Department of Children and Families Submission – Selection Committee on Action to Prevent Foetal Alcohol Spectrum Disorder – May 2014

Foetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe a range of conditions caused by prenatal exposure to alcohol; including the more severe condition known as Foetal Alcohol Syndrome (FAS). FASD affects the neurological and physical development of the foetus resulting in problems such as poor growth, impaired memory and concentration, poor impulse control, behaviour issues, speech and language delays, motor skill impairments, and physical abnormalities of the heart, kidneys and other organs. These problems may be mild or severe and may present at different stages of life.

There are a number of recent comprehensive reports into the medical and epidemiological findings on FASD internationally and in Australia, most notably the House of Representatives Standing Committee on Social Policy and Legal Affairs released in 2012. The outcomes of the committee have been considered by the Department of Children and Families (DCF) in its understanding of FASD and its impact on the Northern Territory child protection system.

This submission does not replicate this information. It describes the potential prevalence of FASD in child protection systems across Australia, with particular relevance to the Northern Territory context, presents the findings of a recent DCF study to identify the potential numbers of children affected by FASD, discusses the issues of child protection relevant to unborn children, and the current and proposed DCF responses to the issues presented with respect to FASD.

Prevalence of FASD

Foetal Alcohol Spectrum Disorder (FASD) is under recognised in Australia, with varying estimates depending on the diagnostic criteria used[1]. International estimates of FAS and FASD are generally in the range of 0.5 - 2.0 births per 1000 for FAS, and 10 per 1000 births for FASD.

Harris and Bucens (2003) conducted the only review of FASD prevalence in the Northern Territory to date. They calculated the prevalence of FAS in Indigenous people as 1.87 per 1000 live births, and in the overall population as 0.68 per 1000 live births[2]. Other studies estimate FASD as affecting 2.97 Indigenous children per 1000[3].

Epidemiological studies have identified low socioeconomic status (SES) is associated with increased risk of FAS and FASD. The low SES characteristics of poor maternal

1 Philip A May, and J. Phillip Gossage (2001) Estimating the Prevalence of Foetal Alcohol Syndrome: A Summary, Alcohol Res Health 25(3):159-164.

2Harris, KR and Bucens, IK, Prevalence of foetal alcohol syndrome in the Top End of the Northern Territory, Journal of Paediatrics and Child Health, Volume 39 Issue 7, Pages 528 – 533.

3 Bower et al, (2000) Ascertainment of birth defects: the effect on completeness of adding a new source of data. Journal of Paediatrics and Child Health 36(6):574-6.

nutrition, high rates of smoking, stress and exposure to violence can be compounded by the cumulative effect of intergenerational maternal drinking[4].

Given the Northern Territory has the highest consumption of alcohol of all jurisdictions, populations with low SES combined with high fertility, it can be assumed that the Northern Territory has a higher rate of FAS and FASD. This likelihood is illustrated by the Northern Territory Government Fact Sheet, *Alcohol use in the Northern Territory* (October 2010), which documents the higher than average alcohol consumption among residents in the Northern Territory and the associated risks:

- average alcohol consumption in the Northern Territory per capita, is 15 litres per year, compared to 10 litres average per capita in Australia;
- 17.2 percent of non-Indigenous adults consumed alcohol at risky levels, compared to the national average of 10.6%;
- 30.1 percent of Indigenous adults consumed alcohol at risky levels;
- 24.8 percent of women aged 35 to 44 consumed alcohol at risky levels;
- 21.4 percent of Indigenous women consumed alcohol at risky levels; and
- overall alcohol consumption by Indigenous people in the Northern Territory is significantly higher than the national average for Indigenous people[5].

