Government of Western Australia
Department of Health

Fetal Alcohol Spectrum Disorder (FASD) Model of Care Implementation Forum Report

A report from the 22 February 2012

Delivering a **Healthy WA**

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1. Background

Fetal Alcohol Spectrum Disorder (FASD) is the umbrella term used to describe adverse outcomes caused by fetal exposure to alcohol. The Child and Youth Health Network (CYHN) is facilitating the whole of government, statewide implementation of the WA Fetal Alcohol Spectrum Disorder (FASD) Model of Care (MOC) which was published by the Child and Youth Health Network in 2010.

1.1 FASD Model of Care

The aim of the FASD MOC is to reduce the number of women consuming alcohol at any stage of their pregnancy and the weeks leading up to conception. The MOC is an evidenced based document which describes the current situation and best practice strategies for the prevention, diagnosis and treatment of FASD. It contains 33 recommendations across the continuum of care and emphasises holistic prevention strategies to reduce the prevalence of this avoidable condition.

The MOC was developed by a working group comprising of diverse representation from various government departments, non-government agencies, clinicians, consumers and carers.

It can be accessed online from:
http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/FASD_Model_of_Care.pdf

1.2 Whole of government approach

WA Health is leading a Project Control Group (PCG) to implement the FASD MOC. The WA Government Community Services Leadership Group (CSLG) has endorsed and committed participation in the whole of government approach to the implementation of the FASD MOC. Other stakeholders include a number of national, state and community organisations and carers.

The reporting framework for this implementation process is described in the FASD Model of Care Implementation Governance Paper and emphasises the whole of government approach. For an outline of the reporting structures between the Implementation working groups, Project Control Group, Community Services Leadership Group and other National committees, see Appendix 1.

FASD Project Control Group	Community Services Leadership Group (CSLG)
The PCG includes representation from: ▪ WA Health Chief Medical Officer ▪ Child and Youth Health Network ▪ Drug and Alcohol Office ▪ Department of Education ▪ Department for Communities.	The CSLG is made up of Director Generals from health and human service agencies. Membership includes Government agencies such as: ▪ Department for Communities (DFC) ▪ Department of Child Protection (DCP) ▪ Department of Corrective Services (DCS) ▪ Department of Culture & the Arts (DCA) ▪ Disabilities Services Commission (DSC) ▪ Department of Education (DOE) ▪ Department of Health (DOH) ▪ Department of Housing (DOH) ▪ Department of Indigenous Affairs (DIA) ▪ Department of Local Government (DLG) ▪ Lotterywest ▪ Mental Health Commission (MHC) ▪ Department of Premier and Cabinet (DPC) ▪ Department of Sport and Recreation (DSR) ▪ WA Police Service.

1.3 Prevention focus

Implementation strategies will prioritise the use of prevention strategies to reduce the prevalence of FASD, recognising that FASD is an entirely preventable condition. All recommendations can be grouped across the prevention continuum, demonstrating the interplay between primary, secondary and tertiary strategies and the role of enabling factors at each stage. For the prevention continuum with mapped recommendations, see Appendix 2.

2. The FASD Implementation Forum – connect, share, improve

2.1 Aim

The aim of the Forum was to engage with all stakeholders across sectors to establish the priorities for the development of the FASD MOC Implementation Plan.

2.2 Objectives

Objectives of the Forum:

- Mapping, gapping and prioritising current FASD related initiatives, projects, resources and stakeholders.
- Developing shared understandings of FASD prevention priorities and enabling factors.
- Facilitating collaboration and partnerships to enable shared understandings across sectors.

2.3 Who participated

There are many stakeholders working across a range of health and human service sectors to prevent, quantify and manage the burden of FASD. The Forum engaged 50 participants from a range of backgrounds. More than 25 participants across 11 rural, regional or remote sites were also involved in a video conference following the forum.

Participants at the Forum included representatives across multiple sectors:

- Government agencies (e.g. CSLG representatives)
- Statewide policy units
- Non-government organisations
- Researchers
- Carers/consumers
- Area Health Services
- Clinicians

CSLG representation

CSLG member agencies which were represented included the Departments of Health, Education, Child Protection, Corrective Services, Sport and Recreation, Culture and the Arts, Communities and Indigenous Affairs.

For a list of participating stakeholders from the Forum, see Appendix 3.

2.4 Forum program

The Forum was planned and facilitated by the Health Networks Branch, with the guidance of the FASD Project Control Group. The Forum used a combination of presentations and facilitated group work to complete mapping, gapping and prioritising exercises to achieve the objectives of the day. The program is available in Appendix 4.

Network approach –Connect Share Improve

Health Networks bring expertise in facilitating cooperation, collaboration and integration between stakeholders. Enabling information sharing across sectors informs the integration of research into policy and practice in ways that meet community and consumer expectations and needs.

Welcome to Country

Kim Collard from Kooya Consultancy opened the Forum with a formal Welcome to Country.

Overview presentation: FASD in WA

The opening address by Dr Simon Towler (Chief Medical Officer (CMO) and Chair of the PCG) and Gary Kirby (Director of Prevention and Workforce Development, Drug and Alcohol Office (DAO) and member of the PCG) provided an overview of the current situation of FASD.

The presentation focussed on:

- Describing the complexity of FASD issues in Western Australia and Australia.
- Emphasising the importance of prevention strategies for this non-curable spectrum disorder.
- Providing an overview of work occurring at the National level, including the FASD Monograph and Parliamentary Inquiries (House of Representatives and WA State Parliament Education and Health Standing Committee).
- Explaining the history and development of the WA Health FASD Model of Care and how the recommendations align with national priorities.
- Discussing the importance of partnerships and collaboration.
- Describing the governance structures and whole of government support for the implementation of the FASD Model of Care. (Refer to Governance Map below).

For a copy of the presentation slides see the Forum presentation in Appendix 5.

Group work: mapping, gapping and prioritising

In facilitated groups, the participants used the continuum of prevention to map and gap current FASD initiatives relating to each of the FASD MOC recommendations.

Mapping and gapping is important for:

- Clarifying the resources, expertise and interests/priorities from participants present.
- Highlighting duplication of representation and/or resources across different sectors and parts of the state.
- Learning what initiatives and strategies can be applied more broadly to other regions and populations.
- Managing influence of interest groups.
- Determining what stakeholders/representation and expertise is missing.
- Informing decision making processes when determining priorities for implementation.

Closing presentation

Gary Kirby closed the Forum with a summary of outcomes from the day and an overview of the implementation process to follow. This presentation is included in the Forum slides in Appendix 5.

2.5 Engaging country based stakeholders

A video conference on 15 March 2012 of 11 sites provided country based stakeholders with an opportunity share the FASD related initiatives they are involved in, through a mapping and gapping process. Participants also provided feedback on outcomes from

the Forum and discussed ways they can contribute to the Implementation process. Input received from the country based stakeholders has been incorporated into this report.

Video Conference participants

The following WA Country Health Service (WACHS) sites participated in the video conference:

1. Perth WACHS Office.
2. Great Southern, Albany
3. Great Southern, Esperance
4. Goldfields, Kalgoorlie
5. Kimberley, Broome
6. Pilbara, South Headland
7. Midwest, Coral Bay
8. Midwest, Carnarvon
9. Midwest, Carnarvon Mental Health
10. Midwest, Geraldton
11. Southwest, Bunbury
12. Wheatbelt, Narrogin
13. Wheatbelt, Northam (apology)

3. Outcomes and analysis

3.1 Session 1: Opening address

The aim on the Opening Address was to increase all participants understanding of previous work completed in Western Australia to develop the FASD Model of Care and the scope, priorities and processes for implementing the Model of Care. Alignment of this work was also discussed in the context of other relevant State and Commonwealth initiatives.

For a copy of the presentation slides see Appendix 5.

Outcomes

Qualitative feedback received relating to the Opening address stated:

- *"Briefing at the start provided a good context".*
- *"Statement by Simon Towler that there is an ethical responsibility to implement MOC, seems that government has will to implement".*
- "*Great to hear the other agencies views and the approach undertaken".*

3.2 Session 2: Mapping

Participants self selected into three groups and mapped their relevant work against the recommendations of the FASD MOC and represented across the continuum of prevention. Contributions from country stakeholders has also been included. Additional opportunities for stakeholders to provide content to the mapping exercise was enabled via email following the Forum and country video conference.

Process

- FASD MOC recommendations were posted across primary, secondary and tertiary prevention stations.
- All participants rotated through each station and mapped their current work against relevant recommendations. Information recorded included:
  - **What** is the initiative?
  - **Who** is leading and other supporting agencies?
  - **Where** is the strategy being implemented/**target audience**?
- Each station also included a mapping section for enabling factors such as:
  - Research
  - data surveillance
  - workforce training and development
  - service delivery and clinical pathways

3.3 Session 3: Gapping

Participants were then assigned to either primary, secondary or tertiary prevention groups and worked together to review mapped information and identify gaps in current stakeholder engagement and/or delivery of services/programs not being addressed.

Process

- Within the three groups participants reviewed the initiatives already mapped and considered what was missing. For instance:
  - Recommendations not currently being addressed.
  - Stakeholders not present in their groups (referring to list of participants provided to them).
  - Which initiatives could be applied to other regions/target groups/statewide.

3.4 Outcomes of mapping and gapping

Key themes identified from the mapping exercises for each prevention phase and enabling factors are presented in the table below, including example initiatives.

For a record of all the initiatives mapped during the Forum and the videoconference, refer to the collated table in Appendix 6.

