal and child health, or another area.

1. What was the activity?
2. What did you measure?
3. Why did you measure it?
4. How frequently were you measuring?
5. How did you measure it?
6. What did you do with this information?
7. How did measuring this help with CQI?
8. Should you have measured other things? What were they?

Record keeping

Group discussion

- What systems do you currently use for record keeping in your health service?
  - patient information systems
  - Quality Assurance or Quality Improvement systems
- How do you monitor the quality of the data that is entered?
- Do you receive feedback reports?
- How are these discussed for quality improvement?

How can we capture information to monitor and evaluate our program?

Many sources of information:

- Surveys – with clients, with staff, with community
- National registries with local data
- Data extraction from medical records (screening tools)
- Accounting systems
- Paper based reports

Surveys

Feedback comments

	Poor	Satisfactory	Neutral	Good	Excellent
Overall experience	-	1	-	8	13
Ease of making appointment	1	3	-	4	14
Transport	-	-	1	5	6
Friendliness and helpfulness of staff	-	1	1	4	15
Reception area	-	2	2	3	15
Waiting time	1	4	3	5	9
Explanation of health issue	-	2	2	8	10
Explanation of treatment options	-	1	2	6	13
Follow up/support	-	1	1	5	15
I feel my personal information is kept private and confidential	-	-	1	1	20

National registries

www.abs.gov.au/websitedbs/censushome.nsf/home/communityprofiles

www.myhealthycommunities.gov.au

http://www.aihw.gov.au/perinatal-data/

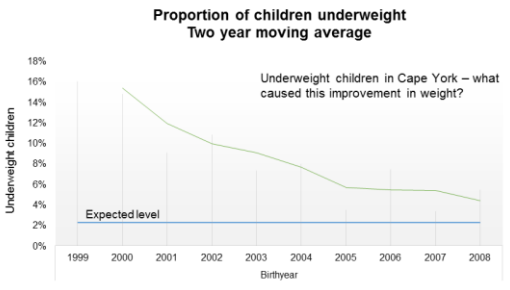
Extracting data from medical records

Group discussion

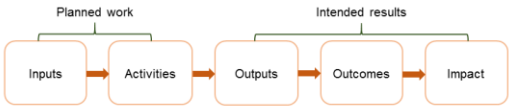
Why do we record information in medical records?

- Record progress of a client
- Remind yourself what you did for the next appointment
- Communicate to other staff what you are doing
- For reporting
- For legal reasons
- So you can fill in performance indicators
- Others?

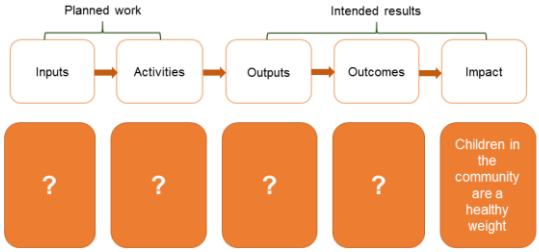
Monitoring for understanding



Logic models[4]



Logic models – Deciding what to measure



Logic models – Deciding what to measure

Examples

Inputs:
- Funding for maternal and child health
- Staff (Aboriginal Health Workers, child health nurses, GPs)

Activities:
- Find out why attendance at antenatal and postnatal visits is currently low and make changes to encourage higher attendance.

Outputs:
- Number of visits per child
- Group sessions (mums and bubs, cooking classes)
- Number of 'health checks' performed

Outcomes:
- Immunisation
- Alcohol consumption and smoking in mothers
- Children born a healthy weight

Developing indicators

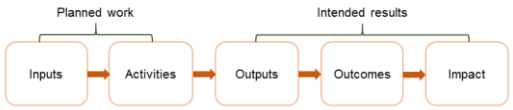
For each indicator ask[5]

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 (ideal vs 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
   Audit antenatal records in 6 months

Creating a logic model and indicators for a FASD plan

Group discussion

1. What do you want to achieve with your FASD prevention program?
2. What will you need to do to achieve this?
3. How are you going to record it?
4. What things will you measure to see if you are on the right track?
5. What can you measure easily?



Screening tools vs Diagnostic tools

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

Linking FASD screening and diagnosis

- The clinician/s completing the Australian FASD Diagnostic Assessment Form will refer to antenatal notes about alcohol consumption.
- Therefore it is important that discussions about alcohol are recorded in the client record.

