nofasard

NATIONAL ORGANISATION FOR FETAL ALCOHOL SYNDROME AND RELATED DISORDERS

A submission to the Inquiry by the House Standing Committee on Social Policy and Legal Affairs Inquiry into Fetal Alcohol Spectrum Disorders

January 2012

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THE NATIONAL ORGANISATION FOR FETAL ALCOHOL SYNDROME AND RELATED DISORDERS (NOFASARD)

NOFASARD is an independent and charitable national organisation working to prevent fetal alcohol exposure and support those living with an FASD and those who support them. NOFASARD is a registered Health Promotion Charity and the national peak community organisation representing the interests of parents, carers and others interested in or affected by FASD.

NOFASARD's Patron is Her Excellency Ms Quentin Bryce, Governor-General of the Commonwealth of Australia.

NOFASARD was incorporated under the Associations Incorporation Act (SA) in 1999. A membership base in excess of 550 individuals represents families (both Indigenous and non-Indigenous) who are caring for one or more individuals who live with an FASD. NOFASARD members also include professionals; non-professionals; and volunteers who represent health and disability, education, corrective services and youth justice, other social services sectors and community-based organizations. NOFASARD has well established national and international networks and collaborative relationships with state, national and international organisations and interest groups.

For over twelve years NOFASARD has voluntarily provided resource and reference information; delivered education and training; provided support, advocacy and referral options for parents/caregivers and families supporting children/adolescents and adults who have been diagnosed with an FASD or are assessed as being at risk. The NOFASARD website is a reference point for online information and electronic resources and publishes a monthly newsletter which is disseminated across the broad membership and beyond.

NOFASARD aims to:

1. Continue to function as the peak body for FASD in Australia
2. Raise awareness of FASD in the broad Australian community
3. Support and advocate on behalf of individuals and families
4. Deliver current, evidence-based information to service providers
5. Build and sustain partnerships
6. Consult and participate in research activities

For more information visit: www.nofasard.org.au

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DEFINITIONS

Fetal Alcohol spectrum Disorders (FASD) is an educational umbrella term used to describe a spectrum (group) of conditions that can affect the unborn child who has been prenatally exposed to alcohol.

FASD encompasses
i) Fetal Alcohol Syndrome (FAS) or partial FAS (pFAS): A minority of children will have FAS. FAS and pFAS are more commonly associated with high risk patterns of drinking. FAS & pFAS typically mean abnormal facial features, growth delays, intellectual impairments, problems with learning, memory, attention problems, communication problems, vision or hearing impairments, or damage to the skeleton or major organs of the body such as the heart and kidneys. They might have a mix of these problems.

ii)Neurodevelopmental Disorders – alcohol exposed. There may be no visual signs (as in FAS facial features). Sometimes there can be significant learning disorders and developmental delays but not necessarily a low IQ. Most often there will be problems with behaviour. Neurodevelopmental Disorders can mean children do poorly in school and have difficulties with maths, memory and attention, judgment, experience poor impulse control and lack social skills. When there are no visible signs of disability other than behaviours, the behaviours are targeted for change with no recognition that alcohol exposure during pregnancy is the cause of individual difficulties.

Fetal Alcohol Spectrum Disorders are the single largest most undiagnosed, unrecognised cause of disability in the Australian Community which attracts no funding and no support or assistance

PREVENTION/MANAGEMENT CONTEXT

Any consideration of FASD prevention/management must acknowledge that an individual exposed to alcohol before birth and who experiences adverse fetal outcomes will live with the disabilities for life. What can be changed to improve the quality of life is dependent on the ‘accommodations’ made which will adjust the environment to meet individual needs and in so doing, will adjust our expectations of the individual. FASD is a physical, brain based disability[1] and the consequences are cognitive and developmental disabilities, often unique in individual presentations but which are most often observed in behaviours. An assessment of risk is difficult for children. It is often in the early childhood years when behaviour becomes unmanageable for parents/carers and educators and the child is referred to the attention of service providers.