Table 1: Themed outcomes from mapping across the prevention continuum

	Themed areas	Example initiatives
Primary prevention	▪ Community resources and education. ▪ School education. ▪ Community action. ▪ Attitudes to Alcohol. ▪ Alcohol availability. ▪ Promotion of pre-conception care and planned pregnancy (nb –many programs overlap with community & school education). ▪ Workforce education.	▪ Population specific/school based education/awareness raising programs. ▪ Resources (brochures, tool kits, websites). ▪ Community forums and educational workshops. ▪ Engagement of GPs, different health practitioners, teachers and other community service professionals.
Secondary prevention	▪ Antenatal care/education. ▪ Regular screening throughout pregnancy (antenatal/each trimester). ▪ Brief intervention strategies addressing maternal alcohol use during pregnancy. ▪ Screen and management of alcohol withdrawal during pregnancy. ▪ Opportunistic screening for alcohol consumption for all	▪ Educational tools/resources for health services and health practitioners re: awareness of risks of alcohol consumption during pregnancy. ▪ Screening and audit tools. ▪ Range of services and resources for brief interventions. ▪ Pregnancy records/data collection and surveillance tools. ▪ Engagement of GPs, different health practitioners and other human service

	Themed areas	Example initiatives
	women of child baring age (including brief interventions where necessary). ▪ Screening for FASD children by Child Health Nurses. ▪ Education/prevention of subsequent births.	professionals.
Tertiary prevention	▪ Identification of at risk newborns (e.g. Child Protection Services, mothers at alcohol & other drug treatment services). ▪ Referral of suspected FASD children for comprehensive assessment and intervention services. ▪ Development of multidisciplinary FASD diagnostic tool and service. ▪ Support for assessment in regional areas. ▪ Treatment programs to support FASD children manage symptoms. ▪ Support for FASD in justice sector.	▪ Information resources –brochures, websites. ▪ Home visits. ▪ Risk assessment and referral tools for diagnosis/support services. ▪ Development of universal diagnostic tools. ▪ Training and education in use of assessment tool. ▪ Mapping of support services/clinical service pathways. ▪ Engagement of multiple sectors including child protection, education, justice/corrective services, health practitioners/primary care, child development service to support needs of FASD children.
Enablers	▪ Research. ▪ Data surveillance and linkage. ▪ Workforce training and development. ▪ Service development and clinical pathways. ▪ Coordinated implementation strategies.	▪ Evidenced based, coordinated. ▪ Universal data collection tools. ▪ Primary care sector, range health sectors, social/human service practitioners (e.g. GPs, midwives, child health nurses, teachers, disability services, child and youth services, corrective services). ▪ Mapping and coordination of services & referral pathways across sectors and across continuum from prevention (prevention, screening, diagnosis, management). ▪ Engagement of across government participation in developing implementation plans and to implement FASD Model of Care as coordinated by WA Health CYHN.

Table 2: Identified gaps across the prevention continuum

	Programs/strategies
Primary prevention	▪ Evidenced based research - evaluation of programs and prevalence studies to define size and characteristics of the problem. ▪ Consistent information to community/consumers. ▪ Targeted and culturally appropriate education for a range socio-demographic groups. ▪ Workforce development/education for future and current workforce – risks and opportunities to educate, screen and intervene. ▪ Coordination between existing services/funding of holistic programs. ▪ Promotion of Fetal Alcohol Syndrome (FAS) Day. ▪ Standardised labels on alcohol products. ▪ Engagement of the alcohol industry.
Secondary prevention	▪ Lack of evidenced based, standardised screening tools throughout antenatal care. ▪ Lack of standard referral pathways/coordination of services. ▪ Education of practitioners. ▪ Population specific programs. ▪ Surveillance of data from alcohol, screening in pregnancy, service delivery.
Tertiary prevention	▪ No standardised diagnostic tool. ▪ No consistent data surveillance collection tools or strategies to count FASD. ▪ On the ground diagnostic services across state. ▪ Evaluated screening and treatment programs. ▪ Training and education of health professionals. ▪ Coordination/linkage of support services and resources for FASD children/families/carers. ▪ Multidisciplinary clinics with experts.
Enablers	▪ Self-directed learning packages for screening and referral. ▪ Defined clinical pathways. ▪ Workforce development, specifically in primary care.

3.5 Prioritising and strategising – call to action

Group participants then determined the top three priority areas for their allocated prevention area.

Process

- Participants developed a list of priority areas based on the information available from mapping and gapping. Each group member then voted to produce the top three areas for action.
- Within each prevention group, participants then self selected to one priority area each to work together to develop strategies for the priority. Each strategy considered:
  - **What** was the priority issue?
  - **How** (what strategies) could the issue be addressed?
  - **Role/needs** for enabling factors (workforce, data, research, service pathways etc)?
  - **Who** are key agencies to drive and support the implementation of the strategy?
  - **Where** –are these transferable to other/broader regions of the state?
- At the conclusion of the day, a representative from each prevention group shared their priority areas with the rest of the Forum participants.

Table 3: Priorities across the prevention continuum

	Priority	What/how: potential strategies to achieve this priority?	Who-stakeholders responsible for leading these initiatives?
Primary prevention	**1. School based education**	▪ Healthy School Framework. ▪ Promoting access/use of SDERA resources. ▪ Advocacy to school leadership teams. ▪ Advocacy in national curriculum. ▪ Teacher training modules including use of Information Communication Technology (ICT). ▪ Development of FASD Prevention and early intervention (EI) specific focus for school based staff training. ▪ Developmentally appropriate curriculum strategies from K-upwards.	▪ School Drug Education Road Aware (SDERA) ▪ Australian Curriculum. Assessment and Reporting Authority (ACARA) ▪ DOE ▪ Australian Independent Schools WA (AISWA) ▪ Chief Executive Officers ▪ DOH ▪ School health nurses ▪ Healthy school coordinators ▪ Parents/community

	Priority	What/how: potential strategies to achieve this priority?	Who-stakeholders responsible for leading these initiatives?
			members ▪ Community drug services.
	2. Community based education	▪ Education about: - Alcohol and stimulants - Pregnancy - FASD. ▪ Not about blaming and educating older generations. ▪ Develop resources/ materials/ tools and visual aids - Campaigning; marketing and media tailored to communications. - Media Champions – local areas, sports and entertainers - Individual targeting groups. ▪ Behavioural Change Model - Ask/involve young people/right people and look at research - Men's Groups, Young Mums, Regional etc. Sporting Groups. ▪ Central Repository of information, campaigns – Health Networks - consistent information and central training for the advocates - Positive case studies - Good news stories.	Stakeholders to feed info into Health Networks: ▪ DOHA ▪ DAO ▪ Maternity Group Practices ▪ DFC ▪ DCP ▪ DOE ▪ Healthway ▪ Women's & Newborns' Health Services (WNHS). Health Networks feed out to: ▪ Health Promotion (DOH) ▪ Health Services

	Priority	What/how: potential strategies to achieve this priority?	Who-stakeholders responsible for leading these initiatives?
	3. Advocacy to reduce harmful alcohol consumption ▪ Political priority across Commonwealth/ State/Local Government.	▪ Ask people for identification at liquor store. ▪ Stay on case by sharing success stories, keep up the advocacy, get agreed priorities. ▪ Community view on getting things changed. ▪ Position paper/memorandum that is agreed on and present to the government. ▪ Unpack other strategies e.g. tobacco smoking. ▪ Long term strategies/projects ▪ NGO to lead/champion $, form coalitions and consensus.	▪ Non Government Organisations (NGOs) ▪ Community action groups ▪ Federal and State Politicians.
Secondary prevention	**1. Development of a universally used standardised screening tool to measure alcohol exposure**	▪ Best practice and evidence of use of tool: ▪ Simple desk-top protocol for clinicians: ▪ Link workforce training (online, face to face), Standards of Care in corporation of protocol into red book, DOH Operational Directives and Audit Medicare.	▪ All socioeconomics groups – GP (Royal Australian College of General Practice(RACGP)), ▪ Midwives ▪ Rural and Remote nurses ▪ Obstetricians and Gynaecologists. ▪ Practice Nurses ▪ Aboriginal Health Workers ▪ Nurse Practitioner. ▪ E.g. HIV pre / post test discussion guide) ▪ GPs

	Priority	What/how: potential strategies to achieve this priority?	Who-stakeholders responsible for leading these initiatives?
			▪ Practice Nurses ▪ Nurse Practitioners ▪ others
	1. Use of the information from the prenatal alcohol exposure tool ▪ Assuming maternal alcohol consumption has been routinely recorded –at the least at first antenatal visit and birth).	▪ Recorded on midwives notification system (mandatory & stored). ▪ Analysis. ▪ Monitoring / Surveillance**.** ▪ Evaluating Process. ▪ Health Impact Assessment. ▪ Research. ▪ Health Professionals assessing to assist clinical care, mother and child. ▪ Brief intervention. ▪ Post – partum follow–up (mum and baby). ▪ Resources: Training / Workforce Development; Policies / Guidelines. <u>How</u>: Engage with: ▪ DOH –midwives notification system ▪ Health professionals ▪ Community members ▪ Other stakeholders.	▪ Midwives and obstetricians. ▪ Health Services – Resources ▪ Researchers ▪ Paediatricians, child health nurses, other health professionals ▪ Justice, DCP, Educational resources.
	1. Establishing referral pathways within context and resources	▪ Agreed, whole of agency, state approach and develop policy at operational level that translates into local implementation and agreed pathways. ▪ Monitor pathways. ▪ Multiagency triage – local context. ▪ Need specific services for women once referral. <u>How:</u> ▪ Mapping and education for service providers of current services. ▪ Primary care	▪ WNHS ▪ Women and Newborn Drug and Alcohol Service (WANDAS) / DOH ▪ Mental Health / Social Work / DCP/ consumers ▪ Area health clinics ▪ Secondary hospitals – Population health Centres

	Priority	What/how: potential strategies to achieve this priority?	Who-stakeholders responsible for leading these initiatives?
		▫ Principles – accessible ▫ Affordable – collaboration ▫ Community – local solutions ▫ Case Management ▫ Collaborative approach ▫ Networking meetings ▫ Dedicated resources ▫ More flexible. ▪ Dedicated funding. <u>To collaborate:</u> ▪ Not project specific. ▪ Information sharing protocols. ▪ Stable workforce – ongoing education of workforce.	▪ Aboriginal Community Controlled Health Services (ACCHS) / NGOs ▪ GP's Medicare Locals ▪ Multi agency approach ▪ FASD working groups ▪ Child & Adolescent Health Service (CAHS) / Health Networks - CYHN.
Tertiary prevention	**1. Development and use of a multidisciplinary diagnosis tool to implement standardised assessments**	▪ Diagnosis ▫ Tools ▫ Assessment ▫ Multidisciplinary ▫ Family focus ▫ Informs treatment ▪ Inclusive of total populations – CALD/Aboriginal populations, remote, men. ▪ Diagnosis pre-requisite for training informed by diagnosis ("simulated learning").	▪ Health Services ▪ Child and Community Health (CACH) ▪ Disability services ▪ DOE
	2. Need for training and education of this assessment tool for service providers and consumers/ carers	▪ Training/professional development/education ▫ Simulated learning ▫ Consumers/carers/families ▫ Health/education/country workers ▫ Social structures/community ▫ Understand context. ▪ Map who is doing what in community; who needs training; and how going to be delivered.	▪ Centre for Excellence with partners from DAO, DOH, Telethon Institute for Child Health Research (TICHR) – research and Child Development Service (CDS).