The fact sheet also identifies the rate of drinking for pregnant women at approximately 1 in 8 Indigenous women and 1 in 12 non-Indigenous women reported consuming alcohol at their first antenatal visit. In 2010 the Health Gains Planning Unit identified one in eight Indigenous pregnant women and one in 12 non-Indigenous pregnant women in the Northern Territory consuming alcohol at the first antenatal visit. Between 8 and 8.7 percent of Indigenous women and 3.6 to 4.7 percent of non-Indigenous women were still consuming alcohol at 36 weeks[6]

High rates of drinking during pregnancy were also identified in the Aboriginal Birth Cohort Study conducted by Menzies School of Health Research. The study tracked over 600 Indigenous people from birth in the Northern Territory since 1987. When the study commenced, the rate of drinking during pregnancy of the mothers in the cohort was 11 percent. At 18 years of age, a third of the girls had already had babies and 30 percent of them had consumed alcohol during their pregnancies.[7] These findings suggest an increase in the level of maternal drinking over the course of the project.

It is important to note that consumption of alcohol during pregnancy does not necessarily or always result in FASD. The relationship between alcohol consumption in terms of quantity and teratogenic[8] effects on the developing foetus are not explicitly

4 Priscilla Pyett et al (2007) Foetal Alcohol Syndrome: A Literature review for the 'Healthy pregnancies, healthy babies Koori communities' project, Victoria

5 Northern Territory Government, (2010) Alcohol use in the Northern Territory, factsheet.

6 Northern Territory Government, Alcohol Use in the Northern Territory, www.healthynt.gov.au, Health Gains Planning Information Sheet, October 2010

7 Australian Government, 2012, House of Representatives Standing Committee on Social Policy and Legal Affairs, FASD the Hidden Harm

8 Teratogenic substances are those that are known to cause birth defects

understood. It is however evident that the child protection system can expect to come into contact with a very high proportion of families affected by chronic alcohol misuse and FASD (whether as parents or as children requiring protection) and that these issues are intertwined and complex.

FASD and Child Protection

Children that are FASD affected or living in alcohol affected families are far more likely to come to the attention of the child protection system for the following reasons:

- the relationship between FASD and alcohol misuse means that parents are likely to have a range of substance misuse issues which impact on their ability to provide care for their children and/or to ensure the child's safety;
- children with FASD and FAS have increased developmental and learning needs that are unlikely to be met due to the parents alcohol use, putting them at increased risk of harm; and
- children who are FASD affected grow up and have their own children and due to cognitive and learning difficulties are unable to appropriately care for them.

Across Australia, FASD is recognised as a significant issue for child protection services and the child protection system and a number of studies have found that parental alcohol misuse is a major factor in child protection reports in Australia each year. Key studies demonstrating the impact and relationship between alcohol misuse and FASD and child protection, are summarised below:

- An Australian study of children diagnosed with FAS between 2001 and 2004 revealed that 60 percent of children in the study were in out of home care, of those 51 percent had a sibling with FAS and 65 percent were Indigenous.[9]
- A South Australian study in 2009 found that substance abuse was a factor in approximately 70 percent of all cases of children entering out of home care. Of these alcohol was identified in 77 percent of the cases. Further, the report identified that 6 percent of children were known to be prenatally exposed to drugs, including alcohol[10].
- In 2010, the Australian Education and Rehabilitation Foundation identified 20,000 children across Australia were subject to substantiated alcohol-related child abuse each year.[11]

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9 Elliot, E., Payne, J et al. (2007)Foetal alcohol syndrome: a prospective national surveillance study, Archives of Diseases in Childhood, 93:732-737.
Laslett, A-M et al. (2010) The Range and Magnitude of Alcohol's Harm to Others, AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.
10 Jeffreys, H., Hirte, C., Rogers, N., and Wilson, R. (2009) Parental substance misuse and children's entry into Alternative Care in South Australia, Department for Families and Communities, Government of South Australia.
11 Laslett, A-M et al. (2010) The Range and Magnitude of Alcohol's Harm to Others, AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.

- A study by Anne-Marie Laslett et al in 2012 of child protection cases in Victoria identified that children of parents who abuse alcohol were more likely to experience repeated interventions by child protection services. 28 percent of children in families with alcohol abuse recorded were subject to court orders compared to 19 percent of other children.[12]

FASD and Northern Territory Context

DCF is directly affected by the individual and community wide impact of FASD as a result of its work in providing family support services, child protection services and through the provision of out of home care.

