Dear Parliamentary committee

On behalf of the Child Development Services, Fetal Alcohol Spectrum Disorders Working Party we would like to make the following submission:

Having recently worked with Chicago's CHILDRENS RESEARCH TRIANGLE, one of our team member's noted Dr Chasnoff's introductory statement to some policy recommendations:

"The extraordinary efforts of clinicians and researchers across the nation have borne fruit as we look at the progress being made in the field of perinatal addictions and child health and welfare. But present efforts are focused on only one aspect of the problem or another, and we continue to operate within the silos of our particular interests. The current situation provides an opportunity for leadership at both the federal and state level. Several approaches that have been implemented at one level or another in different parts of the country can serve as models for more successful overarching policies and procedures, especially a the state level. Although most states have no official statewide body that addresses the full range of effects of prenatal substance exposure on pregnancy and child outcome, such an organizational unit could be an important unifying focal point for action at the state level:…" Chasnoff, Dr. Ira :The Mystery of Risk; Drugs, Alcohol Pregnancy and the Vulnerable Child., NTI Upstream, Chicago, Illinois, 2010.

We consider that this also reflects the circumstances in Western Australia. And would recommend full support for develpoment and implementaion of the WA statewide Model of Care as part of a national process. This will ensure that every child in Australia has consistent access and this will enable better opportunities for nationwide research and advances.

We further suggest (and as recommended by the Childrens' Research Triangle, in consultation with Dr. Ira Chasnoff):

State based **Support for defining and tracking the problem of substance use in pregnancy**

Formation of a council of state and local agencies affected by the problem of prenatal substance exposure to develop baseline data from a variety of agency perspectives.

Key agencies include Department of Health, Health Care Services, DCP, Developmental Services, DSC, Alcohol and Drug Programs, Education, and Mental Health, to name a few.

Presentation of an annual state report compiled from local jurisdictional submissions of data on prenatal screening and determination of the feasibility of follow -up monitoring of birth results in relation to prenatal screening data

2. Development of a centralized database and periodic data compilation to track rates of positive screens for substance use in pregnant women. Eg: track all perinatal substance use data across the state; this information could be incoorporated into the Midwives Notification of Confinement form.

3. Development of guidelines to support any state based Fetal/Infant Mortality reviews in order to assess, link, and track perinatal substance use and its impact on fetal and infant deaths and illnesses.

II. Support prevention, identification and intervention efforts

1.Development and implementation of local and statewide prevention campaigns to address substance use in pregnancy.

a. Targeted separate messages on the particular populations documented to b e at highest risk for using alcohol, tobacco, and illicit drugs in early pregnancy and continuing that use through pregnancy.
b. Provision of prevention materials for clinicians in primary prenatal care and associated settings to support individual prevention/intervention approaches during preconception and pregnancy.
c. Linked steps to existing efforts regarding prevention of tobacco use.

2. Support studies of substance use in pregnant women across the array of racial and ethnic identities in each state.

a. Identification of unique risk factors and patterns of use within each population of women.
b. Definitions of intervention points across the social and health care spectrum.
c. Development of culturally appropriate community education and prevention campaigns

3. Screening for substance use, depression, and domestic violence in a family part of routine prenatal care.

a. Development of validated questions for substance use screening among all providers.
b. Avoiding invasive strategies such as using urine toxicologies to screen for substance use.
c. Supporting existing efforts to make screening and intervention fully reimbursable by Medicare and private insurance providers, utilizing appropriate billing codes Work with Medicare and private insurers to develop support for screening and brief intervention in the primary prenatal care setting.
d. Review of current hospital practice and compliance with Child protection legislation.
e. Review of Child protection legislation in regard to this matter.
f. Education of physicians and other hospital personnel as to the benefits of identifying and reporting newborns affected by prenatal substance exposure.
g. Ensure child welfare workers investigating such cases are fully aware of the risks for the newborns and the variety of appropriate interventions available for mothers and infants.
h. Strengthen the link between child welfare and early infant intervention services in each state, ensuring that all children at risk have the benefit of early intervention services.
i. Discourage any attempts to criminalize a mother’s giving birth to a prenatally exposed infant. Promote dyadic treatment approaches that support the woman’s recovery and the child’s ultimate welfare.

4. Ensuring all children have access to appropriate intervention and treatment services by.

a. Expanding eligibility criteria for early intervention and special education services in all states to include children at risk from prenatal exposure to alcohol or illicit drugs..
b. Utilizing "functional diagnoses", as derived from the DC: 0-3 diagnostic system, to better determine clinician’s planning for young children with co morbid mental health disorders.

5. Raising alcohol excise taxes in every state. This is a proven strategy for reducing excessive drinking and its associated harm and could provide a source of revenue for FAS prevention efforts.

6. Promoting the development of an integrated system of care that spans a continuum. This includes preconception prevention messages and support for both children and parents affected by perinatal substance exposure, including substance use prevention and family planning services for women.

7. Production of guidelines for offering pregnancy testing and contraceptive services to all women entering substance abuse treatment and for linking pregnant women in substance abuse treatment programs to prenatal care.

8. Developing and providing cross-training programs for staff working in agencies and programs that have access to pregnant women and their children:

a. Prenatal care providers
b. Paediatricians and other child health care providers
c. Substance abuse treatment providers
d. Child welfare professionals
e. Educators
f. Judges and other court personnel

III. Build and sustain support for integrated systems of care for pregnant women and their children affected by prenatal substance use

1.Developing relationships with and obtaining endorsement from local and statewide associations of medical personnel to support universal screening of pregnant women

2.Determining and assessing the perinatal substance use efforts implemented by existing agencies and programs in each state and the resulting best practice models for perinatal substance use screening and identification of children at risk from prenatal exposure.

There are those who would protest that these policies would impose too great a financial burden on federal, state, and local governments. However, we already are bearing this burden at two to three times greater cost due to our preference for rescuing children rather than preventing and directly addressing these tragedies.

Yours sincerely

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Child Development Services

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