Linking screening and diagnosis

The Australian FASD Diagnostic Assessment Form[6] includes:

- History – presenting concerns, obstetric, developmental, medical, mental health, behavioural, social
- Birth defects – dysmorphic facial features, other major and minor birth defects
- Adverse prenatal and postnatal exposures including alcohol; Antenatal notes and AUDIT-C contribute to this
- Known medical conditions – including genetic syndromes and other disorders
- Growth

A vital question is 'could this be alcohol related or due to other factors'

Australian FASD Diagnostic Assessment Form[6]

AUSTRALIAN FASD DIAGNOSTIC ASSESSMENT FORM

MATERNAL ALCOHOL USE

Evidence of maternal alcohol use in the three months prior to and during pregnancy should be assessed, including any special occasions when a large amount of alcohol may have been consumed. The definition of a standard drink should be explained prior to administering the AUDIT-C (Q1-3). A Standard Drinks Guide can be downloaded.
http://www.health.gov.au/internet/alcohol/publishing.nsf/Content/drinksguide-cnt

Alcohol use in early pregnancy (if available)

a. Was the pregnancy planned or unplanned? ☐ Planned ☐ Unplanned ☐ Unknown
b. At what gestation did the birth mother realise that she was pregnant? _____ (weeks) ☐ Unknown
c. Did the birth mother drink alcohol before the pregnancy was confirmed? ☐ Yes ☐ No ☐ Unknown
d. Did the birth mother modify her drinking behaviour on confirmation of pregnancy? ☐ Yes ☐ No ☐ Unknown
If Yes please specify:
e. During which trimesters was alcohol consumed? (tick one or more) ☐ None ☐ 1st ☐ 2nd ☐ 3rd ☐ Unknown

Australian FASD Diagnostic Assessment Form[6]

AUDIT-C Reported alcohol use (if available)

1. How often did the birth mother have a drink containing alcohol during this pregnancy?

Unknown	Never [skip Q2+Q3]	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
☐	☐0	☐1	☐2	☐3	☐4

2. How many standard drinks did the birth mother have on a typical day when she was drinking during this pregnancy?

Unknown	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
☐	☐0	☐1	☐2	☐3	☐4

3. How often did the birth mother have 5 or more standard drinks on one occasion during this pregnancy?

Unknown	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
☐	☐0	☐1	☐2	☐3	☐4

AUDIT-C score during this pregnancy: (Q1+Q2+Q3)=_____ Scores= 0=no risk 1-4= confirmed use 5+= confirmed high-risk

Australian FASD Diagnostic Assessment Form[6]

Other evidence of exposure

Is there evidence that the birth mother has ever had a problem associated with alcohol misuse or dependency?
☐ No ☐ Yes (identify below, including source of information)
☐ Alcohol dependency (specify)
☐ Alcohol-related illness or hospitalisation (specify)
☐ Alcohol-related injury (specify)
☐ Alcohol-related offence (specify)
☐ Other (specify)

Information from records: e.g. medical records, court reports, child protection records.

Is there evidence that the birth mother's partner has ever had a problem associated with alcohol misuse or dependency?
☐ No ☐ Yes (identify below, including source of information)

Australian FASD Diagnostic Assessment Form[6]

Information from the previous 3 sections is summarised below:

Alcohol exposure summary

Source of reported information on alcohol use: ☐ Birth mother ☐ Other (specify)
In your judgement what is the reliability of the information on alcohol exposure: ☐ Unknown ☐ Low ☐ High
In your judgement was there high-risk consumption of alcohol during pregnancy? ☐ Unknown ☐ Yes ☐ No
Prenatal alcohol exposure: ☐ Unknown ☐ None ☐ Confirmed use ☐ Confirmed-high risk

Reflection

Group reflection and discussion

**After seeing the diagnostic tool,
what might you do differently
when recording your antenatal visits?**

Module 3: Review

Module 3 aimed to increase:

i. Awareness of the importance of monitoring and evaluating FASD prevention and health promotion strategies.

ii. Knowledge of appropriate indicators to monitor and evaluate FASD prevention and health promotion strategies.

iii. Understanding of the link between antenatal screening records and The Australian FASD Diagnostic Assessment Form.

Finishing up

Any questions?

Additional notes

Module 3 References:

1. World Health Organisation (2004). Monitoring and Evaluation Toolkit. WHO: Geneva, Switzerland. Accessed on February 2017 from http://www.who.int/hiv/pub/me/me_toolkit2004/en/

2. Aboriginal and Torres Strait Islander primary health care: results from December 2014. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no.3. Cat. no. IHW 161. Canberra: AIHW. Accessed January 2017 from http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129553396

3. Australian Institute of Health and Welfare 2016. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15. Aboriginal and Torres Strait Islander health services report No. 7. IHW 168. Canberra: AIHW. Accessed January 2017 from http://www.aihw.gov.au/publication-detail/?id=60129554783

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 model[4].
- 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