In order to better understand clients and to shape its responses/interventions to meet the needs of children, young people and families affected by alcohol, DCF conducted the first ever study into the prevalence of FAS and FASD among its clients. *Foetal Alcohol Exposure among Children in the Child Protection System in the Northern Territory*[13], was undertaken in 2013 to identify the potential numbers of children affected by prenatal exposure to alcohol in the child protection system in the Northern Territory.

A summary of the DCF Study is at Attachment A.

The DCF study reviewed the recorded histories of a sample number of children (a total 230 children) involved with the Northern Territory child protection system between 2011 and 2012 to identify how many children had:

- been exposed to parental alcohol abuse;
- been subject to foetal alcohol exposure; and
- displayed indicators of FASD.

Due to the lack of a recognised FASD screening tool and the absence of a threshold for safe alcohol consumption during pregnancy, the DCF study used 'concerning alcohol use' as the measure to indicate exposure to alcohol and potential risk of FAS and FASD. 'Concerning alcohol use' is defined in summary of the DCF study at Attachment A.

The DCF study found a significant number of children exposed to alcohol while in utero and after birth. Of the 230 children in the study, a fifth of the children were identified as prenatally alcohol exposed, this was confirmed in 7 percent of the cases and probable in a further 15 percent of cases.

Of the children prenatally exposed to alcohol:

- 6 percent had a confirmed FAS diagnosis;
- 8 percent had suspected FAS;

12 Laslett, A-M et al. (2012), Alcohol's involvement in recurrent child abuse and neglect cases, Addiction Vol 107, Issue 10.7 1786.17

13 This is currently an internal document and subject to publication.

- 10 percent experienced growth delay/prematurity/low birth weight compared to 7 percent of non-exposed children;
- 10 percent experienced speech or language delay compared to 4 percent of non-exposed children; and
- 23 percent had behavioural problems compared to 13 percent of non-exposed children

This number of confirmed FAS cases is equal to a rate of 13 per 1000 cases. This is comparable to international estimates of 10 to 15 per 1000 children diagnosed with FAS in care. However, due to the lack of a standardised diagnostic tool and limited access to specialists to undertake the assessment, the number of children with FAS in the Northern Territory child protection system could be higher.

The DCF study revealed 63 percent of parents reported concerning alcohol use, of which maternal alcohol use was most prevalent at 43 percent. Not only were a significant number of mothers drinking while pregnant, half of the children in the study lived in families where long term alcohol use was identified.

In addition to FASD outcomes, high consumption of alcohol has a negative effect on the parents' capacity to care for and protect their children. The DCF study confirmed that parents' alcohol and drug use was the main reason for the substantiation of neglect.

Children that are FASD affected are 10 to 15 times more likely to enter out of home care than other children[14] and once in care, they remain so for longer than non-affected children[15]. The DCF study also found that 100 percent of the children in out of home care that were originally from town camps were FASD affected (n=5) as were 80 percent of the children originally from remote communities.

The study identified higher rates of sibling deaths among foetally exposed children; 12 percent of children with concerning maternal alcohol use and 16 percent of foetally exposed children were from families that had experienced the death of a child.

Unborn children and the *Care and Protection of Children Act*

DCF does not have a legal basis for intervening on behalf of an unborn child. The *Care and Protection of Children Act* (the Act) only enables DCF to respond to a child that is a person less than 18 years of age. An unborn child is legally not considered 'a person' in the Northern Territory.

DCF may offer assistance to a mother if it believes the unborn child is at risk, however, if the mother does not accept that assistance, the Department has no legal authority to compel the mother to accept assistance.

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14 Astley, S, Stachowiak, J, Clarren, S and Clausen, C. (2002) Application of the foetal alcohol syndrome facial photographic screening tool in a foster care population, Journal of Paediatrics, Vol 141 no 5.

15 Budde, S and Harden, (2003) A. Substance-exposed infants in Illinois 1988-2001: Trends in caseloads, placement and subsequent maltreatment, Report to the Children and Family Research Center at the University of Illinois at Urbana-Champaign.

