



WESTERN AUSTRALIA

8 October 2018

The Hon. Roger Cook
Deputy Premier, Minister for Health & Mental Health
Floor 13, Dumas House
2 Havelock Street
WEST PERTH WA 6005
By post & email: minister.cook@dpc.wa.gov.au

Dear Minister Cook 

MANDATE GOVERNMENT DEVELOPED ALCOHOL PREGNANCY WARNING LABELS

I am writing with regards to the Ministerial Forum on Food Regulation's consideration of pregnancy warning labels on alcohol products.

The AMA (WA) strongly supports the introduction of mandatory alcohol warning labels to reduce the prevalence of Foetal Alcohol Spectrum Disorder ("FASD") in Australia. I **attach** the *AMA Position Statement on FASD (2016)* for reference.

This is an important measure, which must occur alongside broader population-level responses to reduce alcohol-related harm and FASD. The voluntary pregnancy warning label scheme has been in place since 2011 and has failed to achieve an acceptable level of coverage or consumer recall.

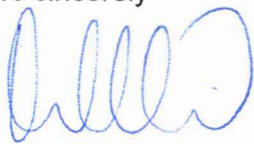
Less than 50% of alcohol products sold in Australia currently display a pregnancy warning label, indicating that regulatory action is required to improve coverage. The AMA (WA) is deeply concerned that the absence of warning labels on all alcohol products may imply to consumers that these products can safely be consumed during pregnancy.

The majority (85.7%) of products carrying a pregnancy warning do so on the back or side of the label. The industry has had seven years to arrive at an effective labelling scheme, and evidently has fallen short. The AMA (WA) is supportive of mandatory, clear, consistent, front-of-pack warning labels of appropriate size, colour and contrast to ensure visibility.

At the upcoming Forum meeting on October 11, it is essential that you vote for pregnancy warning labels to become mandatory on all alcohol products and task Food Standards Australia New Zealand ("FSANZ") to develop an effective, consumer-tested labelling standard.

Thank you for your ongoing leadership in protecting the health of Australian children and communities.

Yours sincerely



Dr Omar Khorshid
AMA (WA) President

Enc: *AMA Position Statement on FASD (2016)*

Fetal Alcohol Spectrum Disorder (FASD) 2016

The AMA acknowledges that FASD occurs in Australia and recommends:

1. Measures to improve clinician awareness of alcohol harms to the fetus and increase the likelihood of health professionals engaging in conversations with their patients about alcohol consumption during pregnancy and providing advice consistent with the NHMRC *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*.
2. Dissemination to, and use by, health professionals of the recently published *Australian Guide to the Diagnosis of FASD*. This should be complemented by efforts to increase awareness about specialist FASD diagnostic centres and services in Australia.
3. Ongoing education and training for clinicians to increase knowledge about populations at risk of FASD and increase early FASD diagnosis and management.
4. Investment to improve access to, and affordability of, specialist FASD diagnostic and treatment services and ensure that management is evidence-based.
5. Acknowledgement that culturally appropriate diagnostic and treatment approaches are required for at-risk populations.
6. Inclusion of FASD to the Australian Government Department of Social Services' List of Recognised Disabilities. This should be complemented by efforts to increase awareness and understanding of FASD among National Disability Insurance Scheme (NDIS) assessors to improve access to NDIS.
7. Implementation of strategies that identify and support people with FASD who come into contact with the education, criminal justice and child protection systems.
8. A coordinated national approach to reducing FASD, that is consistent with the broader campaign for combatting problem drinking in Australia, including efforts to reduce availability, affordability and accessibility of alcohol.
9. Mandatory, informative, front-of-pack warning labels on all alcohol products to inform the public about the harms of alcohol use in pregnancy and discourage pregnant women from drinking alcohol.
10. Funding to allow for the collection of nationally consistent and representative FASD data.
11. Government commitment to ongoing funding and support for the outcomes of the Commonwealth Action Plan, including: the National FASD Hub, National FASD Technical Network, National FASD Clinical Network, and National FASD Register; Implementation and Evaluation of the *Australian Guide to the Diagnosis of FASD*, and treatment services for alcohol misuse in pregnancy.

Background

Fetal alcohol spectrum disorder (FASD) is a diagnostic term used to describe the permanent, severe neurodevelopmental impairments that may occur as a result of maternal drinking during pregnancy. Globally, it is estimated that alcohol is the leading cause of preventable birth defects and intellectual disability¹, however, failure to identify children at risk or to consider a diagnosis of FASD means that many individuals with the disorder are not identified and do not receive appropriate support and early intervention. FASD is associated with a range of birth defects and the average life expectancy for a child with FASD is only 34 years of age.² FASD is extremely costly to our health, education and justice systems, yet is potentially preventable.