The following problems emerge in childhood and in the absence of appropriate accommodations/interventions transition into adolescence and adulthood:

- Understanding and applying mathematical concepts
- Conceptualising and understanding abstract concepts like time and money
- Thinking things through / reasoning / planning / decision making
- Poor judgment
- Learning from past experience/s and applying learning in different settings
- Understanding consequences – cause and effect reasoning
- Memory impairment
- Poor social skills
- Generalising learning

Competency in meeting expected daily life activities can be affected. Advocacy and support, mentoring and other practical assistance may be needed to:

- To handle money – budgeting, paying rent and shopping
- To make & keep appointments - medical, counselling, criminal justice sentence requirements, income support, employment
- To change behaviour
- To interact and sustain safe relationships with others
- To complete their education
- To secure and maintain employment, income and housing accommodation
- To instruct legal representation, manage court appearances and ensure obligations are met
- Ensure income security

SECONDARY ISSUES AND FASD

When individuals whose lives are affected by FASD have not been diagnosed, or are improperly assessed or mis-diagnosed, there is an expectation and insistence that behaviours change. Anger and frustration towards self and the community can be an understandable reaction. Criticism and punishment is a very common experience for this group and can lead to the development of secondary issues such as the incompletion of schooling, mental health problems, trouble with the law, unemployment and homelessness, alcohol and drug problems and a heightened vulnerability to physical, sexual (victim and/or offender), financial, social and emotional abuse. Isolation and loneliness can lead to a range of other behaviours such as unsafe relationships including relationships with violent and unsafe partners. Protective factors can mitigate against secondary issues.

Too often, unplanned pregnancies combined with alcohol and other drug use feature among this group resulting in another generation of alcohol exposed children. Parents of children living with an FASD may be at a higher risk of undiagnosed or assessed fetal alcohol exposure with tragic results.

In such cases, parenting children is a risk. One must only reflect on the lists above to appreciate the burden this places on parents who cannot meet expectations. Parents living with an FASD should not be subjected to family re-unification unless the full range of long term supports are in place. The risk to their children and the re-affirmation of parental failure is too high. This is a group who do not choose to fail at parenting but will struggle to gain the skills to be effective parents.

NOFASARD accepts evidence of an overrepresentation of children in the out of home care system who are affected by fetal alcohol and other substance use both in the pre-birth period and in the environments in which they live. There is increased strain on grandparents and others involved in kinship care and different supports are required for this group of carers who are older, often retired and dealing with the challenge of an adult child who is sometimes estranged and unable to safely or competently care for their own children.

KEY RECOMMENTATIONS

NOFASARD makes these recommendations based on available evidence, our collective experiences of the impact FASD has on individual and family's lives, as well as the level of responsiveness within communities.

Fetal alcohol exposure and the adverse outcomes known collectively as Fetal Alcohol Spectrum Disorders (FASDs) are but one of a myriad of harms known to be caused by alcohol. Although risk increases incrementally with higher patterns of alcohol use, FASDs are unlike other alcohol-related conditions - any alcohol use in pregnancy is considered to carry a risk to healthy fetal development across gestation. This claim is supported by the most contemporary research by May et al (2012)[2].

1. The prevention of fetal alcohol exposure and FASDs is the responsibility of everyone and warrants the attention of all government jurisdictions in Australia with a National FASD Prevention Plan. Such a Plan must address the implementation of a range of socially inclusive prevention strategies to address fetal alcohol exposure and FASDs.
    a. Develop and implement a national education campaign which focuses on:
        - Gender specific education programs for girls and women on alcohol use and the impact on health and wellbeing across the lifespan.
        - Inform all pre-conceiving and pregnant parents of the risks of alcohol use in pregnancy.

    b. Visible, mandatory alcohol warning labels:
        - on all alcohol beverage products sold in Australia
        - on all home brewing kits sold in Australia
        - on all alcohol product advertising in Australia
        - at all points of sale

2. Ensure strategies implemented to prevent/manage FASDs are developed with wide consultation with parents and/or carers of those living with or at risk of FASDs.

3. Recognise FASD as a national registered disability and ensure open access to Better Start programs for children.

4. Building service provider capacity:
    - Introduce a criterion in all government funding contracts which requires introductory training modules on women centred practice and FASD to be completed by all service providers working in Commonwealth, state and territory and local government in the helping professions.
    - Include information sessions in all post- secondary education courses for service providers who will encounter girls and women who use/misuse alcohol. Include

information on FASD and strategies for intervention with children and families at increased risk.
- Include FASD education in the curriculum at training colleges for doctors, police, educators, social workers etc. For example: Refer http://www.cdc.gov/ncbddd/fasd/curriculum/fasdguide_web.pdf

5. Community screening (the prevention of FASD is not just a health issue):
    - Embed screening in service provider organisational practice as an opportunity to educate on the risk of fetal alcohol exposure and other harmful alcohol use and normalise conversations about the risks of alcohol use.
    - Sponsor ongoing skills training for professional and non-professional service providers in the community.