3.6 Issues identified on the day

An ‘Issues Parking Bay’ was available for participants to list outstanding issues or items that were out of scope discussing at the Forum. Issues listed here included:

- Length of antenatal appointments for screening and referral if needed.
- Lack of time for midwives to effectively screen in pregnancy when currently already screening for: post natal depression, smoking and domestic violence. Midwives also have to attend routine pregnancy checks.
- Inability to count or screen if cannot diagnose.
- Available diagnosis facilities are essential in primary education.

Implementation working groups will be informed of these issues for consideration.

4. Evaluation of the Forum

A brief evaluation survey was provided to participants. It included 10 statements with a likert rating scale (ranging through strongly disagree, disagree, neither agree nor disagree, agree and strongly agree) and three open ended questions seeking qualitative feedback. For a copy of the Evaluation Form, see Appendix 7.

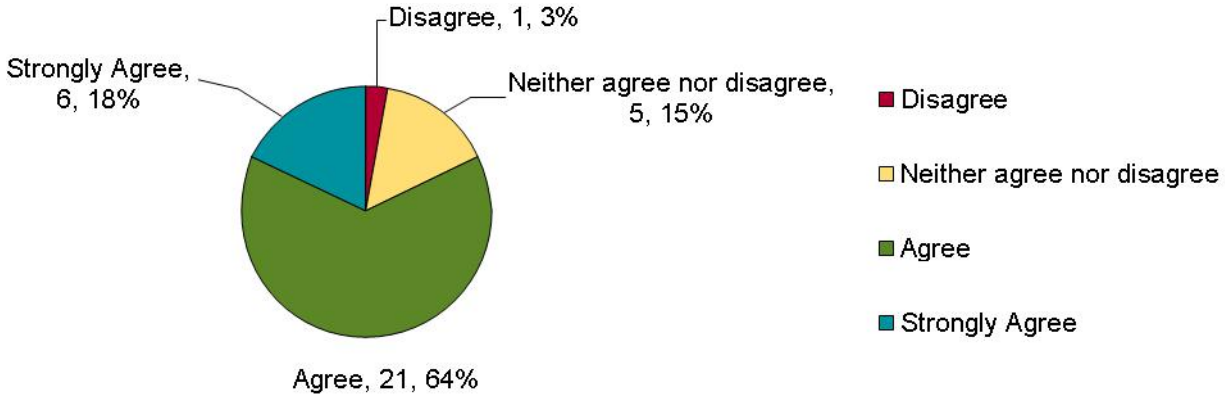
Of the participants, 33 (66%) completed evaluation surveys and 36 returned forms committing to the implementation working groups.

Quantitative data

Quantitative results from the statements were as follows:

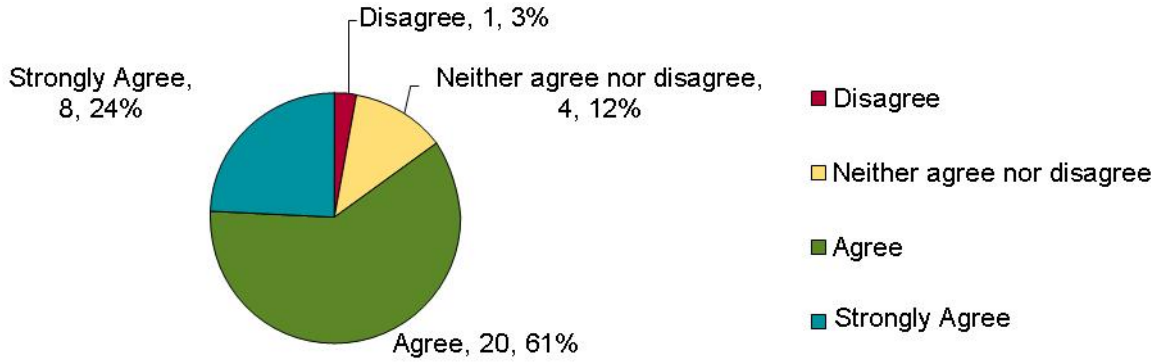
- 82% strongly agree (SA)/agree (A) the event increased understanding of need for whole of government approach to the MOC implementation.

Figure 1: Increased understanding of need for whole of government approach



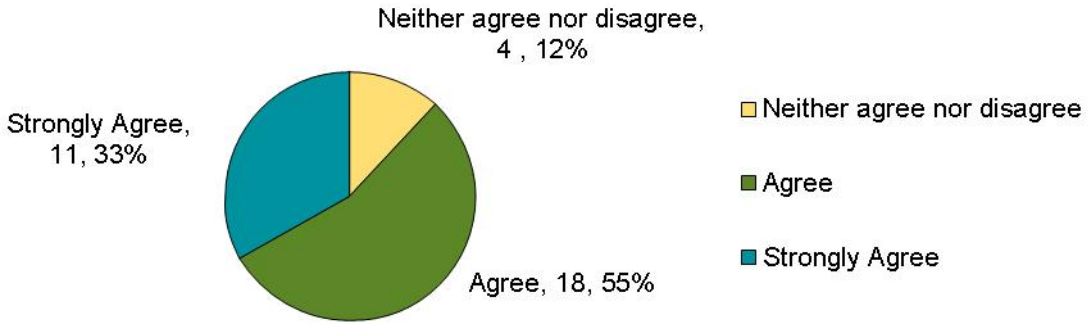
- 85% SA/A the Model of Care is a useful tool to map and plan FASD related activity across WA.

Figure 2: Usefulness of the Model of Care as a tool to map FASD activity in WA



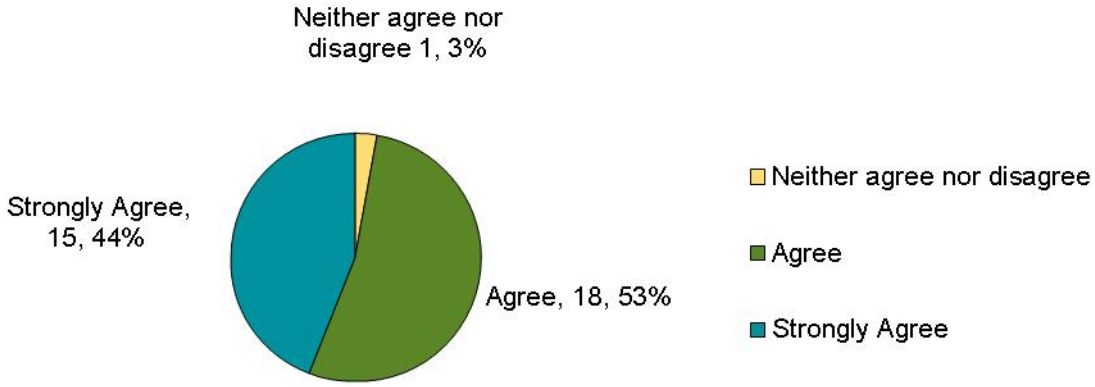
- Almost 100% can see how their work contributes to the prevention of FASD.

Figure 3: Association of work with the Prevention of FASD



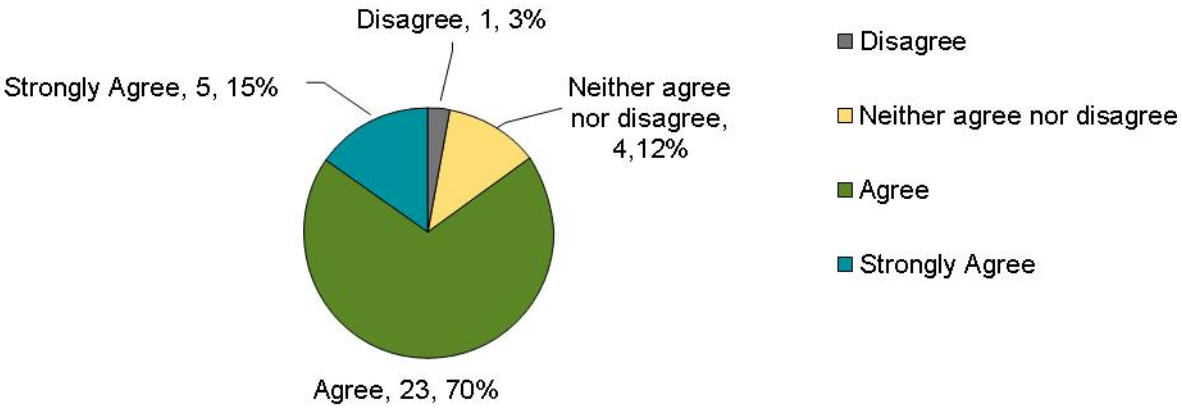
- 100% felt they had an opportunity to contribute on the day.

Figure 4: Opportunity to contribute on the day



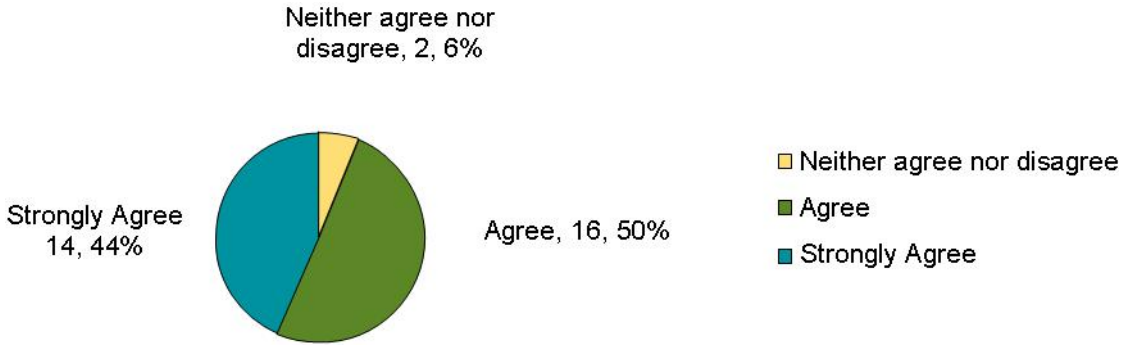
- 85% were satisfied with coordination of Model of Care implementation process.