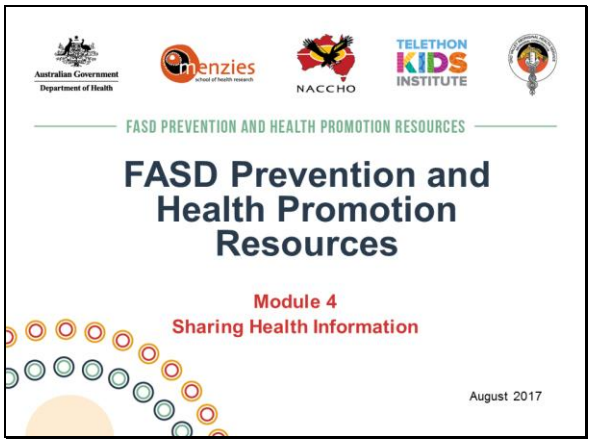
- In order to be meaningful, indictors generally contain the following: population, change target, threshold and timeline[5].
- For each indicator ask:

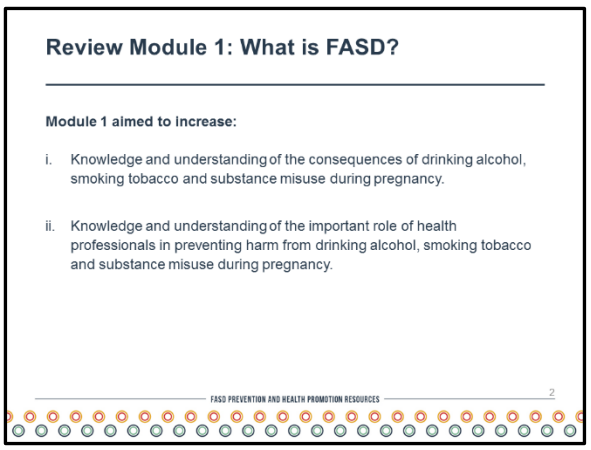
  1. Who do you want to change?
  2. How many do we expect will succeed in changing?
  3. What sort of change are we looking for, how much change is enough?
  4. When does this outcome expected to happen?

Module 4: Sharing Health Information

My learning goals for this workshop

Goal





Review Module 2: Brief interventions and motivational interviewing

Module 2 aimed to increase:

i. Confidence in using brief interventions and motivational interviewing techniques with antenatal clients for alcohol consumption, tobacco smoking and substance misuse during pregnancy.

ii. Knowledge of the AUDIT-C screening tool.

Review Module 3: Monitoring and evaluating

Module 3 aimed to increase:

i. Awareness of the importance of monitoring and evaluating FASD prevention and health promotion strategies.

ii. Knowledge of appropriate indicators to monitor and evaluate FASD prevention and health promotion strategies.

iii. Understanding of the link between antenatal screening records and The Australian FASD Diagnostic Assessment Form.

Module 4: Learning objectives

Module 4 aims to increase:

i. Knowledge of health promotion and health education strategies for FASD prevention.

ii. Awareness of the FASD Prevention and Health Promotion Resources Package.

iii. Skills to plan, implement and evaluate FASD health education and health promotion strategies for a range of target groups, within health services.

Health promotion

Best practice Health Promotion (HP) uses a whole of community approach

Many factors influence health in pregnancy

Socio-Ecological Model[1]

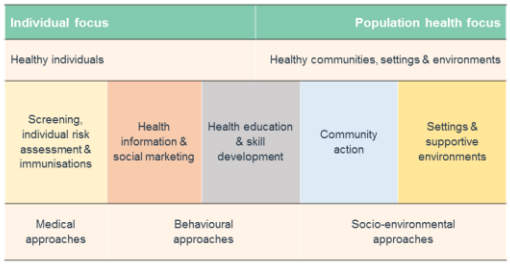
Cultural considerations – Aboriginal and Torres Strait Islander communities

It is important to consider the specific needs of your community.
Have you got permission?

- Relationships within the community (particularly with elders and men)
- Cultural diversity
- Socioeconomic circumstances
- Numerous languages and dialects
- Geographical location and accessibility to services

Programs aimed at changing individual risky behaviour may fail to acknowledge the way in which *the person is inextricably tied to the culture* in which he or she exists[2].

Health promotion continuum[3]



Health promotion continuum

Screening, individual risk assessment, immunisation	Health information & social marketing	Health education and skills development	Community action	Settings and supportive environments
		AIM		
Early detection &management of diseases to improve physical risk factors	Improve knowledge, attitudes, confidence & individual capacity to change psychosocial & behavioural risk factors	Influence behavior change through the provision of health information & development of personal skills	To increase community control over the determinants of health, through collective efforts, community participation	To develop healthier physical, social & cultural environments where people live learn work and play
	To improve health literacy of individuals, communities & organisations	To advocate for broader social and environment change agendas	Empowerment, & increasing health literacy	Organisational development economic & regulatory activity

Health promotion vs health education

Health promotion	Health education
Group activities that involve education about health needs and optimal health	An essential element of health promotion
Focus on environmental, educational, cultural, socio-political determinants of health	May be more of a focus on individual health
Preventive perspective aims for legislative reform, empowering communities, paying attention to cultural or economic disparities, political advocacy	Activities that raise awareness giving the person health knowledge required to decide on a particular health action
	Could be considered disease-centered (medical)

Health promotion and social media

Indigenous Hip Hop Project

Tennant Creek – Alcohol It effects your babies
Strong Baby Strong Life
https://www.youtube.com/watch?v=BWzQ83i6OcU

Broome – Stand up
https://www.youtube.com/watch?v=p2cspvmNSgE

Health education is not about telling people what to do

Image source: Egger, Spark, & Donovan, 2005, p. 18

What are the implications for taking this approach to health education?