6. Assessment and diagnosis
    - Establish and implement a national diagnostic tool with training on its use and with particular emphasis on incorporating the complete spectrum of adverse outcomes in the assessment process.

    - Standardise assessments for children and young people entering the out of home care systems in Australia to ensure inclusion of fetal alcohol exposure and FASDs.

    - Ensure multidisciplinary teams are in place in every state and territory and that team membership is inclusive of a parent/carer with experience in caring for individual/s living with FASDs.

7. Supporting individuals living with FASDs and their parent/carers/families:
    - Screen individual children, young people and adults on intake to all government services including criminal justice, foster care, child safety and child and family centres and implement management plans.

    - Incorporate training on FASDs for magistrates and judges to then consider enhanced supervision as a sentencing option for those at risk or diagnosed with an FASD.

    - To account for the transgenerational pattern of fetal alcohol exposure and FASDs, ensure those biological parents at risk for alcohol and other drug use whose children come to the attention of child safety systems are themselves screened for FASD.

    - Ensure assessment and diagnosis is complimented with a management plan of no less than 5 years in advance to account for developmental delay and cognitive impairment. Management planning should be inclusive of:

        - Education: to mitigate against bullying victimisation and/or patterns of truancy, school refusal and incomplete schooling and
        - Financial independence: future employment and training programs
        - Criminal justice: strategies for increased supervision and mentoring
        - Foster care placement: strategies for eliminating or reducing multiple placements

    - Regularly review management plans and ensure transition of planning across systems over time to reduce individual and family stress.

- Ensure ongoing funding to NOFASARD as the peak Australian national body offering support to those living with an FASD and their parents/carers /families and the service provider community who engage in a support role.

INTRODUCTION

The following quote was written in 1997 and its wisdom remains tragically relevant in 2012.

> *"Most children with fetal alcohol spectrum disorder face more stress, more obstacles, more loneliness, more failure, and less success in a single day than most non-affected people face in a far longer time. These children are not exceptional because they have the condition, they become exceptional through trying to survive despite all odds. The tragedy lies not in the reality that some people have FAS. The tragedy lies in the reality that they are denied their basic human rights to have an appropriate education, to be raised in a supportive environment, and to grow up to be adults who participate in life in a productive and satisfying manner."*
>
> (McCreight B (1997) *Recognizing and Managing Children With*
> *Fetal Alcohol Syndrome/Fetal Alcohol Effects: A Guidebook*

NOFASARD welcomes the opportunity to make this submission to the Inquiry on Fetal Alcohol Spectrum Disorders in Australia in the hope that change will follow. Governments have been aware of alcohol and its teratogenic properties at least since the late 1990s when NOFASARD was established and lobbying began in earnest and yet, the policy response has been ad hoc. NOFASARD recognises the prevention of fetal alcohol exposure and FASD is a complex issue and will require multiple strategies developed in collaboration and implemented in national, state and local contexts.

Within the spectrum of fetal alcohol disorders, the majority of individuals living with an FASD will have hidden adverse fetal outcomes which, if diagnosed would be determined to be neurodevelopmental disorders. The Australian community needs to have greater awareness that fetal alcohol exposure does not typically result in the more visible Fetal Alcohol Syndrome; that otherwise socially acceptable patterns of drinking in pregnancy may risk cognitive impairments which manifest in behaviour. The mobilised bias towards stereotyping FAS and its features as justifying diagnosis of FASDs perpetuates the false and misleading perception that the absence of observable facial features means the fetal alcohol exposed child has not had any adverse outcomes.

FASD is a physical brain injury. Neurodevelopmental Disorders – alcohol exposed (sometimes referenced in North American publications as ARND) is a neurocognitive disability without apparent and observable biomarkers and the subsequent 'invisibility' paradoxically costs the community in economic terms whilst individuals (and their families) are left without appropriate and empathic support. Yet, for the majority of Australian children, adolescents and adults, Indigenous and non-Indigenous, who are living with an FASD, support services are neither available nor accessible.

Appropriately trained health and community professionals for diagnosis and ongoing support and management are limited.