Figure 5: Satisfaction with coordination of MOC implementation process



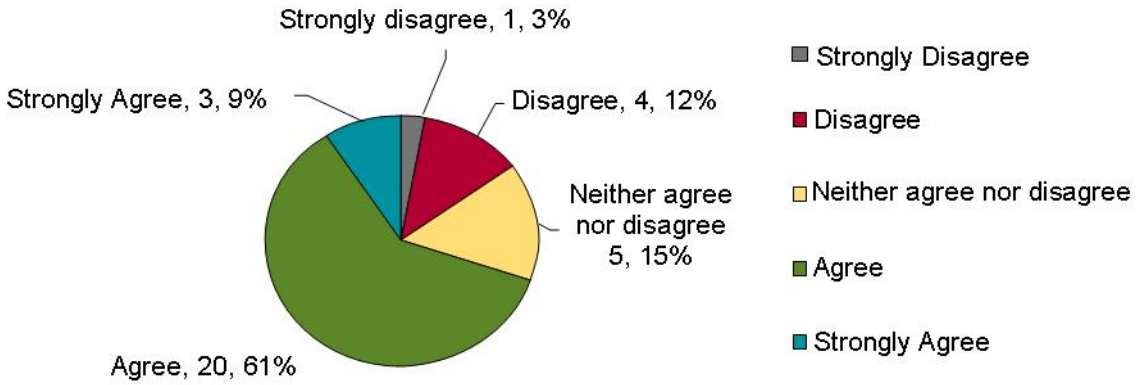
- 90% wish to continue participation in the implementation process through involvement in working groups.

Figure 6: Interest to continue participation in FASD working groups



- 70% SA/A there was sufficient time was allocated to each area for discussion; 12% disagreed and 15% neither agreed nor disagreed.

Figure 7: Sufficient time given for discussions



- The remaining three questions measured satisfaction levels regarding the venue and each received strong support.

Qualitative Data

Key themes identified as strengths from the Forum include the Chief Medical Officer's (CMO) opening presentation, group discussions and information sharing, the wide range of stakeholders present and the organisation and coordination processes behind the Forum. Some comments are grouped below.

- *"CMO's opening address provided good context and demonstrated commitment to the issue."*
- *"Organised groups worked well", "collaboration", "gathering of information", "robust discussion", "information sharing", "opportunity to participate, discuss, share information and prioritise", "acknowledgement for my input".*
- *"Wide variety of participants", "diversity of professionals", "great to hear other agencies views", "opportunity to engage with wide variety of agencies".*
- *"Pre-planning", "excellent organisation", "aligning and guiding discussion ok re: prevention and recommendations", "approach been taken", "got outcomes".*

The key theme identified to consider doing differently related to timing and the implication of this on the opportunities for discussion. Example comments demonstrating this feedback are listed below in addition to other items identified to do differently.

- *"Timing allocated to sessions throughout the day –tight program", "whole day", "more time for tasks".*
- *"Discussion was only the beginning", "more time to learn what others do", "invite submission as well was the forum", "opportunity to talk in detail about agency responses".*
- *"Bringing together metro and regional feedback"*
- *"More consumer representation"*
- *"Sound", "hard to hear some speakers"*
- *"Outline Model of Care", "the working parties that will be convened/an overview prior to targeting only one aspect", "Difficult keeping linear focus".*

The final qualitative feedback question provided participants an opportunity to note any other additional comments. Responses provided were similar to the examples listed below:

- *"Well done"*
- *"Useful"*
- *"Would like regular updates to go to all of group even if not on working groups"*
- *"Appreciate Health Networks leadership in getting cross-government commitment"*
- *"Thank you".*

5. Progressing implementation

The next stages in implementing the FASD MOC involve:

- The PCG finalising membership for each of the FASD Implementation Working Groups.
- Implementation Working Groups to convene from May.
- Draft Terms of Reference to be provided for group to endorse.
- Guidance will be provided to develop collaborative work plans for each working group and the MOC Implementation Plan.
- Each working group will develop strategies for the priority areas identified across the prevention continuum.
- A communication and engagement strategy will be developed to keep all stakeholders informed of the Implementation Working Groups' progress and new initiatives occurring across the sectors.

Appendices

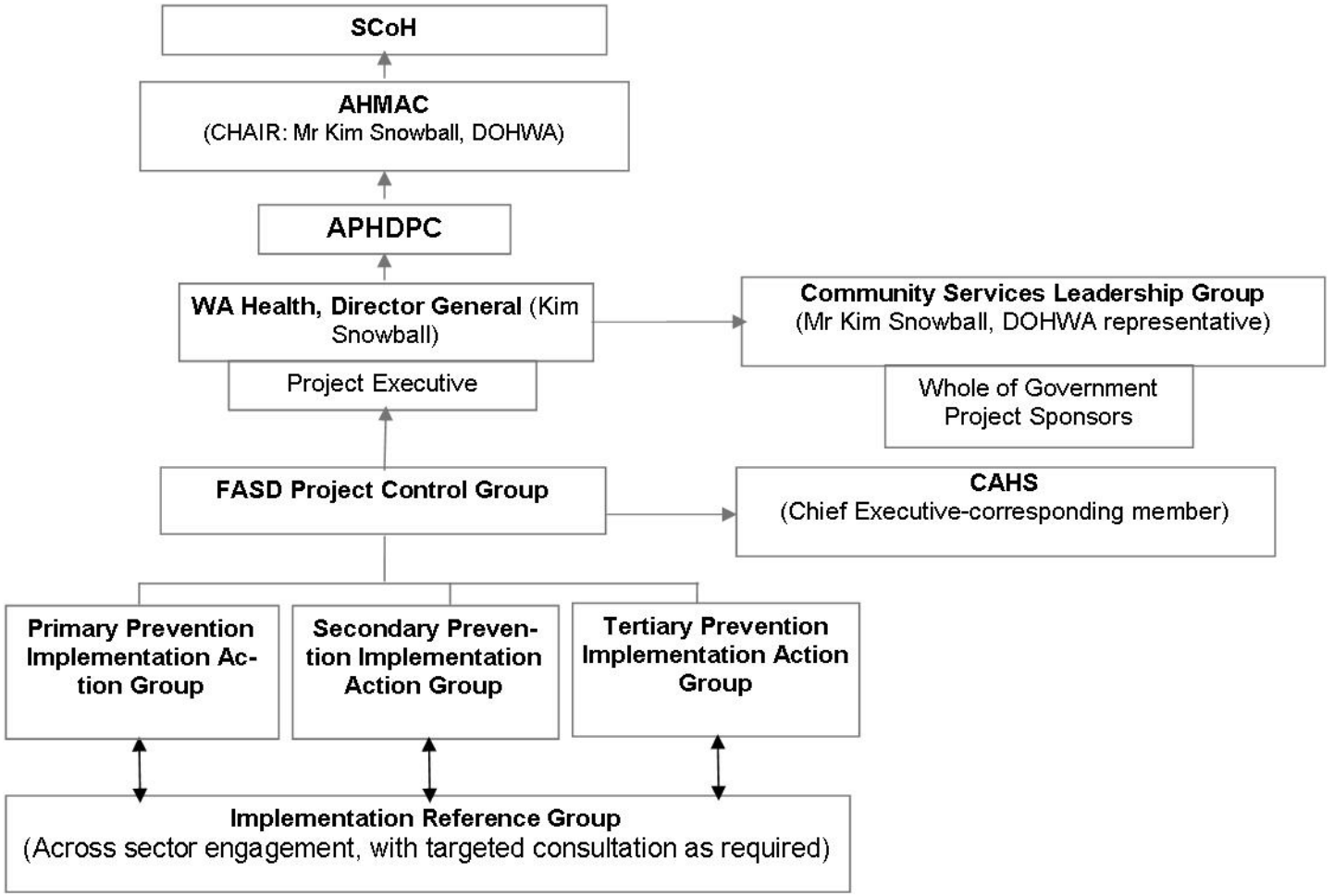
Appendix 1: Governance structure

Areas of Responsibility
National Committees
FASD Monograph
FASD Advice Paper
Inquiry into FASD

Areas of Responsibility

Leadership and oversight of the WA whole of government responsibility for the implementation of the FASD Model of Care

Areas of Responsibility
WA stakeholders responsible for the development of statewide and local strategies for the development of the FASD implementation Plan – 33 recommendations of the FASD Model of Care as mapped across continuum of prevention



Member Agencies on Project Control Group
Department of Health WA
Drug and Alcohol Office
Department of Education and Training
Department of Communities

Acronyms

AHMAC	Australia Health Minister's Advisory Council
APHDPC	Australian Population Health Development Principle Committee
FASD	Fetal Alcohol Spectrum Disorder
SCoH	Standing Council on Health

Appendix 2: Continuum of prevention of FASD

Continuum over Lifespan →

Stage of Health Continuum	***Well Population***	***At Risk of FASD***	***Diagnosis and Early Intervention of FASD***	***Management of FASD***
Level of Prevention & Management	**Primary Prevention**	**Early Detection of Risk Factors & Secondary Prevention**	**Disease Management & Tertiary Prevention**	
	▪ Promotion of healthy behaviours ▪ Safe drinking behaviours ▪ Planned pregnancy ▪ Alcohol free ▪ Promotion of healthy environments ▪ Universal approaches ▪ Social marketing/use of media ▪ Health education ▪ Regulation and legislation ▪ Targeted approaches ▪ Access to range of strategies to suit cultural & socioeconomic requirements	▪ Screening ▪ Drinking ▪ Surveillance & recall/ monitoring ▪ Periodic health examinations ▪ Early intervention	▪ Advice on options for management of FASD ▪ Acute Care ▪ Treatment ▪ Management of complications ▪ Surveillance & recall/monitoring ▪ Self Management	▪ Self Management ▪ Continuing Care ▪ Monitoring and recall ▪ Management of complications ▪ Education re minimisation of complications ▪ Rehabilitation
Relevant Recommendations	**1:** Public education & community action, responses to alcohol-related problems **2:** Prevent harmful alcohol consumption, responsible supply & service of alcohol. **3:** Reduce harmful alcohol consumption by youth, addressing risk factors, protective factors & resilience. **4:** Healthy behaviour practices & pre-conception care for females of child bearing years, abstinence from alcohol prior to pregnancy. **5:** Reduce unplanned pregnancy **7:** Information, all pregnant/families - substance use/risks associated with alcohol use during pregnancy, abstinence.	**8:** Protocols, using brief interventions -maternal alcohol use during pregnancy. **11:** Screen/manage alcohol withdrawal for pregnant women. **13:** Opportunistic alcohol consumption screening, all women of child-bearing age +interventions. **14:** Universal screening in pregnancy (first antenatal visit & each trimester) & interventions. **19:** Include screening in child health nurse screening assessments of children in DCP care.	**16:** Identify at risk newborns/children for further screening/FASD assessment. **17:** Refer suspected FASD to appropriate assessment & intervention services. **20:** Develop clinical pathways for screening &/or assessment of children of mothers attending D&A treatment services. **23:** Multi-disciplinary FASD diagnostic service for CDS children. **26:** Scheduled visits/telehealth by metro based FASD assessment team to support regional centres.	**21:** Magistrates/juvenile justice officers support potential FASD clients. **28:** Treatment programs -support child/environment & support systems - child's potential/modify secondary effects. **31:** Channels of agreed & confidential communication, all sectors any FASD diagnosed child.
Intervention Objective		**Prevent movement into the "a risk" group**	**Prevent progression to established disease and hospitalisation**	**Prevent/delay progression to complications and prevent re-admissions**

Enablers: Each stage requires critical assessment and coordination of research, data surveillance & linkage, workforce training & development, service delivery & clinical pathways.