In 2011/12, DCF commenced a comprehensive review of the Act which included options to reform the legislation to give legal authority to protect unborn children. Public consultation became very focused (and polarized) on the issues of alcohol and alcohol consumption by pregnant women and the risks to unborn children, particularly FASD.

The ensuing debate centered on the rights of the mother as separate from the rights of the child. This was further exacerbated by the lack of an agreed 'safe' drinking level for pregnant women in Australia, which would allow thresholds to be clearly identified and risks to be better managed. The National Health and Medical Research Council (NHMRC) released the revised Australian Alcohol Guidelines in March 2009 recommending that abstinence from alcohol during pregnancy was the safest option for the developing foetus. As part of its comprehensive review of the medical evidence to draft the guidelines, the Council was unable to clearly identify a threshold level of safe (or unsafe) drinking while pregnant. The inability to pinpoint the levels at which alcohol become teratogenic during pregnancy relate to the amount of alcohol consumed (both in terms of quantity and alcoholic content), the stage of development of the foetus at the time of exposure and the individual characteristics of the mother[16].

Without a clear threshold, it is highly problematic to construct a legislative framework around child protection interventions for unborn children, particularly when those interventions would have involved a degree of restriction on the mother and her rights.

Views were also divided on the form of intervention. Traditionally, child protection agencies provide intensive support to improve parenting capacity and skills, and failing this option, have the authority to remove the child and place them in care. This hierarchy of consequences can not apply to unborn children. The options discussed were therefore bans on alcohol consumption or other forms of restriction or restraint on pregnant women, and the acknowledgement that these options were extreme from a human rights perspective, complex to administer and expensive to operate.

Since the public consultation on the Act, the Northern Territory Government has introduced legislation and a service system for mandated alcohol treatment across four regional centres. The Alcohol Mandatory Treatment Program presents an option for abstinence and/or treatment for pregnant women that could protect unborn children and it is feasible that pregnant women will access the program in its current form or through extended criteria under the *Alcohol Mandatory Treatment Act*.

It is DCF's position that while mandated treatment would provide health and psychosocial benefits to some women and their unborn children, a more effective investment to prevent FASD would be in education for the general population and targeted groups, alcohol supply management and contraception for high risk individuals.

16 Australian Government (2009) National Health and Medical research Council, Australian Guidelines, TO REDUCE HEALTH RISKS; from Drinking Alcohol

Responses and Recommendations

FASD is a complex health and social issue, which is integrally linked to broader debate and strategies to address alcohol misuse in the community. It is therefore not possible to have recommendations about FASD without also touching on issues such as community awareness of alcohol misuse and harm, attitudes to drinking and drinking while pregnant.

DCF has however identified a number of recommendations that are within its responsibility as a child protection agency and which will improve its responses to clients and their families presenting with FASD. These can be summarised as:

1. equipping staff and carers to better meet the needs of children and families affected by FASD;
2. improving record keeping and documentation with respect to FASD; and
3. improving case coordination, planning and case work with other agencies and organisations for families and clients affected by FASD.

1. Equipping staff and carers to better meet the needs of children and families affected by FASD

Since 2012, DCF has engaged a consultant to regularly provide contemporary information and training to DCF child protection practitioners about FASD including; understanding the needs of FASD affected children in the child protection context and risk assessment and case planning for families where FASD may be present. This training is also open to family support workers in non-government organisations funded by DCF.

As part of the reform of out of home care, DCF is developing strategies to increase the number and proportion of foster and kinship carers delivering out of care services. This includes the requirement to develop the level of training and support to carers to ensure they have the requisite understanding of a range of conditions and behaviours such as FASD. DCF is reviewing the current Foster and Kinship Carer training to ensure it provides clear information about caring for children with FASD to improve placement stability and client outcomes.

2. Improving record keeping and documentation with respect to FASD

Infants[17] and very young children affected by FASD are more vulnerable as a consequence of their age and require early identification to ensure that medical, disability and behavioural interventions can be prioritised.

[17] The Department of Children and Families identifies infants and children 0 to 2 years of age.