The aims of health education:

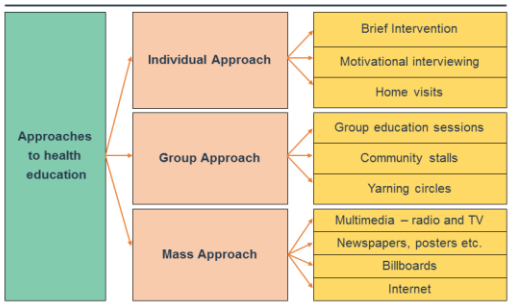
a) To encourage people to adopt and sustain health promoting lifestyle and practices

b) To promote the proper use of the health services available to them

c) To arouse interest in new knowledge, improve skills and change attitudes to make rational decisions to solve their own problems

d) To stimulate individual and community self reliance and participation to achieve health development through individual and community involvement

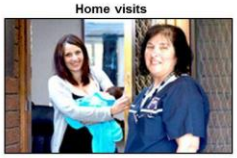
Opportunities for health education



Approaches to health education – Individuals

One-on-one education sessions

Home visits



Waiting room displays

Approaches to health promotion and health educations – Groups

Group education sessions

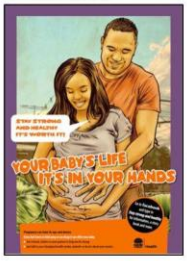
Community stalls

Yarning circles

Shopping centre stalls

Approaches to health promotion and health educations – General public

Printed materials



Social media

TV and radio campaigns

THE RIVER OF HEALTH

PREVENTION
To stop health trouble before it begins.

INTERVENTION
To see the beginning of health trouble and to do something before it gets bad.

TREATMENT
To see health trouble that has happened, and to treat those who are sick.

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.

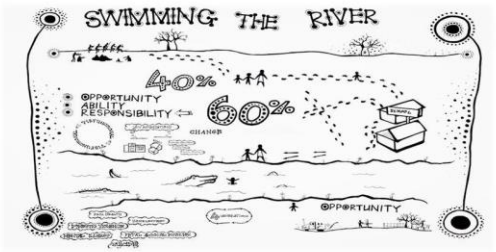
In her heart she knew that many people would still fall into the river so she thought she should teach people to look after themselves and their families when the got sick.

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'.

NT Dept of Health & Community Services. 1989. Aboriginal health promotion training manual

Historical perspective – Swimming the River



https://www.youtube.com/watch?v=0P9FRacTji0

Wunan Foundation, 2013

FASD Prevention and Health Promotion Resource Package

What is in the Package?

Publicly available, current and culturally appropriate resources to support health professionals develop and deliver programs to raise awareness of, and prevent, FASD in Aboriginal and Torres Strait Islander communities.

Resources for:

- Pregnant women
- Women of childbearing age (15-45 years of age)
- Grandmothers and Aunties
- Men, fathers and partners
- Health professionals

Search for resources using the **Resource Directory.**

Using the FPHPR Directory to search for resources – example (1)

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
Additional resources of interest	Click here	Click here	Click here	Click here	Click here

Using the FPHPR Directory to search for resources – example (2)

Author	Title and year	Material type	Target population	Details	Location
Brisbane Indigenous Media Association	Stayin' strong: drugs and alcohol (2015)	Audio visual – video	All	Free online: http://www.bimaprojects.org.au/tag/drugs-and-alcohol/ Focus: Specific for Aboriginal and Torres Strait Islander people Summary: *Stayin' strong: drugs and alcohol* 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. Podcasts of particular relevance to this package include: - Alcohol and healthy pregnancy - Foetal Alcohol Spectrum Disorder The resources can be used by psychiatrists and other healthcare professionals, researchers, or those aiming to address their own alcohol and other drug use.	Australia – QLD
Queensland Department of Health	Growing strong - Alcohol, tobacco and other drugs during pregnancy and breastfeeding (2012)	Booklet	Pregnant women, women of childbearing age, and men.	Free to download: http://www.healthinfonet.ecu.edu.au/uploads/resources/17641_17641_2012.pdf Focus: Specific for Aboriginal and Torres Strait Islander people Summary: This resource is part of the Growing strong: feeding you and your baby 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	Australia – QLD

Planning health promotion programs

Key elements:

- Who is your target audience?
- What needs to change? How much? By when?
- How will you do it? What is your message?
- Where will you do it?
- How will you know whether you have achieved change?