Enablers: Each stage requires critical assessment of workforce requirement, resource allocation, data requirements, evidence base for intervention (incl. cost effectiveness), quality measures, guidelines and standards, monitoring & evaluation, roles & responsibilities (Commonwealth/State), public/private, equity impact, consumer involvement, etc…	
Research	**33:** Research -accurately determine prevalence, specific communities/regions & changes in prevalence over time.
Data surveillance and linkage	**15:** Routine data collection alcohol use during pregnancy & annual reporting in WA Perinatal Statistics Report. **32:** Data linkage ability all sectors -record, evaluate & share health/other needs & service access of FASD individuals.
Workforce training and development	**25:** Workforce training & development in FASD diagnosis, staff in regional centres. **30:** Training & education to all relevant health professionals -alcohol use, FASD & healthy behaviour change.
Service delivery and clinical pathways	**6:** Access antenatal & maternity services, disadvantaged groups. **9:** Collaboration -GPs, maternity & newborn service providers, Alcohol & Drug services -ensure comprehensive Alcohol & Drug maternity services, including rural & remote regions. **10:** Gaps -provision of antenatal care for women with alcohol-related dependency + state-wide protocols/streamlined process -accessing maternity services. **12**: Refer pregnant & post-partum with alcohol-related dependency to services -parenting &child &family wellbeing. **18:** Initiate consultation by Department of Health -screening into Medicare-funded child health checks & develop clinical pathways/referral protocols. **22:** FASD education resources & services appropriate for individual communities. **24:** Clinical pathways, joint FASD assessment + other relevant health services/agencies. **27**: Map referral pathways/existing clinical services & family support, identify gaps + develop resources.
Coordinated implementation strategies	**29:** Inter-agency FASD steering group + reference group.

Appendix 3: List of attendees at the Forum

	First name	Surname	Organisation
1	Michelle	Atkinson-De Garis	Consumer
2	Revle	Bangor-Jones	Public Health Division, DOHWA
3	Lisa	Bastian	Communicable Disease Control Directorate, DOHWA
4	Carol	Bower	Telethon Institute for Child Health Research (TICHR)
5	Frances	Cadden	Coolibah Medical Centre
6	Llinos	Chapman	Aboriginal Maternity Services, DOHWA
7	Catriona	Coe	Department of Education
8	Julie	Dixon	Department for Child Protection
9	Kate	Gatti	Clinical Lead, Child Youth Health Network
10	Denese	Griffin	North Metropolitan Area Health Service, DOHWA
11	Kim	Hawkins	West Coast Institute of Training
12	Mindy	Horseman	State Child Development Centre
13	Iren	Hunyadi	Consumer
14	Wynne	James	Mental Health Commission
15	Kim	Johnson	Ngala
16	Heather	Jones	Telethon Institute for Child Health Research (TICHR)
17	Gary	Kirby	Drug and Alcohol Office (DAO)
18	Bruce	Loo	Aboriginal Health Division, DOHWA
19	June	Lowe	Alison Xamon MLC Office
20	Nicole	McCartney	Aboriginal Health Division, DOHWA
21	Anne-Marie	McHugh	Aboriginal Health Council WA (ACHWA)
22	Sarah	McKerracher	Health Networks Branch, DOHWA
23	Joanne	Mizen	Child and Community Health, DOHWA
24	Karina	Moore	Health Networks Branch, DOHWA
25	Fraser	Moss	Department of Corrective Services
26	Ailsa	Munns	Curtin University
27	Raewyn	Mutch	Child and Adolescent Health Service, DOHWA
28	Sharon	Nowrojee	Fremantle Hospital
29	Angela	O'Connor	Women and Newborn Drug Alcohol Service, KEMH
30	Hayley	O'Connell	Department of Sport and Recreation
31	Colleen	O'Leary	Curtin University
32	Dionne	Paki	Drug and Alcohol Office (DAO)
33	Jan	Payne	Telethon Institute for Child Health Research (TICHR)
34	Kristie	Ponchard	St John of God
35	M	Rimes	Department of Education
36	Anne	Russell	Russell Family Fetal Alcohol Disorders Association (RFFADA), QLD
37	Anne	Simpson	Department of Education
38	Naomi	Smith	Health Networks Branch, DOHWA
39	Julie	Spratt	Drug and Alcohol Office (DAO)
40	Annie	Thomson	Department of Culture and The Arts
41	Simon	Towler	Chief Medical Officer, WA Health
42	Alison	Turner	Department of Education
43	Rochelle	Watkins	Telethon Institute for Child Health Research (TICHR)
44	Sarah	Weightman	Armadale Health Service, DOHWA
45	Jenni	White	North Metropolitan Area Health Service, DOHWA

	First name	Surname	Organisation
46	Belinda	Whitworth	Health Networks Branch, DOHWA
47	Amanda	Wilkins	Koondoola Child Development Centre
48	Carmel	Wilkinson	Department of Communities
49	Coralie	Wright	Department of Indigenous Affairs
50	Ruth	Young	Health Networks Branch, DOHWA

Appendix 4: Forum program

FASD Model of Care Implementation Forum

Child and Youth Health Network

Wednesday, 22 February 2012
Time 8.45am – 12.00pm
Swan Room, Burswood on Swan, 1 Camfield Drive Burswood

Program

8.15 – 8.45	**Registration**	**Swan Room**
8.45	Introduction and Housekeeping	Karina Moore – Facilitator Senior Development Officer, Health Networks Branch
8.50	Welcome to Country	Kim Collard, Director, Kooya Consultancy
9.10	Opening Address Overview of the development of the FASD MoC	Dr Simon Towler, Chief Medical Officer Gary Kirby, Director, Prevention and Workforce Development, Drug and Alcohol Office.
9.30 am	Introduction of mapping session	Karina Moore – Facilitator
9.35 am	Mapping session	All
10 am	**Morning Tea**	**Swan room**
10.30 am	Gapping session	All
10.45 am	Prioritising and strategising session	All
11.15 am	Feedback of priorities to the floor	All
11.30 am	Wrap up and evaluation	Kate Gatti, Lead Child and Youth Health Network, WA Health Gary Kirby, Director Prevention and Workforce Development, Drug and Alcohol Office
12.00pm		**Close**

Appendix 5: Presentation slides from the Forum

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Department of Health

WA FASD Model of Care Implementation Forum
22 February 2012

Organised by the
FASD Project Control Group and Health Networks Branch,
Department of Health WA

Facilitator: Karina Moore, Senior Development Officer, Health Networks

Delivering a **Healthy WA**

Today's Program

8:15-8:45 Registration
▪ Welcome to Country ▪ Opening address ▪ Mapping session
10:00 - 10:30 Morning Tea
▪ Gapping session ▪ Interest groups –prioritising and strategising ▪ Feedback of priorities
11: 30 -12 noon Closing Address
▪ Evaluation

Delivering a **Healthy WA**

Government of Western Australia
Department of Health

Welcome to Country

Kim Collard

Delivering a **Healthy WA**

Government of Western Australia
Department of Health

Response to Welcome to Country

Kate Gatti

Delivering a **Healthy WA**

Government of Western Australia
Department of Health

Opening Address:
Where are we at?

Dr Simon Towler
Chief Medical Officer / Chair of the FASD Project Control Group

Delivering a **Healthy WA**

Setting the scene

- Complex but **entirely preventable** condition
- National level
- Parliamentary inquiries
- WA Health -Model of care
  - Prevention focus
  - Partnerships & collaboration
- Implementation plan
  - Whole of Government approach
  - Governance structure

Delivering a **Healthy WA**

FASD Monograph

- Provides an update:
  - current research, policy & practice
  - Australia wide
  - WA Leading state
  - Whole of population issues
  - Target approaches for at risk groups
  - Coordinated whole of government responses (> health) to prevention, diagnosis/screening & data collection.
- Written by FASD experts across Australia
- Aligns with directions of FASD Model of Care

Parliamentary Inquiries

- **Commonwealth** House of Representatives standing committee on social policy and legal affairs
  - Focus areas: prevention strategies, intervention needs
    & management issues
- State Education & Health Standing Committee - improving educational outcomes for all ages.
  - Item 5: prevalence, prevention, identification, funding and treatment of FASD in WA
  - To improve education, social & economic outcomes

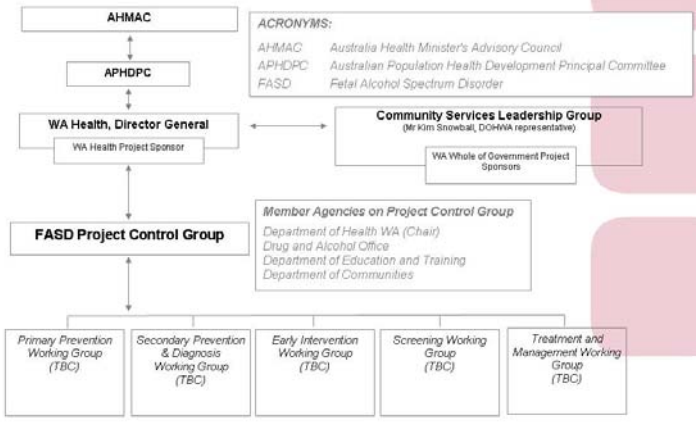
FASD Model of Care

- Published March 2010, Child and Youth Health Network, WA Health
- Multi agency working group
- Aligns with national directions
- Implementation phase
  - Whole of government & across sector collaborations
  - Focus on prevention

Health Networks

Connecting people together across boundaries to share ideas to improve the lives of all West Australians through a process of understanding, humility and respect.