There is emerging evidence that alcohol use around the time of conception and during pregnancy can also have epigenetic effects that may be transmitted to future generations.³

Few data on FASD prevalence are available for Australia, however alcohol consumption statistics and epidemiological data on FASD prevalence from comparable countries suggest that FASD prevalence is higher than previously thought in Australia.⁴ Given the significant personal and community impacts of FASD, targeted and ongoing attention is warranted to alleviate its impact.

Australian and international guidelines advise that there is no safe level of alcohol consumption during pregnancy.⁵ Alcohol crosses the placenta and the fetal liver cannot effectively metabolise it, meaning the fetus is vulnerable to any level of exposure at any stage of pregnancy.

Prevalence

FASD is an issue that is not confined to a particular community or demographic; it is a disorder that crosses socio-economic, racial and education boundaries. Few accurate data on the prevalence of FASD in Australia is available but it is estimated that FASD affects roughly between 2% and 5% of the population in the United States.⁶

The prevalence may be as high as 12% in some high-risk Indigenous communities.⁷ It is important that culturally and linguistically appropriate diagnosis services are made available in communities with a high prevalence of FASD.

Whilst the high prevalence of FASD in some communities warrants targeted intervention, it is important to consider FASD in the context of a broader societal problem, and not one that only affects particular parts of the community.

Prevention

Because no safe level of maternal alcohol consumption has been established, current Australian guidelines recommend that women abstain from alcohol consumption when planning, and throughout, their pregnancy. Despite this it has been estimated that at least 38% of Australian women continue to drink while pregnant.⁸ The percentage of women drinking during pregnancy falls to about 7% after the first trimester⁹, indicating that many women cease consuming alcohol upon finding out that they are pregnant.

The reasons that women continue to drink alcohol when pregnant are likely to be varied and complex. Identified risk factors include: having a tolerant attitude towards alcohol consumption during pregnancy, if their partner continues to drink throughout the pregnancy, and stressful living circumstances.¹⁰ In a minority of cases it may be due to an underlying mental illness or addiction.

Recognising that half of all Australian women will experience an unplanned pregnancy¹¹, it is important that messages regarding the harms of fetal alcohol exposure are emphasised in broader non-judgmental public health campaigns.

Research has shown that women will tend to avoid preventive health messages that they perceive as too alarmist or extreme.¹² Balancing this with the need to provide consistent and unambiguous information about the risks of even minimal fetal alcohol exposure is challenging, and highlights a need for further research to establish the most appropriate prevention strategies. Once identified, these messages should be included in the alcohol-related education that occurs within school-based health and sexual education curricula.

Pre-pregnancy counselling presents an invaluable opportunity for physicians to discuss alcohol consumption with parents as part of a broader discussion around pre-pregnancy health. Physicians consulting their patients in the lead up to a pregnancy should be ensuring that both parents are physically healthy, and this should include discussions around nutrition, vaccination, mental health and alcohol consumption. Women with existing mental illness or addiction problems require increased

support to reduce the risk of alcohol-related harm to the fetus.¹³ Women at risk should be identified as early as possible and information must be provided to GPs about the appropriate local referral pathways to specialised treatment and support services.

Diagnosis

A FASD diagnosis can be made at any time from infancy to adulthood, although it may be more difficult to establish neurodevelopmental impairments in infants and antenatal alcohol exposure in older patients.

Due to the perceived stigma about diagnosing FASD, there can be a reluctance by health professionals to engage in conversations regarding the possibility of fetal alcohol exposure. This commonly leads to a misdiagnoses including: Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, or other behavioural or learning problems.¹⁴ Antenatal consultations provide an opportunity to screen for fetal alcohol exposure, but to be effective, these conversations must be conducted with due sensitivity.