DCF has already introduced a number of program and policy initiatives to prioritise infants in the child protection system such as:

- all reports to the Central Intake Team for infants are classified as priority 1 and undergo a specific assessment deigned to identify the risks and needs of children under 2; and
- developing and training staff in the Tune in to Little Ones (TILO) resources which provide comprehensive information on infant development, needs and milestones across the domains of physical health, emotional wellbeing and relationships. TILO also provide resource information on (FASD) and how to help little ones who might be FASD affected.

These initiatives should be augmented by the development of more explicit policy guidance about investigation techniques, intervention types and referral mechanisms for children affected by FASD for DCF staff and for family support services to ensure consistency in identification and in the provision of appropriate interventions/supports.

3. Improving case coordination, planning and case work with other agencies and organisations

A child affected with FASD will have specific needs as a result of the condition/s that will vary from child to child. Families too will have needs potentially relating to addiction, substance misuse and are at increased risk of any further children being FASD affected. These complexities require a comprehensive assessment of the child's and the family's needs, and a coordinated approach to care and support interventions across multiple agencies.

Within DCF, the Family Strengths and Needs Assessment tool is the mechanism and also the process for a case worker to better understand a family's risks and needs and to make decisions about referrals to specialist services in the community. This process could be developed by:

a. providing guidance to practitioners on the treatment options available for clients;
b. the processes of referral and shared case planning and case management; and
c. skills in motivational interviewing techniques to encourage clients to access alcohol treatment.

DCF could also develop protocols to improve access to specialist services for children in care affected by FASD. These protocols would cover the following:

a. work with the Department of Education to ensure children diagnosed with FASD can access the educational and learning support provided by the Student Support Services program;
b. work with the Department of Health to ensure children and families affected by FASD can access appropriate disability support services; and

c. ensure children who are taken into care where there is a history of maternal alcohol use undergo a paediatric assessment and referrals to specialist services where there are indicators of a developmental delay.

Foetal Alcohol Exposure among Children in the Child Protection System in the Northern Territory

Introduction

Foetal Alcohol Spectrum Disorder (FASD) is an umbrella term that encompasses a range of conditions caused by the unborn child being exposed to alcohol during pregnancy. In its most severe form, children diagnosed with Foetal Alcohol Syndrome (FAS) have characteristic facial features. Other effects include poor growth, impaired memory and concentration, behavioural issues, speech and language delays, motor skill impairments, and physical abnormalities in the heart, kidneys and other organs. Individuals may experience mild or severe impairment. The spelling of *foetal* in this report is consistent with the Australian NHMRC guidelines.

The purpose of the 'Foetal Alcohol Exposure among Children in the Child Protection System in the Northern Territory' study (the Study) was to identify the proportion of children affected by foetal alcohol exposure within a sample of children involved with child protection services in the Northern Territory between 2011 and 2012, specifically how many children:

- been exposed to parental alcohol abuse;
- been subject to foetal alcohol exposure; and
- displayed indicators of FASD or diagnosed with FASD/FAS.

The Department of Children and Families (DCF) conducted this first ever study authored by Ms Prue Walker, into the prevalence of FAS and FASD to better understand its clients and to shape its responses/interactions to meet the needs of children, young people and families affected by alcohol.

The research was initially developed in conjunction with staff of the Child Protection Research Program at Menzies School of Health Research and staff from DCF in 2011. The project received ethics approval from the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research in April 2012. Final approval by DCF for the research to commence, including access to client files, was received in June 2012.

Alcohol consumption in the Northern Territory and FASD

Alcohol consumption

Concern about the levels of alcohol use in the Northern Territory has been well documented. Data from the National Drug Strategy Household Survey in 2007 indicated that 17.2 percent of non-Indigenous adults in the Northern Territory consumed alcohol at a level consistent with a risk to health in the long term[1] , compared to the national average of 10.6 percent. Rates among Indigenous adults were higher, with 30.1 percent of Indigenous adults consuming alcohol at a high risk level.