Governance structure



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Opening Address:
Model of Care

Gary Kirby
Director, Prevention & Workforce Development, Drug and Alcohol Office

Overview

- Model of care 2010
- 33 recommendations, align with national agenda
- More than health involvement to implement 33 recommendations
- Focus is on prevention
- Working groups will inform the development and implementation of state-wide strategies to prevent FASD

Who participated

Gervase Chaney - Co-chair and Network Lead, **CYHN/Postgraduate Medical Education, PMH**
Gary Kirby - **DAO**
Anita Banks **- Regional Paediatrician**, WACHS -Pilbara
Susan Bradshaw - **Child and Adolescent Community Health**
June Councillor **- Communities WA**
Kym Crawford - **Department of Education and Training**
Heather D'Antoine **- Telethon Institute for Child Health Research** (TICHR)
Carly Dolinski - **Mental Health Division**
Francine Eades - **Aboriginal Health Council of WA**
Liz Everard - Mental Health Division
Erin Gauntlet - **Child and Adolescent Health Service**
Trish Heath - Office of the **Commissioner for Children and Young People**
Claire Henderson - **Women's and Newborn Drug and Alcohol Service, KEMH**
Mindy Horseman - **State Child Development Centre**
Penelope Jackson - WANDAS Clinic, KEMH
Anne Mahony - **Population Health, WACHS** – Goldfields
Raewyn Mutch **- Paediatrician** + TICHR
Lesley Nelson - **NMAHS Public Health Unit , Aboriginal Health**
Colleen O'Leary - TICHR
Tony Romanelli - Department of Education and Training
Bev Stone - **Office of Aboriginal Health**
Jill Watson - Child and Adolescent Health Service
Julie Whitlock - **Consumer representative, Health Consumers Council of WA**
Amanda Wilkins - Community Paediatrician, Child Development Service

FASD Model of Care Implementation to date

- **2010: Wrote & published FASD MOC**
- **2011: drafting MOC Implementation Plan**
- **June 2011: Implementation Plan meeting**
  - CMO & Networks staff
  - DAO
  - CAHS
  - Other AHS
  - Public Health & Epidemiology
- **Aug - Dec 2011:FASD PCG meeting, 4 key agencies**
  - Greater focus on prevention
  - Across Government involvement –CSLG sign off
  - EOI to establish working groups
- **February 2012 forum:**
  - Bring everyone together to map, gap and prioritise
- **April 2012: FASD Implementation Working Groups**
  - Working groups to develop and implement specific plans from outcomes of today

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Phase One Mapping

Karina Moore

Phase One - Mapping

- Session outcome: document current activity across all sectors
- 33 recommendations for action fit across continuum of prevention
- Prevention: Primary, Secondary, Tertiary
- Rotating through 3 stations
- Enabling issues
- Mapping the initiatives you're involved in:
  - What are you doing?
  - Who's leading it?
  - Where is it occurring, is it applicable statewide?
- Involvement of Country based stakeholders

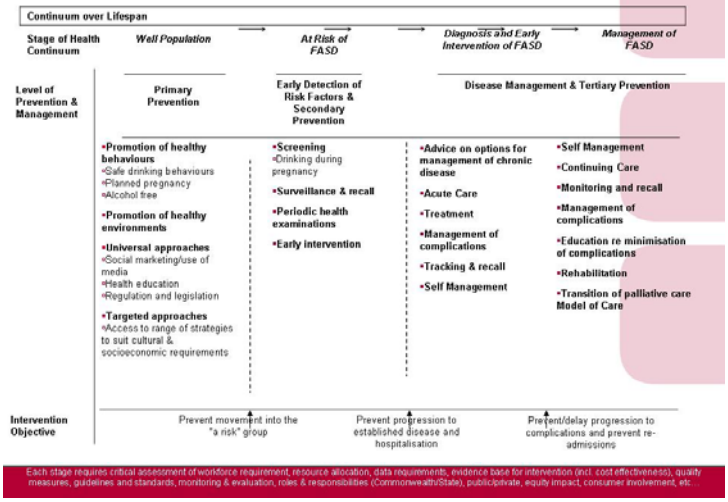
Phase One - Mapping
Definitions of Prevention

- **Primary Prevention**: Prevent scenarios where pregnant women consume alcohol/women don't know they are pregnant.
  - Promoting health behaviours and environments
  - Education & community attitudes
  - Universal approaches + targeted approaches to vulnerable groups.
- **Secondary Prevention**: Reduce the risk of alcohol related harm to the fetus.
  - Screening & periodic health examinations
  - Early interventions to reduce risk & impacts of alcohol related harm
  - Surveillance & recall
- **Tertiary Prevention**: Identifying and preventing progression of complications resulting from alcohol related harm
  - Includes diagnosis, early intervention, acute care, self management, management of symptoms/access to support services.

Enablers

- **Considerations across the continuum of prevention:**
  - **Research**
  - **Data surveillance and linkage**
  - **Workforce training & development**
  - **Service delivery and clinical pathways**
  - **Coordination**

Continuum of Prevention



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Morning Tea Break

- Consider what you've seen and heard so far
- Chat to others
- Are other people doing similar things to you?
- What colour dot is on your name tag?
- Anything you need to place in the issues parking bay?

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Phase Two Gapping

Karina Moore

Phase Two - Gapping

- Session outcome: identify what & who is missing/still needed
- Assemble in allocated group at relevant station
- Review what initiatives have been mapped at your stations & the stakeholder list
- Is there anything not on there you are aware of?
- Are there things that need to be on there but aren't in existence?
- Who else should be in your prevention group (may or may not be here today).
- What initiatives can be applied to other regions/statewide?

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Phase Three Prioritising & Strategising

Karina Moore

Phase Three – Prioritising & Strategising

- Session outcome: top 3 priorities for your prevention area
- Consider what has been mapped and what has been identified as gaps
- **What** are the priority issues for action
- What strategies can be developed to address these priority issues –**How**
  - **Enabling factors**
- **Who** are the key agencies to drive these strategies
  - Broader support across sectors

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Feeding back your priorities

Karina Moore

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Wrap up & evaluation

Gary Kirby & Kate Gatti

Wrap up & evaluation

- Call to action
- Indicate your intention to continue in Working Groups
- Diversity of participation here, including research
- Importance of translating research into policy, practice & evaluation
- Where to from here
  - Summary document of outcomes
  - Video conference with country stakeholders (mid-March)
  - Communications strategy
  - Finalisation of working group membership (late march)
  - Working groups commence April.
- Evaluation forms

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Close

Thank you for coming. Your participation is appreciated.

Additional questions and feedback? Contact Sarah McKerracher at Health Networks Branch

Appendix 6: Collated information from mapping exercises

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
Community resources & education	▪ Building partnerships between Indigenous communities & government service providers to prioritise community needs & develop agreed plans for service development/implementation. ▪ FASD information resources – schools, health professionals, doctors surgeries. ▪ Physician and GP training to educate community. ▪ Community education & public action workshops. ▪ Population specific resources. ▪ Brain development DVDs. ▪ Nutrition workshops –harms of alcohol. ▪ Held a community workshop attended by ~ 50 people from the community and various health professionals for those interested in learning about FASD. ▪ Information kits for schools and health professionals. ▪ Chocolate slogans attached to FASD information flyers. ▪ 20 FASD information kits to schools and doctors surgeries. ▪ Flash mobs – pregnant pauses for 90 seconds in shopping centres and then information on FASD were distributed via business card sized flyers. ▪ Has an emphasis on using Core of Life in schools and FASD education is part of this. We have commenced with the year 8's at Kalgoorlie-Boulder Community High School. ▪ Antenatal education about alcohol (Boodjarri Yorga Aboriginal Antenatal Program). ▪ Community Based Education	▪ Indigenous communities and government service providers ▪ Community members ▪ Health professionals ▪ E.g. indigenous resources; CALD groups ▪ Schools / Teachers to encourage	▪ DIA ▪ TICHR ▪ Aboriginal Community Antenatal Program (ACAP) ▪ Community Health Nurses – Aboriginal Antenatal Program. ▪ CHNs and Health Promotion Officers ▪ Noongar radio

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
	(discuss impact of alcohol on the foetus during pregnancy and discourage use). ▪ Alcohol programs using powerful messages to promote dangers. Also all radio stations can be used to promote dangers. Also all dangers of alcohol during pregnancy. ▪ SDERA state strategy for drug education in schools (including alcohol abuse). We offer education, aims to prevent and reduce drug related harm through school populations. We do this through WA education and early intervention to assist staff to educate students and support.		
School education	▪ Prevention messages. ▪ Performing arts activities that involve young children learning risks of alcohol through creative methods. ▪ Information kits. ▪ Parents & kids school education. ▪ Resources & training for school staff to support practice and local communities & recognise students in need of support. ▪ School curriculum -resource production to educate, build resilience & reduce harm from alcohol use through promotion of protective vs risky lifestyle factors. ▪ K-10 syllabus curriculum for schools re: sexual risk taking. ▪ 'Get the Facts' program, holistic development, statewide program. ▪ Implementation of Tobacco and Alcohol Brief Intervention Policy. ▪ Paul Dillon is great and has wrote books educates students by working in schools, however SDERA works with schools and does just as good work just not known for what they achieve.	▪ High school students/young people ▪ Young children ▪ School staff, all regions of WA ▪ School staff	▪ RFFADA ▪ Healthways and DCA ▪ National Drug Research Institute (NDRI) ▪ SDERA ▪ COPD and AOD coordinators / Public Health ▪ Paul Dillon

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
Community action	▪ Flash mobs –none for nine campaign. ▪ Identify links between Liquor Accord strategies and FASD prevention. ▪ Opportunistic FASD awareness raising using media and newsletters. ▪ Strong Spirit Strong Future; Promoting Healthy Women and Pregnancies Community Grant (in application process).	▪ Community members, in public spaces – e.g. shopping centres, town malls.	▪ NOFASARD ▪ AOD coordinator and Local Government with police and licenses. ▪ NGO's and Local Government and community advocates ▪ Midwest Community Drug Service Team (MWCDST)
Attitudes to alcohol	▪ Alcohol related health promotion messages/education via radio. ▪ Community education and public action workshops. ▪ Alcohol free entertainment and events. ▪ Building connections between schools and local communities through involving parents input for communications around alcohol and other drug addicted children – build resilience. ▪ Prison Health program – support/mentor women upon release into the community regarding alcohol use. ▪ Mind Matters/Kid Matters programs. ▪ Positive Parenting Program ▪ Programs/services to engage youth in healthier behaviours (e.g. sport & recreation) rather than risky behaviours such as alcohol, drugs, crime etc). ▪ Health Promotion training – training health/welfare workers, preventing antisocial behaviour in at risk groups through engagement in courses & promoting well-being. ▪ Programs to work together to	▪ Metro based Aboriginal listeners ▪ Community members ▪ Parents of school children/local community members ▪ Women in prisons nearing end of sentences ▪ At risk young people ▪ Training of nurses & welfare workers ▪ Disengaged youth ▪ Aboriginal academy focus	▪ Noongar FM ▪ South Metropolitan Public Health Unit ▪ DSR ▪ West Coast Training Institute ▪ NMAHS COAG initiative and Aboriginal Health Unit/NMAHS Aboriginal Maternity Group Practice. ▪ AOD, DAO support and Local Government.