Identifying your target group

- Who are they?
- How old are they?
- Where do they live and/or how are they connected?
- What might influence their behaviour? (consider enablers and blockers)

Goals: What are you trying to achieve?

Goals: to increase awareness of the risks of drinking during pregnancy as well as improve Aboriginal and Torres Strait Islander peoples' awareness of and access to health care services and programs.

Example goals:

- To raise awareness of the risks of smoking during pregnancy and promote quitting smoking for the baby
- To increase awareness of the benefits of antenatal health checks and promote visiting the clinic for regular check-ups

Strategies: How will you do it?

How will you do it?

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

What is your message?

- What do you want to say to your audience? *eg drinking and smoking harms your baby*
- What do you want your audience to know? *eg Aboriginal health workers know how to keep you and your baby healthy*
- What do you want your audience to do? *eg visit the clinic and talk to Aboriginal Health Worker about you and your baby's health*

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

- To assess whether you've achieved your goal and made a difference.
- First, gather data and record what has happened.
- Other examples:
  - Record the number of people who have health checks
  - Record the number of people who participate in your program
  - Prepare a short survey to get people's feedback on the activity; ask about their awareness of FASD and/or the risks of drinking alcohol or smoking during pregnancy
  - Organise a community meeting after the event to discuss how it went and next steps

It is important to design your evaluation during the planning phase NOT as an afterthought

Finalise your plan

Have you identified:

1. Your target audience?
2. What needs to change? How much and by when?
3. How you will you do it?
4. What your key messages are?
5. How you will know you've achieved change?

Module 4: Review

Module 4 aimed to increase:

i. Knowledge of health promotion and health education strategies for FASD prevention.

ii. Awareness of the FASD Prevention and Health Promotion Resources Package.

iii. Skills to plan, implement and evaluate FASD health education and health promotion strategies for a range of target groups, within health services.

Finishing up

Any questions?

Additional notes

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/0P9FRacTji0
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.

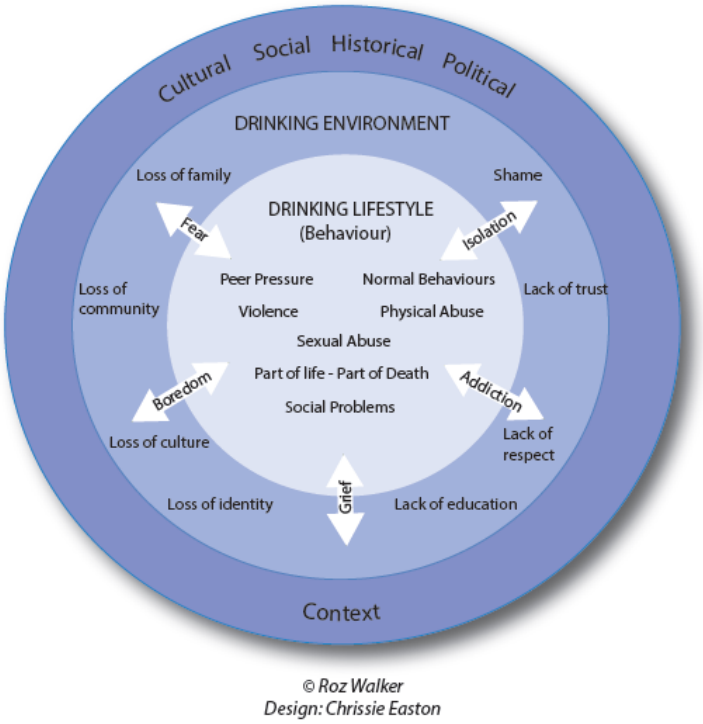
Module 4 Further Reading and Additional Information:

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 below[2] 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.



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Design: Chrissie Easton

Slide 19: River of Health. Text from the PowerPoint slide.

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 should 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'.

Reference: Northern Territory Department of Health & Community Services. 1989. Aboriginal health promotion training manual.

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 groups[10]. 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 be[11]:

- 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 about[11]:

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

Goals and objectives checklist[11]:

- 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 ach of the activities. To identity 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]:

1. Implementation (what has been done)
   a. Workshop outlines
   b. Procedures developed

c. Copies of media coverage

2. 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
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.

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?

Networks

Use this page to collect contact details of health professionals you would like to keep in contact with after this training session.