The Northern Territory Government Fact Sheet, *Alcohol use in the Northern Territory* (October 2010), documents the higher than average alcohol consumption among residents in the Northern Territory:

- average alcohol consumption in the Northern Territory per capita is 15 litres per year, compared to 10 litres average per capita in Australia;
- 17.2 percent of non-Indigenous adults consumed alcohol at levels posing a long term risk to health, compared to the national average of 10.6 percent;
- 30.1 percent of Indigenous adults consumed alcohol at risky levels;
- 24.8 percent of women aged 35 to 44 consumed alcohol at risky levels;
- 21.4 percent of Indigenous women consumed alcohol at risky levels;
- approximately 1:8 Indigenous women and 1:12 non-Indigenous women reported consuming alcohol at their first antenatal visit; and
- at 36 weeks pregnancy, this had fallen to between 8.0 to 8.7 percent of Indigenous women and 3.6 to 4.7 percent of non-Indigenous women who continued to consume alcohol.[2]

It has also been identified that alcohol use in pregnancy also occurs at risky levels. In 2010 the Health Gains Planning Unit identified one in eight Indigenous pregnant women and one in 12 non-Indigenous pregnant women in the Northern Territory consuming alcohol at the first antenatal visit. Between 8 and 8.7 percent of Indigenous women and 3.6 to 4.7 percent of non-Indigenous women were still consuming alcohol at 36 weeks[3].

Given that the Northern Territory has higher rates of alcohol consumption than other states and territories and high rates of alcohol consumption while pregnant, it is likely that rates of FASD are similarly higher.

Prevalence of FASD

FASD is under recognised in Australia. The 2012 national inquiry into FASD by the

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1 Defined as: For males, consumption of 29 or more standard drinks per week; and for females, consumption of 15 or more standard drinks per week. One standard drink contains 10 grams of alcohol (equivalent to 12.5 mls of alcohol).

2 Northern Territory Government, (2010) Alcohol use in the Northern Territory, factsheet.

3 Northern Territory Government, Alcohol Use in the Northern Territory, www.healthynt.gov.au, Health Gains Planning Information Sheet, October 2010

House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD the Hidden Harm,* identified the lack of data or screening for FASD as a key factor in the limited responses to FASD in Australia.

> *The true extent of the incidence and prevalence of FASD in Australia is currently unknown. There is no nationally consistent definition; diagnostic criteria for FASD; nor biomarker for all conditions within the spectrum. Children are not routinely screened in infancy or early childhood and data which accurately reflects estimates of FASD incidence and prevalence in Australia are lacking.*[4]

International estimates of FAS and FASD are generally in the range of 0.5 to 2.0 births per 1000 for FAS, and 10 per 1000 births for FASD. Estimates vary based on the diagnostic criteria used.[5]

FASD is reported at higher rates among Aboriginal children in Australia, though there is still no clear understanding of the prevalence of FASD.

Harris and Bucens (2003) conducted the only review of FASD prevalence in the Northern Territory to date. They calculated the prevalence of FAS in Indigenous people as 1.87 per 1000 live births, and in the overall population as 0.68 per 1000 live births.

Other studies estimate FASD as affecting 2.97 Indigenous children per 1000[6] while Professor Marcia Langton, estimates that FASD affects 1:40 Indigenous children.[7]

Children that are FASD affected or living in alcohol affected families are far more likely to come to the attention of the child protection system for the following reasons:

- the relationship between FASD and alcohol misuse means that parents are likely to have a range of substance misuse issues which impact on their ability to provide care for their children and/or to ensure the child's safety;
- children with FASD and FAS have increased developmental and learning needs that are unlikely to be met due to the parents alcohol use, putting them at increased risk of harm; and
- children who are FASD affected grow up and have their own children and due to cognitive and learning difficulties are unable to appropriately care for them.

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4 House of Representatives Standing Committee on Social Policy and Legal Affairs (2012), FASD the Hidden Harm, op cit, p10.

5 Philip A May, and J. Phillip Gossage (2001) Estimating the Prevalence of Foetal Alcohol Syndrome: A Summary, Alcohol Res Health 25(3):159-164.