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
	create, research & develop/deliver education information to assist families on alcohol. ▪ Provides prevention initiatives. ▪ Integration of FASD awareness into Alcohol Management Plan Strategies that are being implemented in Collie and Manjimup. ▪ Advocate for inclusion of FASD awareness strategies at SW Leavers Dunsborough.	▪ Aboriginal men, women and children	▪ WACHS –SW representation on SW Leavers planning group meetings
Alcohol availability	▪ Identify links between Liquor Accord strategies and FASD prevention. ▪ Remote Service Delivery (RSD) Priority communications –building capacity in local communities to identify & address priority community issues (Alcohol and other drug). ▪ Responsibility Service of Alcohol Training. ▪ Responsible management of alcohol program in sport & recreation clubs.	▪ Remote Indigenous communities ▪ All hospitality training students ▪ Community sport & recreation clubs	▪ AOD coordinator and Local Government with police and licenses ▪ DIA ▪ Commonwealth and State Government partnerships ▪ West Coast Training Institute ▪ DSR
Promotion of pre-conception care and planned pregnancy (nb –many programs overlap with community & school education)	▪ GP prenatal counselling, health checks, reducing unhealthy behaviours. ▪ Family therapy –usually involving whole family –opportunity to intervene & advocate for healthy lifestyles. ▪ K-10 syllabus curriculum for schools re: sexual risk taking. ▪ 'Get the Facts' program, holistic development, statewide program. ▪ Recreational & community Families program –peer led family support/education program re: alcohol consumption by pregnant women. ▪ Evaluated Sexual Health and Blood Borne Virus Program. Includes: youth website,	▪ Women at child bearing age ▪ Women at risk of unplanned pregnancy/risky sexual behaviour/risky alcohol and other drug consumption ▪ K-10 and training of teacher ▪ Youth focus ▪ Halls Creek community members ▪ Youth -14-17 years	▪ GP ▪ Family counselling ▪ Other primary care service providers ▪ DOE ▪ Curtin University ▪ CDCD, DOH ▪ CDCD and DAO

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
	information, Unsafe sex/risky behaviour/decision making skills acknowledged. ▪ Hard resources and website re: cross-over/nexus of risky alcohol/drugs and sexual health. ▪ Curriculum to support materials growing & developing healthy relationships (online resources). ▪ Education programs in schools to mothers of young children & education for nurses. ▪ Hey Dad Antenatal class –alcohol consumption for dads & mums. ▪ Model of Maternal & Child Health for the ACCHS (endorsed by ACHWA & CMO). ▪ Contraception and Baby Think it Over programs. ▪ Talk Soon Talk Often –Parent & Families (sexual development program). ▪ Nutrition workshops – no alcohol. ▪ Parent support programs Group-community family Group. ▪ Pregnancy packs. ▪ Health Promotion- television. ▪ Community education by GPs. ▪ Antenatal program – use FASD doll to talk to identified at risk women about FASD.	▪ Teachers ▪ Mothers of young children & nurses ▪ Dads ▪ Statewide ▪ Metro and rural regions ▪ Halls Creek	▪ CDCD and DOE ▪ CHNs ▪ Ngala ▪ ACCHS ▪ NM Network ▪ Ngala ▪ RACGPs ▪ Edith Cowan University (ECU) ▪ GPs
Workforce education	▪ Physician and GP education. ▪ CDS – across metropolitan area, talk to families and have a conversation with client groups/parents about promotional material at pregnancy exhibitions State-wide training of staff to begin conversations on FASD. ▪ GP education, training, exams. ▪ Pre-service education for child and school health nurses. ▪ Build capacity amongst NGO's to develop FASD awareness including GP divisions where possible.	▪ GPs ▪ Family counsellors ▪ Primary care service providers ▪ Nurses/welfare workers	▪ Professional education associations –e.g. RACGP ▪ Curtin University ▪ GP divisions, Mission Australia, Investing in our youth, Womens' health and SW youth coordinating network, SW CDST. ▪ RFFADA

Primary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
Reduce unplanned pregnancy	▪ Contraception – 'Baby Think it Over'. ▪ Education of community. ▪ Talk soon Talk Often. ▪ Nutrition workshops – no alcohol, metro and rural. ▪ Parent support- group, Community Family Group Halls Creek. ▪ Pregnancy Packs. ▪ Television. ▪ GP Education.		▪ NM Network ▪ GP networks ▪ Parents and Families, Sexual development, Statewide ▪ Ngala ▪ RACGP ▪ Health Promotion ECU
Substance use and the risks	▪ Great southern Aboriginal Health services run an antenatal program. They use a FASD doll to talk to identified at-risk women about FASD as part of their antenatal visits. They are also planning on running some FASD educational sessions for all Aboriginal women in the region by the end of the year. ▪ Has 'Grandmothers' who are employed to provide cultural learning/advice/yarning education to women and their families/partners that included drug and alcohol. ▪ Community antenatal care program. Working with GP divisions. ▪ Kwinana Rockingham GP division. Aboriginal focused antenatal care. ▪ Prevention of pre-natal alcohol exposure health promotion messages developed by K France ECU for television media. ▪		▪ Great Southern Aboriginal Health Services ▪ NMAHS ▪ SMAHS ▪ Moodjit Koort

Secondary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
Brief interventions of maternal alcohol use	▪ GP website. ▪ Stork database ▪ There should be an audit for pregnancy. ▪ 'Audit C'. ▪ Database should be contacted twice during pregnancy, make use of resources we have. ▪ 'Better Start Initiative' – no alcohol inclusion from the beginning. ▪ 'Healthy for Life'. ▪ Key Aboriginal Advisory Group. ▪ Paul Dillon is great and has wrote books educates students by working in schools, however SDERA works with schools and does just as good work just not known for what they achieve. ▪ Alcohol programs using powerful messages to promote dangers. Also all radio stations can be used to promote dangers. Also all dangers of alcohol during pregnancy. ▪ GP may do an audit or may not, its doctors own choice. Need a standardised tool. ▪ Need to provide seminars around alcohol to GP. To show how important an audit can be that it's vital for children's development. NHMRC guidelines ▪ True Care True Culture (TCTC)		▪ Aboriginal Health Organisation ▪ Mary G ▪ Paul Dillon, SDERA ▪ Noongar radio ▪ GPs ▪ Health Education Network ▪ TCTC Nurse and Aboriginal Liaison Officer (ALO)
Screening and managing alcohol withdrawal during pregnancy	▪ 'Next Step' – depending mothers KEMH. ▪ All need to watch out for alcohol during pregnancy and audit, encourage expecting mothers to withdraw for unborn baby's health and safety. ▪ School drug and alcohol awareness WA state strategy for drug education in schools (including alcohol abuse). We offer education, aims to prevent and reduce drug related harm through school populations. We do this through WA education and early intervention to assist staff to educate students and support. ▪ Run an antenatal program. They use		▪ WANDAS ▪ Aboriginal Drug Services ▪ Child Health services ▪ Midwives ▪ Great Southern Aboriginal Health Services

Secondary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
	a FASD doll to talk to identified at-risk women about FASD as part of their antenatal visits. They are also planning on running some FASD educational sessions for all Aboriginal women in the region by the end of the year. ▪ In routine antenatal care, prompt to ask in the MR220 hand held pregnancy record about alcohol consumption.		
Opportunistic screening women child baring age/alcohol use	▪ Should be encouraged. ▪ Indigenous people / lower class who are more liable to be target harm. ▪ Mostly already pregnant its almost too late, need education to prevent unexpected pregnancies but to screen for these so that aware of alcohol consumption before pregnancy occurs so doctors / nurses are aware of risks during pregnancy. ▪ Area needs development. Brief interventions 'Audit C'. ▪ DAO co-educational Aboriginal FASD project. ▪ Early education on young teenagers. ▪ Overall momentum is its reality needs to be changed. ▪ Community Child Health. ▪ Implementation of Tobacco and Alcohol Brief Intervention Policy.		▪ TICHR ▪ CDS ▪ COPD and AOD coordinators / Public Health
Screening assessments of children by child health nurses	▪ In routine antenatal care, prompt to ask in the MR 220 hand held pregnancy record about alcohol consumption. ▪ Routine screening in prisons. ▪ WACHS – only admitted patients ▪ During antenatal. ▪ Pregnancy hand held record. ▪ Look at the Lip, lift the Lip. ▪ North and South Metro do ask during visits. 'New Direction Program' ▪ Life scripts for GP's. ▪ WANDAS do. ▪ No standard question but it is been encouraged. ▪ It needs more training ▪ Submission was made but was		

Secondary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
	knocked back, need to make it happen. ▪ Assessment of physical and psychological needs. ▪ GP's may ask but just no process. ▪ Train CHN to screen with digital photo. ▪ Screen Lip, train guidelines. ▪ Observation and clinical judgement. ▪ All are aware of the symptoms of FASD and have access to the materials from TICHR so will discuss alcohol use in subsequent pregnancies and breastfeeding. ▪ Increased contact with pregnant women antenatally. ▪ Provision of more culturally appropriate, accessible antenatal education and advocacy. ▪ Child Health Checks.		▪ CHN at Community Health ▪ Community Midwife and Aboriginal Maternal Support Worker just recruited ▪ CHNs (happens in Carnarvon Hospital)