A diagnosis of FASD requires confirmation of antenatal alcohol exposure, and severe impairment of central nervous system function in several domains. Ideally, diagnostic assessments are carried out by specialist multi-disciplinary teams. As a means of bridging the gap between the availability and demand for these specialist assessment teams, alternative avenues of consultation should be explored including Child Development Units, developmental and general paediatricians. Initiatives including the use of technology-based consultations through which a patient in a remote area could be assessed by a specialist team through a secure videoconference connection should also be considered.¹⁵

As part of the Commonwealth FASD Action Plan¹⁶, the *Australian Guide to the diagnosis of FASD*¹⁷ has been developed to educate clinicians, to standardise and streamline FASD diagnoses, and ensure that the Australian diagnostic framework is consistent with comparable countries. All doctors who consult with children and adolescents should be aware of this tool and be comfortable in making a referral for a diagnostic assessment of FASD. An e-learning package is available to complement the Guide.

Treatment/Support

International studies have identified a range of psychosocial and pharmacological treatment strategies to manage FASD, although few are evidence-based. Effective interventions included family, educational and parental support, increased social-skills education for FASD children, and prescription medications to help manage the attention deficit issues associated with FASD.¹⁸

Early intervention and support following timely diagnosis improves psychosocial and behavioural outcomes for those affected by FASD. At present, though, many people with FASD are not identified until relatively late in life, or not at all.¹⁹

Newly diagnosed adult FASD patients may benefit greatly from increased support to assist them with financial management, employability, interpersonal relationships or legal situations as a result of their neurocognitive disability.²⁰

FASD is currently not recognised as a disability in Australia²¹, and this restricts access to traditional disability support mechanisms. Although the National Disability Insurance Scheme does not require a specific diagnosis to receive funding for services, this lack of disability recognition drastically reduces the availability of cohesive and comprehensive support services for people with FASD.

Canadian research has found that people with FASD are approximately 19 times more likely to be arrested than their peers²², significantly increasing the costs of both the adult and juvenile custodial systems.²³ The impact of FASD on the criminal justice system is multifaceted in that it increases the likelihood of a person coming into contact with the system, and subsequently impairs their ability to

navigate it effectively.²⁴ Given this problem, an important aspect of early intervention is to provide skills that reduce the likelihood that an individual with FASD will come into contact with the criminal justice system.

Most children who enter the criminal justice system have previously been recognised by child protection authorities.²⁵ These families should be assessed for signs of FASD and, where appropriate, afforded the necessary treatment.

Reproduction and distribution of AMA position statements is permitted provided the AMA is acknowledged and that the position statement is faithfully reproduced noting the year at the top of the document.

This position statement was developed by the AMA's FASD Working Group. The Working Group would like to acknowledge the contribution of Prof Elizabeth Elliott AM.