6 Bower et al, (2000) Ascertainment of birth defects: the effect on completeness of adding a new source of data. Journal of Paediatrics and Child Health 36(6):574-6.

7 Doing Time, Time for Doing: Indigenous youth in the criminal justice system, (2011) Report of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs

Methodology

The Study included both those children and families who underwent a child protection investigation and those who had been placed in care. The Study used a randomized population based sample of 230 children:

- 180 children who were under child protection investigation (referred to as *children under investigation*) where investigation had been completed between 1 January and 31 December 2011; and
- 50 children who were in residential, foster or kinship care (referred to as *children on orders*) as at 7 July 2012;

Other data elements accessed included:

- demographic data, (for example, Gender, age, number of siblings, Aboriginality);
- involvement with the child protection system (for example; location at commencement of child protection involvement, substantiation of harm/type, number of previous and subsequent reports, whether child or siblings were in care);
- data in relation to the presence of risk factors (for example, concerning alcohol use by either mother or father of child, intergenerational alcohol use in family, alcohol use by mother during pregnancy with subject or other child, death of sibling);
- the Study used the information available to identify whether the subject children or his/her siblings were diagnosed FAS/FASD diagnosis or demonstrated indicators of FASD ie behavioural issues, learning difficulties, developmental delay, speech/language delay, intellectual disability, physical abnormalities, prematurity and growth delay;
- information was also collected in relation to interventions provided to parents or children;
- case files were viewed on the child protection database, CCIS to determine to what degree alcohol as a factor in the child protection report was identified as an issue during the course of the investigation, what interventions took place and what outcomes were documented; and
- a search of national and international literature (Appendix A refers).

The identification of children who were prenatally exposed to alcohol or those that may be suspected FASD was difficult for the researcher because:

- there is no threshold for safe or unsafe consumption of alcohol while pregnant; and
- case notes do not often record the level of parents' alcohol use consistently in any detail.

To address this, the Study used "concerning" alcohol use by parents or carers. Concerning alcohol use in this study includes cases where:

- parental alcohol use was reported as one of the reasons for the report to child protection;

- parental criminal histories include alcohol-related offences;
- alcohol use appears to impact on parenting capacity (children left unattended, lack of supervision);
- children are placed at risk due to issues including alcohol use by parents (exposed to alcohol related violence, being dropped);
- parents are referred to alcohol treatment;
- an alcohol-related harm substantiation is recorded;
- extended family members identify parenting is affected by alcohol use;
- parents were asked to modify their alcohol use or to establish safety plans around their drinking;
- long term alcohol use has impacted on care of other children;
- children placed with others by their parents due to alcohol use; and
- previous alcohol-related reports of harm to children.

Findings

The characteristics of the 230 children in the Study were identified as:

- the average age was 7.4 and the median age was 7;
- children aged 0 to 3 comprised 30 percent of the sample;
- 54 percent were male and 46 percent female;
- the average family size was 3.4 children;
- 81 percent of the children were Aboriginal or Torres Strait Islander; and
- a breakdown of where the children resided showed:
    - 38 percent resided in Darwin or Palmerston;
    - 11 percent resided in other regional towns;
    - 28 percent resided in remote communities; and
    - 10 percent resided in town camps.

Just over one fifth of the children (n=40) in the Study were in the care of others when the child protection investigation commenced.

The Study found that significant numbers of children were from families with concerning alcohol use by both parents:

- 57 percent of children under investigation were exposed to concerning alcohol use by one or both parents;
- 86 percent of children on Protection Orders were exposed to concerning alcohol use by one or both parents; and
- 21 percent of children in the study experienced foetal alcohol exposure.

The Study found a significant number of children exposed to alcohol while in utero and after birth. Of the 230 children in the study, a fifth of the children were identified as prenatally alcohol exposed, this was confirmed in 7 percent of the cases and probable in a further 15 percent of cases.