The stress on family relationships in particular cannot be understated. NOFASARD receives many inquiries from family members struggling to care for children/adolescents and adults with FASD because professional service providers do not recognize or understand the disability nor do they respect parent/carer efforts to describe FASDs. Parents/carers/families are often overwhelmed if not physically and emotionally exhausted from dealing with challenging behaviours that arise from this brain based disability. Too often, professional assessment assumes the behaviours to be an individual's choice; the product of a dysfunctional family; poor parenting practices; or other environmental factors. More concerning is the application of cognitive-behavioural therapeutic approaches which simply result in failure.

> *My partner and i are having so much trouble getting assistant for our kids it is so i had to search for a school that will give them the support that they need, they said that if my 3 yr didnt have autism and only had fas he wouldnt be entitled to early intervention it really frustrates me. How does fas not fall under a disability do i have it wrong is it not a disability i see the struggles my tiny little ones have to go through now it breaks my heart. Who can i go to in nsw to get all the support and that i need for my kids sometimes i feel i banging my had against a brick wall thank u* (Email to NOFASARD from a carer (6/2/09)

Incidence and Prevalence

The true extent of the incidence and prevalence of FASD in Australia is currently unknown. There is no nationally consistent definition; diagnostic criteria for FASD; nor biomarker for all conditions within the spectrum. Children are not routinely screened in infancy or early childhood and data which accurately reflects estimates of FASD incidence and prevalence in Australia are lacking.

Instead, data collected for other purposes can mask the probability of FASD within population groups – children's health – non-genetically attributed low birth weight, intellectual disability, co-occurring disorders (increased rates of ADD/ADHD; autism spectrum disorders; behavioural disorders); child and adolescent mental health; children entering foster care placements as a result of parental substance use to name a few.

What might also corroborate the incidence of fetal alcohol exposure are: (1) the numbers of girls and women estimated in various research studies who are consuming alcohol; (2) the patterns of alcohol consumption by Australian girls and women; and (3) rates of per capita ethyl alcohol consumption in Australia which according to the World Health Organisation, exceed comparative estimates for the United States and Canada.[3]

It is more than likely that prevalence would at least compare with these estimates. Recent epidemiological studies carried out in schools (general population) in three countries, have found the rate of FASD to be 2-5 out of every 100 children (2-5%)[4].

PREVENTION

The prevention of fetal alcohol exposure and FASDs requires attention to three target groups to prevent fetal alcohol exposure and to be able to meet the support needs of individuals living with FASD and those who support them:

1. Parents – pre-pregnancy and pregnant;
2. Those individuals already living with an FASD; and
3. Families and supporters.

Secondly, the prevention of FASD has no single solution and traditional linear policy approaches will probably fail. In the section which follows, an attempt has been made to tease out some of the major concerns using a three tier prevention model however the scope and breadth of the problem can only be surmised or at best, estimated. Moreover, other considerations influence prevention which need addressing i.e. the normative use of alcohol and the population groups of users inclusive of politicians, policy makers, service providers. FASD and its prevention is a value laden issue and the expression of the technical details of the problem and perceptions of the problem will be contested and diverse.

Primary prevention – whole of community

To date, the Australian government jurisdictions have relied on some local community and state/territory based initiatives. They have also relied too heavily on an overworked GP system, overstretched women's and children's hospitals and the limited number of FASD informed paediatricians, educators and advocates (paid and voluntary) to deliver messages about risks from alcohol consumption in pregnancy. Inconsistent and unclear messages arising from professional mainstream values and belief systems confuse parents and seldom reflect the recommendations in the current Alcohol Guidelines. Population groups at intermediate or lowered risk of using alcohol during pregnancy are not the default position when it comes to health warnings and needs to change. Given the range of research estimates on the numbers of parents, who continue to consume alcohol in pregnancy (47% to 80%) in Australia, and the escalating number of women who consume alcohol in high risk patterns of use, primary prevention activities must saturate the population.

Secondary prevention – service providers, parents and foster carers

Service providers (alcohol and pregnancy):

- The capacity of service providers to respond must begin with ensuring that skills and knowledge are commensurate with building relationships with girls and women so that barriers to disclosure in respect to alcohol use are reduced; and to recognise the FASD risk.
- Encouraging self-reflection on individual values and beliefs about alcohol use is critical given its normative social and cultural acceptance.
- Distinct government funding allocated to build community based expertise, education and advocacy is needed.
- There are few Australian training programs and resources and those that do exist do not reflect national geographical or cultural applications and conversations about risk. Materials developed must be templates which can be applied in diverse settings to account for difference - culture, gender, age, and location of community.
- Support the implementation of a NOFASARD ‘train the facilitator’ model to build community capacity; to reflect local need and improve sustainability.