Name	Email address	Contact phone

Helpful websites

1. **Telethon Kids Institute – Alcohol, Pregnancy & FASD**

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

   This website contains information on the Australian Guide to the Diagnosis of FASD and resources for community, parents and carers, schools and health professionals. The resources section also includes materials for Aboriginal and Torres Strait Islander communities. The website features the latest research from FASD Research Australia.

2. **Health*Info*Net Australian Indigenous Alcohol and Other Drugs Knowledge Centre – FASD Portal**

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

   The Health*Info*Net is useful site for information on 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.

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

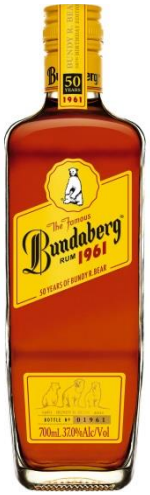
   NOFASD Australia aims to prevent alcohol exposed pregnancies in Australia and improve quality of life for those living with FASD by providing a strong and effective voice for individuals and families living with FASD. You will find several resources directed at preventing FASD and assisting families 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 resources and information and contacts for local support groups.

Appendix 1: Standard drinks quiz

How many standard drinks are in each of these drinks? Match the drink to the correct answer.



4L of white wine	2L of port	2L Darwin stubby	700ml bottle of rum	30 x 375mL cans VB
42	7.7	28	26	22

How many standard drinks are in each of these drinks? Match the drink to the correct answer.

1.5 1.4 1 1.4 0.9

Answers - Standard drinks quiz

4L of white wine = 28

2L of port = 26

2L Darwin stubby = 7.7

700ml bottle of Bundaberg rum = 22

Cans of VB 30 x 375mL = 42

Bundaberg rum and coke can 375mL = 1.4

xxxx Gold 375mL = 1

Carlton Draught 375mL = 1.4

Lemon Ruski vodka 275mL = 0.9mL

Glass of red wine = 1.5

Appendix 2: Motivational Interviewing Summary Sheet

O Ask open-ended questions

A Affirm what the patient is saying

R Reflect back what the client has said

S Summarise to ensure you and the client are on the same page

Strengthen commitment to change

- What are the good things about staying the same?
- What are the bad things about staying the same?
- What is hard about changing?
- What are the benefits of changing?

Create a change plan

- Ensure the client is driving the plan
- Set goals with the client
- Ask them identify at least one person to support them

The Readiness Ruler

How <u>important</u> 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 <u>confident</u> 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)?

Appendix 3: Women want to know – Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C

See over page

Australian Government
Department of Health

women want to know
discuss pregnancy & alcohol

Information for **health professionals** on

assessing alcohol consumption in pregnancy using AUDIT-C

To provide women with the information they need to know about alcohol consumption during pregnancy it is important to know how much a woman is drinking and how this has changed since she found out that she is pregnant. This assessment of alcohol consumption, combined with education and support, can assist women to stop or reduce alcohol use in pregnancy and prevent adverse consequences from alcohol consumption such as Fetal Alcohol Spectrum Disorders.[1]

One way to assess a woman's alcohol consumption is by using the AUDIT-C (Alcohol Use Disorders Identification Test – Consumption). This tool has three short questions that estimate alcohol consumption in a standard, meaningful and non-judgemental manner. The total score from these questions provides an indication of the risks to the woman's health and can be used to guide conversations about alcohol and pregnancy. However it is safest for pregnant women not to consume any alcohol during pregnancy.

The AUDIT-C is a shortened version of the 10-item AUDIT tool, first developed by the World Health Organization in 1989. AUDIT-C has been validated for use with pregnant women[2] and is recommended for use by an Australian study that examined what questions should be asked about alcohol consumption and pregnancy.[3]

AUDIT-C questions

The three AUDIT-C questions that measure the amount and frequency of a person's drinking are included below. Add the scores for each question to get a total score and match the score to the risk of harm overleaf.

Questions	Scoring system					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Australian standard drinks

Standard drinks are a measure of alcohol consumption and are used in the AUDIT-C questions. It is more reliable to count standard drinks than to count glasses or bottles or cans as alcohol is served in many different containers. The Australian standard drink measure contains 10grams of alcohol (equivalent to 12.5mls of pure alcohol).[4] For example:

- 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% acl vol = 1.2 standard drinks.[5]

Many Australian women aren't aware of what a standard drink is so it is a good idea to have a chart that demonstrates this. Download these at: http://www.nhmrc.gov.au/your-health/alcohol-guidelines

Information and guidance for pregnant women following the AUDIT-C

The best advice for all women, regardless of whether or not they drink alcohol is that:

- No alcohol is the safest choice when pregnant or trying to get pregnant.
- No safe level of alcohol consumption during pregnancy has been determined.[4]

This advice is consistent with the National Health and Medical Research Council's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*.

Feedback should be provided to the woman based on the total AUDIT-C score (out of 12).