References

- ¹ Mather, M., Wiles, K., O'Brien, P. (2015). Should Women Abstain from Alcohol Throughout Pregnancy? *BMJ* 2015;351:h5232. Available at: <http://www.bmj.com/content/351/bmj.h5232>
- ² Thanh, NX., Jonsson, E. (2016) Life Expectancy of People with Fetal Alcohol Syndrome. *Journal of Population Therapy and Clinical Pharmacology*, 2016;23(1):e53-9. Epub 2016 Mar 9. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26962962>
- ³ Sarkar, D. (2015) Male germline transmits fetal alcohol epigenetic marks for multiple generations: a review. *Addiction Biology*, 21: 23–34. doi: 10.1111/adb.12186. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/adb.12186/pdf>
- ⁴ Burns, L., Breen, C., Bower, C. et al. (2013). Counting fetal alcohol spectrum disorder in Australia: the evidence and the challenges. *Drug Alcohol Rev.* 2013 Sep 32 (5):461-7. Doi: 10.1111/dar.12047. Epub 2013 Apr. 25. Review. PMID: 2361743
- ⁵ National Health and Medical Research Council. (2009). Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Available at: https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf
- ⁶ Burns, L., Breen, C., Bower, C. et al. (2013). Counting fetal alcohol spectrum disorder in Australia: the evidence and the challenges. *Drug Alcohol Rev.* 2013 Sep 32 (5):461-7. Doi: 10.1111/dar.12047. Epub 2013 Apr. 25. Review. PMID: 2361743
- ⁷ Fitzpatrick JP, Elliott EJ, Latimer J, et al. (2015). Prevalence of fetal alcohol syndrome in a population-based sample of children living in remote Australia: the Lillilwan Project. *Journal of Paediatric Child Health.* 2015 Apr;51(4):450-7. doi: 10.1111/jpc.12814. Epub 2015 Jan 15. PMID: 2559424
- ⁸ O'Keeffe, L., Kearney, P., McCarthy, F. (2015) Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies. *BMJ Open* 2015;5:e006323 doi:10.1136/bmjopen-2014-006323. Available at: <http://bmjopen.bmj.com/content/5/7/e006323.full>
- ⁹ O'Keeffe, L., Kearney, P., McCarthy, F. (2015) Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies. *BMJ Open* 2015;5:e006323 doi:10.1136/bmjopen-2014-006323. Available at: <http://bmjopen.bmj.com/content/5/7/e006323.full>
- ¹⁰ Peardon, E., Payne, J., Henley, N. et al. (2011) Attitudes and behaviour predict women's intention to drink alcohol during pregnancy: the challenge for health professionals. *BMC Public Health* 2011 11:584. DOI: 10.1186/1471-2458-11-584
- ¹¹ Marie Stopes International. (2006). *What Women Want: When faced with an unplanned pregnancy*. Available at: <http://www.mariestopes.org.au/wp-content/uploads/2014/07/KeyFindings.pdf>
- ¹² Holland, K., McCallum, K., Blood, R.W. (2015) Conversations about alcohol and pregnancy (FARE). Available at: <http://www.fare.org.au/wp-content/uploads/research/Conversations%20about%20alcohol%20and%20pregnancy.pdf>
- ¹³ Foundation for Alcohol Research and Education (FARE) . The Australian Fetal Alcohol Spectrum Disorders Action Plan 2013 – 2016. Available at: <http://www.fare.org.au/wp-content/uploads/research/FARE-FASD-Plan.pdf>
- ¹⁴ House Standing Committee on Social Policy and Legal Affairs. (2012). FASD: The Hidden Harm. Available at: http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_representatives/Committees?url=spla/fasd/report.htm
- ¹⁵ Foundation for Alcohol Research and Education (FARE) . The Australian Fetal Alcohol Spectrum Disorders Action Plan 2013 – 2016. Available at: <http://www.fare.org.au/wp-content/uploads/research/FARE-FASD-Plan.pdf>
- ¹⁶ The Department of Health. (2012). Responding to the Impact of Fetal Alcohol Spectrum Disorders in Australia: A Commonwealth Action Plan. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-drugs-alcohol-index.htm>
- ¹⁷ 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)". Available at: https://www.fasithub.org.au/siteassets/pdfs/australian-guide-to-diagnosis-of-fasd_all-appendices.pdf
- ¹⁸ Closing the Gap Clearinghouse (AIHW & AIFS). (2014). Fetal alcohol spectrum disorders: a review of interventions for prevention and management in Indigenous Communities. Produced by the Closing the Gap Clearinghouse. Resource sheet no. 36. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550296>
- ¹⁹ National Organisation for Fetal Alcohol Spectrum Disorders. (2013). What is FASD? Available at: <http://www.nofasd.org.au/resources/what-is-fasd-1>
- ²⁰ Spohr, H-L, et al. (2007) Fetal Alcohol Spectrum Disorders in Young Adulthood. *The Journal of Pediatrics*. Volume 150 , Issue 2 , 175 - 179.e1. Available at: [http://www.jpeds.com/article/S0022-3476\(06\)01124-3/fulltext](http://www.jpeds.com/article/S0022-3476(06)01124-3/fulltext)
- ²¹ Department of Social Services. (2014). Guide to the List of Recognised Disabilities. Available at: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/benefits-payments/carers-allowance/guide-to-the-list-of-recognised-disabilities>

²² Brown, N., Burd, L., Grant, T., et al. (2015). Prenatal alcohol exposure: An assessment strategy for the legal context. *International Journal of Law and Psychiatry*. Volumes 42–43, September–December 2015, Pages 144–148. Available at: <http://www.sciencedirect.com/science/article/pii/S0160252715001296>

²³ Popova, S., Lange, S., Burd, L., Rehm, J. (2015). Cost attributable to Fetal Alcohol Spectrum Disorder in the Canadian correctional system. *International Journal of Law and Psychiatry*. 2015 Jul-Aug;41:76-81. doi: 10.1016/j.ijlp.2015.03.010. Epub 2015 Apr 4. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25846557>

²⁴ Parkinson, S. & McLean, S. (2013). Foetal Alcohol Spectrum Disorder in children: Implications for judicial administration, *Journal of Judicial Administration*, 22(3), 138-145

²⁵ Cashmore, J. (2011). The link between child maltreatment and adolescent offending: Systems neglect of adolescents. *Family Matters*, 89, 31-41. Available at: <https://aifs.gov.au/publications/family-matters/issue-89/link-between-child-maltreatment-and-adolescent-offending>