Tertiary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
Identify at risk newborns/children for further assessments	▪ Consultation and resource development. ▪ Child Health Checks.		▪ DAO ▪ CHNs
Refer suspected FASD children for diagnosis and intervention	▪ Early brain development program and indigenous in progress. ▪ Referral pathway – Community Health. ▪ Operational Directive risk assessment and referral. Funding for paediatrician not commenced. ▪ Best Beginnings Program and Indigenous specific universal enhanced schedule. ▪ School education and awareness in progress. ▪ Schools.		▪ Ngala – Universal ▪ KEMH / all maternity ▪ AMSSU ▪ DCP and DOH ▪ SDERA ▪ DAO
Clinical pathways for screening and assessment	▪ Universal home visit and screening at risk developmental children.		▪ CACH
Multidisciplinary diagnostic service	▪ Knowledge only resource is an issue. ▪ Survey of DSC staff. ▪ WA inform/ values/ attitude ▪ Referral and Pathway.		▪ OVAHS – Kununurra and Tenant Creek ▪ TICHR ▪ CDS FASD working group
Support for FASD in justice sector	▪ Lectures to Clinical Psychologists. ▪ Dedicated team for Children's Court – item chapter and paragraph in bench book / Magistrates/Judges and recognition of FASD / Schedule of visits/ screening up to 5th year. Limited Resources.		▪ Mental Health Commission (MHC)
Treatment programs/services to support needs of child/foster development potential	▪ National diagnostic tool in development and communities – FASD book for services and parents. ▪ Resources/ Facebook/website. ▪ Memorandum of understanding for working collaboratively.		▪ TICHR ▪ RFFRDA ▪ CDS and Neurosciences working collaboratively
Support regional	▪ Use Telehealth MDI.		▪ WANDAS

Tertiary Prevention			
Mapping themes	**What**	**Target audience**	**Who**
areas	▪ Follow up of children in community issues. ▪ KEMH. ▪ Follow up outcomes.		▪ CACH - Aboriginal team ▪ WANDAS ▪ Fitzroy Crossing project

Enablers			
Mapping themes	**What**	**Target audience**	**Who**
Research	▪ Fitzroy Valley Lilliwan Project – Carol Bower. ▪ Knowledge attitudes, justice system. ▪ Foster carers. ▪ TICHR – Research program of FASD. ▪ Curtin University– Alcohol Research Program. ▪ KEMH and WADAS – research project on women using substances. ▪ WA Register for Anomalies and counts FASD. ▪ DCP Best Beginnings expanded across state. ▪ SDERA - What is produced is backed by research. ▪ TICHR – research is there main focus. Getting some interesting information from foster carers. ▪ West Coast students may do some as part of an assignment or study, however up to individual. ▪ Curtin students are very active in research area, looking at data and outcomes. ▪ Ngala base there work on research. ▪ NMAHS – ongoing evaluations, area health services, anti-natal clinics. ▪ Aboriginal Alcohol and Drug Services – range of services and out reach programs to community, lots of development. ▪ FARE → FASD 2012 TICHR Corrective Services survey to look at knowledge/attitudes/practice and needs in area of FASD – good buy in. ▪ Access to grant money (with ethics) – DCP → screening and assessment of children coming into care. → foster carers → what resources/want & need → strategies.	▪ Justice system ▪ Foster parents ▪ Women using substances ▪ Services evaluation/ program development (e.g. Area Health Services, SDERA, Ngala)	▪ KEMH ▪ WADAS ▪ DCP ▪ Tertiary students ▪ Program/service evaluators ▪ FARE

Enablers			
Mapping themes	**What**	**Target audience**	**Who**
Data surveillance and linkage	▪ WANDAS. ▪ Stork Database captures Developmental Fetal Anomalies. ▪ WANDAS Team – data surveillance and reporting. ▪ TICHR – not directly but hoping to start in the future. ▪ National data. ▪ Midwives ask but not encouraged to record which could be beneficial for future issues. ▪ Access to WA datasets –e.g. for last 10 years. ▪ Health records –linking between mothers and children.		▪ WANDAS ▪ TICHR ▪ WA Health data linkage teams ▪ CDS
Workforce training and development	▪ Educating Aboriginal Health workers in maternal and child health about FASD. ▪ Strong Spirit Strong Future: Promoting Healthy Women and Pregnancies Training – Plus development of Flipchart. ▪ Programs developed for whole school approach on evidence-based research. ▪ CDS (CACH) – Statewide Training of staff and this is actioned by government departments then Telehealth and other country services. No funding for this. ▪ All CHNs at CACH are aware of the symptoms of FASD and have access to the materials from TICHR so will discuss alcohol use in subsequent pregnancies and in breastfeeding. ▪ Self directed learning package on approaching this type of screening. ▪ Ngala – community training. ▪ Training for working with indigenous people (see development). ▪ West Coast – training future nurses, welfare workers, mental health workers. FASD is perhaps not strongly recognised but may be used in health promotion and projects with industry.	▪ Aboriginal workers ▪ Maternal and child health workers ▪ CHNs ▪ Teachers ▪ Health professionals ▪ Community workers/ social service providers and program deliverers (e.g. drug and alcohol services, Justice sector, education institutions, GPs, school psychologists, sexual health clinics) ▪ Medical students ▪ All PMH staff	▪ DAO ▪ CDS ▪ SDERA ▪ Ngala ▪ Curtin University ▪ Training institutions (i.e. West Coast) ▪ AHS ▪ TICHR ▪ WANADA ▪ RFFADA

Enablers			
Mapping themes	**What**	**Target audience**	**Who**
	■ AHS – Sexual health teacher training. Family Planning WA. WA Health Education Services. Online and face-to-face training. ■ Aboriginal Alcohol Drugs Services – range of services and outreach program to community, development. ■ Training by TICHR of health professionals/community workers. ■ RFFRDA training programs in partnership with Training Connections Australia: developed and delivering training on FASD in Australia aimed at any and all service providers, individuals and workforce. Delivered by highly experienced trainers. ■ Drug and alcohol community training. ■ NADA developing resource/AOD sector. ■ AMSSU training package attention. ■ Collaboration between CDS (CACH) and Neurosciences unit. ■ Paediatrician with FASD expertise in complex ADHD clinic (CAMHS Service). ■ Presentations at professional development events/conferences with clinicians. ■ CDS has delivered training to: 1. CHNs 2. School Psychologists 3. Broome DCP, health and education professionals 4. Paediatricians/trainee registrars 5. Medical students, 5th year at PMH.		
Service delivery and clinical pathways	■ ACCHS. ■ Commonwealth funded programs. ■ New Directions. ■ Healthy for Life. ■ WANDAS. ■ Service Delivery. ■ Clinical Pathways. ■ Ongoing research.	■ Program planners and service deliverers	■ Whole of government approach

Enablers			
Mapping themes	**What**	**Target audience**	**Who**
	■ New pregnancy handheld record. ■ Aboriginal Maternity Group Practise. ■ NMAHS – COAG Funded provides antenatal and postnatal (up to 4 weeks). ■ Clinical Services and education to Aboriginal women and their families ■ Strong focus on Drug and alcohol use in/before and after pregnancy. ■ CDS fully developed. ■ TICHR Diagnostic tool (in development). ■ DOE - Schools plus funding for FASD diagnosed/ developmental delay and eligibility issues.		

Appendix 7: Evaluation form

FASD Model of Care Implementation Forum

Child and Youth Health Network

Evaluation Form

To assist us to evaluate the effectiveness of this event, and to plan future events, please take a few moments to complete this form. All responses will remain confidential.

Please rate this event by circling the number that corresponds to your level of agreement with each statement below.

Please circle one number for each statement	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1 The event increased my understanding of the need for a whole of government approach to implementing the FASD Model of Care.	1	2	3	4	5
2 The FASD MOC was a useful tool to map and plan FASD related activity across WA.	1	2	3	4	5
3 I can see how my work contributes to the prevention of FASD.	1	2	3	4	5
4 I was given the opportunity to actively contribute during the day.	1	2	3	4	5
5 Sufficient time was allocated to each area of discussion.	1	2	3	4	5
6 I am satisfied with the approach being taken to coordinate the implementation of the FASD Model of Care.	1	2	3	4	5
7 I intend to continue my participation in the FASD Implementation Working Group	1	2	3	4	5
8 The venue was satisfactory	1	2	3	4	5
9 Parking availability was satisfactory	1	2	3	4	5
10 The catering was satisfactory	1	2	3	4	5

11 Please outline what you thought the strengths of the day were:
12 Please feedback things that you believe could have been differently:
13 Additional comments:

Appendix 8: Table of acronyms

ACAP	Aboriginal Community Antenatal Program
ACARA	Australian Curriculum Assessment and Reporting Authority
ACCHS	Aboriginal Community Controlled Health Service
ACHWA	Aboriginal Health Council, WA
ADHD	Attention Deficit Hyperactivity Disorder
AHS	Area Health Service
AISWA	Australian Independent Schools WA
ALO	Aboriginal Liaison Officer
AMSSU	Aboriginal Maternity Services Support Unit
AOD	Alcohol and Other Drugs
CACH	Child and Adolescent Community Health
CAHS	Child and Adolescent Health Service
CALD	Cultural and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CDCD	Communicable Disease Control Directorate
CDS	Child Development Service
CDST	Community Drug Service Team
CHN	Child Health Nurse
CMO	Chief Medical Officer
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CSLG	Community Services Leadership Group
CYHN	Child and Youth Health Network
DAO	Drug and Alcohol Office
DCA	Department of Culture and the Arts
DCP	Department of Child Protection
DCS	Department of Corrective Services
DFA	Developmental Fetal Anomalies
DFC	Department for Communities
DIA	Department of Indigenous Affairs
DLG	Department of Local Government
DoE	Department of Education
DoH/DOHWA	Department of Health
DOHWA	Department of Health WA

DPC	Department of Premier and Cabinet
DSC	Disability Services Commission
DSR	Department of Sport and Recreation
ECU	Edith Cowan University
EI	Early Intervention
FARE	Foundation for Alcohol Research and Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
KEMH	King Edward Memorial Hospital
MDI	Multiple Document Interface
MHC	Mental Health Commission
MLC	Member of the Legislative Council, WA State Parliament
MOC	Model of Care
MOU	Memorandum of Understanding
MWCDST	Midwest Community Drug Service Team
NADA	Network of Alcohol and other Drug Agencies
NDRI	National Drug Research Institute
NGO	Non Government Organisation
NMAHS	North Metropolitan Area Health Service
NOFASARD	National Organisation for Fetal Alcohol Syndrome and Related Disorders
OVAHS	Ord Valley Aboriginal Health Service
PCG	Project Control Group
PMH	Princess Margaret Hospital
RACGP	Royal Australian College of General Practice
RFFADA	Russell Family Fetal Alcohol Disorders Association
RSD	Remote Service Delivery
SDERA	School Drug Education Road Aware
SMAHS	South Metropolitan Area Health Service
SW	South West
TCTC	True Care True Culture
TICHR	Telethon Institute for Child Health Research
WACHS	WA Country Health Service
WANADAS	WA Networks of Alcohol and other Drugs Agencies
WANDAS	Women and Newborn Drug and Alcohol Service
WNHS	Women's and Newborns' Health Service

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