AUDIT-C Score	Advice to be given*
0 – 3 = low risk of harm	• Provide positive reinforcement if she has scored zero and encourage her to continue not to drink any alcohol during pregnancy. A score of zero indicates no risk of alcohol-related harm to the fetus. • If she scores between zero and 3 advise that the risk to the fetus is likely to be low but it is safest not to drink any alcohol at all during pregnancy. • Advise that the risk of harm to the developing fetus increases with increasing amounts and frequency of alcohol consumption and that any score above zero indicates potential risk to the fetus. • Encourage her to stop drinking alcohol altogether during pregnancy and arrange a follow-up session if required.
4 – 7 = medium risk of harm	• Advise that the safest option is not to drink alcohol during pregnancy. • Discuss that the AUDIT-C score indicates that she is drinking at a level of increasing risk for her health and if scoring above 5 at high risk for the baby's health. • Advise that the risk of harm to the developing fetus increases with increasing amounts and frequency of alcohol consumption. • Discuss the effects of current alcohol consumption levels and outline health concerns for both herself and her baby. • Reinforce the benefits of stopping drinking at any stage during her pregnancy to minimise further risk to herself and her baby. • Ask her how she feels about stopping drinking or cutting down and establish: — Positives and negatives of taking action — How confident she is in being able to stop or cut down — Tips, strategies and plans for taking action — If she would like assistance, including from support networks and partners — Offer to arrange referral if it is determined that she requires this • If you suspect that she may be alcohol dependent arrange to refer her to a specialist treatment service.
8+ = high risk of harm	• Discuss that the AUDIT-C score indicates that she is drinking alcohol at a level of high risk for her health and high risk for the baby's health. • Discuss the positives and negatives of taking action and determine what assistance she requires to be able to stop or cut down. • Refer to a specialist alcohol service as she may be at risk of alcohol dependence. Specialist support should be organised for her before advising her to stop or cut down her alcohol consumption, as without support alcohol withdrawal can be dangerous to both her health and the baby's health.

* Advice has been adapted from the following resources: the Australian Government's Lifescripts '*Alcohol methodology card to help patients reduce health risks from alcohol*[6];' the literature review of existing alcohol consumption in pregnancy measures as part of the '*Asking QUestions During Pregnancy' study*[3]; Drug and Alcohol Office '*Promoting Healthy Women and Pregnancies resource for professionals*'[7] and AUDIT-C advice from *Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: a Resource for Health Professionals.*'[8]

About the Women Want to Know project

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.

The *Women Want to Know* project is funded by the Australian Government Department of Health.

For more information on the *Women Want to Know* project visit www.alcohol.gov.au

Information on referral points to specialist services for each state and territory are available at www.alcohol.gov.au

Foundation for Alcohol Research & Education

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Appendix 4: FASD Education Program Plan

FASD Education Program Plan

1. Identifying your target audience(s) (Hint - who do you want the project and its message to reach?)

Who are they? (e.g. pregnant women; women of childbearing age; men; grandmothers; health professionals); where do they live and/or how are they connected? (e.g. by a sporting activity); what might influence their behaviour? (consider the blockers discussed in Module 2).

2. Project goal

What needs to change? (consider the blockers discussed in Module 2); what is measurable? (e.g. how much? By when?).

3. Message

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?

4. Strategies & Activities

What actions contribute to the programs goal?; how will you do this? (e.g. by *[timeframe]* we will hold *[number]* of *[activities]*)

5. Monitoring and evaluation (Hint - How will you measure the success of your project?)

List the indicators you will use to measure changes made by your program.

List the things you will do. For example: review what you did and write a report. Ask the people in your target audience to answer some questions. Have another person external to your program evaluate your program.

How will you do this? List the things you need to do and who will be responsible for doing them. You should include how much money and time is needed to do this.

What will you do with this information? You could write a report for the agency that provided the funding for your program, use the information to make changes to the program and run it again, give the information to another organisation that is going to run this program again or run a similar program, and/or share the information with your community.

Appendix 5: FASD Support Services

FASD Support Services
1. What can you do? (Hint – with individuals or in group sessions)
2. What can other staff at your service do? (Hint – with individuals or in group sessions)
3. What visiting services do you have available to you?
4. What external services do you available to support yourself, your clients, and your health service?

Appendix 6: Scenarios for Module 4

Scenario One

There has been a recent increase in the number of young women requesting an Implanon removal at your health service. As a local community member you're also aware that there has been an increase in partying among the young people in your community. It is well known that a large amount of alcohol, tobacco and marijuana is consumed at these parties.