Service providers (supporting those living with FASD):

There are resources and programs examples to support the large number of people who care for someone with FASD but this knowledge has not translated to service provider practices across Australia.

- Building the capacity of service providers to recognise the risk of FASD will begin with increased awareness of the problem, its presentation in behaviours and advocating for systems change to accommodate the unique needs of individuals. To do otherwise will be wasting vital resources and result in perpetual tragedy for the individual and disillusionment for service providers and their workplaces.
- Service providers need strategies. Awareness of a problem needs to be supported by a suite of practical tools known to improve quality of life outcomes for those living with an FASD and reduce stress for families.

Parents and foster carers:

Caring for an individual living with the neurobehavioural conditions from fetal alcohol exposure is a 24/7 role. The caring relationship is a critical landscape in which the quality of life and futures for individual children, adolescents and adult living with FASD can be determined. The investment of resources in supporting care arrangements now; in listening and acting on the advice of carers who are best placed to inform the service provider community of individual needs and the needs of those in their care will assure the resources currently allocated in criminal justice; homelessness; unemployment; economic dependence to maintain adults affected by the neurobehavioural conditions which evolve without intervention and support across the lifespan.

Australian research demonstrates children who have been prenatally exposed to alcohol and/or drugs are over represented in out-of-home care. Numerous Australian studies suggest that probably the equivalent of approximately 450,000 children are at risk of exposure to binge drinking in the household by at least one adult[5].

The WA Child and Youth health network have recently released a report Fetal Alcohol Spectrum Disorder Model of Care in which they acknowledge that that the prevalence of FASD in Australia is under-ascertained. This is due to a number of factors including: lack of screening, lack of diagnosis and lack of sufficient data[6]. In this report a number of recommendations are made including the following:

> *Routine health screening and assessment of all children coming into the alternative care system should include screening for FASD using a combination of assessment of growth parameters, child developmental screening and ante-natal exposure to alcohol.*

Another study undertaken in South Australia has demonstrated that 467 children entered out of home care for the first time in 2006 and that parental drug or alcohol misuse was associated with children's entry into care in approximately 70% of cases (40% mothers were the users). This study also claims that parental drug and alcohol misuse is not a peripheral issue but rather it is a "driver" for children entering into care[7].

To avoid poor outcomes and multiple placements it is imperative that these children are identified. *S*creening of children coming into care should involve a combination of assessment of growth parameters, child developmental screening and post natal environmental exposure to alcohol.

Carers need information that is specific to FASD, extra support, guidance and respite. Maturation is delayed for children/young people with FASD and the current practise of allowing them to leave state care systems at 18 without lifelong supports in place leads to affected individuals going into repeated predictable crises that perpetuate a life-time of failure.

Early intervention

Population groups at high risk of FASD are not receiving FASD specific intervention strategies.

Longitudinal studies demonstrate that the odds of escaping adverse life outcomes are increased 2-4 fold by receiving a diagnosis under the age of 6 and being raised in a good stable environment. [8] Assessment and diagnosis of FASD begins the process of assessment, planning and appropriate interventions. Post diagnosis, FASD seldom remains totally a health issue but rather it is the involvement of cross systems of government; family and community who will take the lead in improving quality of life outcomes for those living with an FASD.

Diagnosis is also the key to preventing further affected births. Those women at highest risk of giving birth to a child with FASD are those that have already given birth to a child adversely affected by prenatal alcohol exposure.

At this time, access to specialist FASD centres or services is very limited and there is no clear policy direction to address this. Diagnosis is restricted to the medical profession and yet, this profession has received very little information or training about the disorder or its prevention and elements can be in denial. Nor is there any specific training in respect to the gender based needs of girls and women who misuse alcohol.

There are no Australian clinical guidelines for diagnosing FASD and there are no government funded multidisciplinary diagnostic teams. FASD is not on the Government list of registered disabilities and there is no Medicare number for rebate for a diagnostic assessment.

FASD is rarely listed as an alcohol related harm and it is not mentioned in most major policy and discussion documents where it should be receiving priority attention. FASD as an issue impacts across the majority of government systems whether this be health; social; economic; or judicial and must be included in every government strategy pertaining to these systems.