Complete your FASD Education Program Plan:

1. Who are your "primary" and "secondary" audiences?
    - Complete step 1 – 'Identifying your target audience(s)'

2. What needs to change, how much and by when?
    - Complete step 2 – 'Project goal'

3. What are your key messages?
    - Complete step 3 – 'Message'.

4. How you will you do it?
    - Complete step 4 – 'Strategies and activities'

5. How will you know you've achieved change?
    - Complete step 5 – 'Monitoring and evaluation'

Consider:

- What are the potential implications of the decrease in contraceptive use and increase in alcohol, tobacco and marijuana use?
- What other services, settings and programs could you link in with?
- Which resources in the FASD Prevention and Health Promotion Resources package would be useful?

Scenario Two

During your latest reporting period you have noticed a significant increase in cases of STDs and STIs in the young clients seen at your health service. As a local community member you're also aware that there has been an increase in partying among the young people in your community. It is well known that a large amount of alcohol, tobacco and marijuana is consumed at these parties.

Complete your FASD Education Program Plan:

1. Who are your "primary" and "secondary" audiences?
    - Complete step 1 – 'Identifying your target audience(s)'

2. What needs to change, how much and by when?
    - Complete step 2 – 'Project goal'

3. What are your key messages?
    - Complete step 3 – 'Message'.

4. How you will you do it?
    - Complete step 4 – 'Strategies and activities'

5. How will you know you've achieved change?
    - Complete step 5 – 'Monitoring and evaluation'

Consider:

- Why might the young people in your community not be using contraception?
- When is a good time to talk to young people about their contraceptive use?
- What other services, settings and programs could you link in with?
- Which resources in the FASD Prevention and Health Promotion Resources package would be useful?

Scenario Three

Your team has been invited to attend a health information session that has been organised for the local men's football teams. You and three others from your health service will be given 30 minutes each to discuss a range of health topics that you feel would be relevant to the men. This discussion can be done in any format you like and can include activities and resources.

Complete your FASD Education Program Plan:

1. Who are your "primary" and "secondary" audiences?
    - Complete step 1 – 'Identifying your target audience(s)'

2. What needs to change, how much and by when?
    - Complete step 2 – 'Project goal'

3. What are your key messages?
    - Complete step 3 – 'Message'.

4. How you will you do it?
    - Complete step 4 – 'Strategies and activities'

5. How will you know you've achieved change?
    - Complete step 5 – 'Monitoring and evaluation'

Consider:

- What health topics could you use this opportunity to discuss?
- Who else from your health service could attend with you?
- What other services, settings and programs could you link with?
- Which resources in the FASD Prevention and Health Promotion Resources package would be useful?

Scenario Four

As a maternal health worker, you have been consistently asking all of your pregnant clients about their alcohol consumption and advising that there is no known safe amount of alcohol that can be consumed during pregnancy. During these conversations majority of your pregnant clients express shock at the recommendations for alcohol consumption as they've had very different advice given to them from other women in their social networks, particularly older women who have experienced a pregnancy themselves. A number of your clients have found it difficult to deal with the pressures to consume alcohol that are put onto them by these older women who continue to explain that they drank during their pregnancies and their kids are fine.

Complete your FASD Education Program Plan:

1. Who are your "primary" and "secondary" audiences?
    - Complete step 1 – 'Identifying your target audience(s)'

2. What needs to change, how much and by when?
    - Complete step 2 – 'Project goal'

3. What are your key messages?
    - Complete step 3 – 'Message'.

4. How you will you do it?
    - Complete step 4 – 'Strategies and activities'

5. How will you know you've achieved change?
    - Complete step 5 – 'Monitoring and evaluation'

Consider:

- What can you do to help your pregnant clients to deal with these social pressures?
- What could be done to prevent this from continuing?
- What other services, settings and programs could you link with?
- Which resources in the FASD Prevention and Health Promotion Resources package would be useful?

Scenario Five

During your latest reporting period, you noticed that there are minimal records being kept on the alcohol consumption rates of the pregnant clients seen at your health service. When you raise this at your team meeting you're told by over a third of your colleagues that they don't feel comfortable talking about alcohol consumption with their pregnant clients because they fear it will make the woman feel judged and they're not sure what information they should be providing the women anyway. The rest of your colleagues say that they are asking their pregnant clients about their alcohol consumption but they don't know how to record this in your online system.

Complete your FASD Education Program Plan:

1. Who are your "primary" and "secondary" audiences?
    - Complete step 1 – 'Identifying your target audience(s)'

2. What needs to change, how much and by when?
    - Complete step 2 – 'Project goal'

3. What are your key messages?
    - Complete step 3 – 'Message'.

4. How you will you do it?
    - Complete step 4 – 'Strategies and activities'

5. How will you know you've achieved change?
    - Complete step 5 – 'Monitoring and evaluation'

Consider:

- What could be done to increase the rate of your fellow health professionals discussing alcohol consumption with their pregnant clients?
- What changes should to be made to improve your records of alcohol consumption?
- What other services, settings and programs could you link in with?
- Which resources in the FASD Prevention and Health Promotion Resources package would be useful