NATIONAL REGISTERED DISABILITY STATUS

Feedback from NOFASARD members, supporters and stakeholders (refer Annexure 1) presents the reality for carers and families who are unable to access appropriate supports and services for individuals in their care who have or are suspected of living with a Fetal Alcohol Spectrum Disorder.

We draw your attention to this situation which we believe contravenes Article 25 (b) of the Convention on rights of Persons with Disabilities (ratified by Australia) which states:

- *Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.*

And in particular,

- *Parties shall: (b)* ***Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons…***

The Australian FASD Collaboration[9] has worked on a Department of Health and Ageing contract to develop a screening-diagnostic instrument for FASD in Australia, however NOFASARD appreciates the Report is still being considered by the Department of Health and Ageing, and the detailed conclusions of the Project remain confidential. NOFASARD fully supports as a matter of urgency the development of national guidelines for the diagnosis of FASD, preferably by a multidisciplinary team.

SUMMARY

FASD evokes emotive responses including an overwhelming sense of futility and a lack of faith in the possibility of solutions. In a context of social acceptance of alcohol use in Australia, primary prevention through raising public awareness is a critical government obligation. Information does not necessarily equate with attitudinal and behavioural change which means secondary prevention efforts must break down those barriers which mobilise mythology about alcohol consumption in pregnancy; make conversations about alcohol misuse as normative in daily life as the use of alcohol; and above all else, create comfort for women to seek help. All service providers must have baseline skills to have these conversations in the pre-conception phase of life.

Failing to provide the proper services for individuals with FASD who are living amongst us is un acceptable. Those living with FASDs, their parents and families are 'doing it tough.' As a parent or carer, it is one thing to be managing misunderstood behaviours in a child, it is quite another to be ignored or blamed and denied the services they need and deserve.

Sue Miers & Vicki Russell
NOFASARD Representatives 2012

Enc
Excerpts from emails received from parents/carers
Two case studies
Alcohol & Pregnancy brochure
FASD brochure

References

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[1] Malbin, D. (2011) Fetal alcohol/Neurobehaviour Workshop; Drug Education Network Tasmania, 29 Nov to 1 Dec 2011, Hobart, Tasmania

[2] In this new study, patterns of drinking specific to timing of exposure during pregnancy, data was collected while the mother was pregnant "instead of after pregnancy. Numerous associations were found, the most significant ones during the second half of the first trimester of pregnancy… Both Feldman and May believe these findings reinforce the warning that there is no "safe" level of alcohol consumption during pregnancy. "Clinicians should continue to follow the recommendations to encourage women who are planning a pregnancy or have the potential to become pregnant to avoid alcohol, and to advise women who become pregnant to stop alcohol consumption," said Sawada. "These new findings can also help clinicians quantify the importance of discontinuing alcohol as early as possible." May et al (2012) **"**Researchers quantify the damage of alcohol by timing and exposure during pregnancy**"** http://www.eurekalert.org/pub_releases/2012-01/ace-rqt010812.php

[3] World Health Organisation "Management of Alcohol Use" http://www.who.int/substance_abuse/publications/alcohol/en/index.html

[4] May et al, (2009). *Prevalence and Epidemiologic Characteristics of FASD from Various Methods with an Emphasis on Recent In-School Studies*. Developmental Disabilities Research Review 15: 176-192.

[5] Dawe et al (2007). Drug use in the family: impacts and implications for children. ANCD Research Paper 13.

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[6] Department of Health, Western Australia. Fetal Alcohol Spectrum Disorder Model of Care. Perth: Health Networks Branch, Department of Health, Western Australia; 2010.

[7] Jeffreys et al *"Parental substance misuse and children's entry into Alternative Care in South Australia* (2006) www.dfc.sa.gov.au/Pub/LinkClick.aspx?fileticket...tabid=811

[8] Streissguth A, Barr H, Kogan J and Bookstein F (1996). *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE).* Final Report. University of Washington School of Medicine Department of Psychiatry and Behavioural Sciences.

[9] The Australian FASD Collaboration is a group of experienced health professionals, researchers, parents and carers, consumer advocates, policy makers and public health personnel. They are dedicated to the prevention, diagnosis and management of children, adolescents and adults with a Fetal Alcohol Disorder in Australia. http://www.ichr.uwa.edu.au/files/user76/October_Newsletter.pdf