Of the children prenatally exposed to alcohol:

- 6 percent had a confirmed FAS diagnosis;
- 8 percent had suspected FAS;
- 10 percent experienced growth delay/prematurity/low birth weight compared to 7 percent of non-exposed children;
- 10 percent experienced speech or language delay compared to 4 percent of non-exposed children; and
- 23 percent had behavioural problems compared to 13 percent of non-exposed children.

The number of confirmed FAS cases is equal to a rate of 13 per 1000 cases. This is comparable to international estimates of 10 to 15 per 1000 children diagnosed with FAS in care. However, due to the lack of a standardised diagnostic tool and limited access to specialists to undertake the assessment, the number of children with FAS in the Northern Territory child protection system could be higher.

The Study revealed 63 percent of parents reported concerning alcohol use, of which maternal alcohol use was most prevalent at 43 percent. Not only were a significant

number of mothers drinking while pregnant, half of the children in the study lived in families where long term alcohol use was identified.

In addition to FASD outcomes, high consumption of alcohol has a negative effect on the parents' capacity to care for and protect their children. The DCF study confirmed that parents' alcohol and drug use was the main reason for the substantiation of neglect.

Children that are FASD affected are 10 to 15 times more likely to enter out of home care than other children[8] and once in care they remain so for longer than non-affected children[9].

The Study found that 100 percent of the children in out of home care that were originally from town camps were FASD affected as were 80 percent of the children originally from remote communities.

There were indicators that children exposed to foetal alcohol use experienced more significant behavioural and health issues than other children:

- of the foetally alcohol exposed children, 23 percent had behavioural problems compared to 13 percent of non-exposed children; and
- 10 percent of exposed children had a speech delay and 15 percent had a developmental delay.

Children who experienced concerning maternal alcohol use had three times the number of previous reports to child protection than other children. 10 percent of the sample children had previously been in care. For the children for whom alcohol related harm was substantiated, over a third had previously been in care.

The study also found higher rates of sibling deaths among foetally exposed children with 12 percent of children with concerning maternal alcohol use and 16 percent of foetally exposed children were from families which had experienced the death of a child.

Review of case files

The case file review identified a slight improvement in the collection and recording of information about parents alcohol use. Since 2006, records have transitioned from paper to electronic files. This has resulted in improvements in intake records case closure reports, investigation summaries and higher quality court reports, however a few areas for improvement were also identified:

- information about parental alcohol use from other sources, historical court reports, interview notes were not always transcribed into current risk assessments, case summaries or current court reports.

8 Astley, S, Stachowiak, J, Clarren, S and Clausen, C. (2002) Application of the foetal alcohol syndrome facial photographic screening tool in a foster care population, Journal of Paediatrics, Vol 141 no 5.
9 Budde, S and Harden, (2003) A. Substance-exposed infants in Illinois 1988-2001: Trends in caseloads, placement and subsequent maltreatment, Report to the Children and Family Research Center at the University of Illinois at Urbana-Champaign.

- information about parental alcohol use may not always be on all the children's records particularly when reports for different children in the family were received at different times and for different reasons; and
- inconsistent approaches to recording the information about the health and wellbeing of the children in care. Some practitioners scan documents such as paediatric records into the record keeping system, others summarise these documents, in others the information is missing.

Review of case studies

The case study review found a range of practices, some positive and others that identified a need for information and support to child protection practitioners respond to the needs of families and children where concerning alcohol use and/or FASD is present. Key findings of the case reviews are below:

> Information about older younger siblings who were confirmed or suspected alcohol exposed was not sought or not recorded on the subject child's file. Information about older siblings is a key part of the assessment of parenting capacity and patterns of parental substance use. Extensive histories and identification of the family structure through the development of a genogram prepared with the family can provide vital information about the duration, nature and severity of addiction and identification of appropriate interventions.
>
> Families with concerning alcohol use informed DCF that their children are cared for other people when they drink, though no follow up of the arrangements was recorded on file. Safety planning which involves parents sending children to relatives when they are drinking is ineffective where alcohol use is unplanned.
>
> There was inconsistent information sharing between DCF and the health services about parental alcohol use or foetal alcohol exposure. Where confirmation exists this information should be clearly documented and repeated in all referrals to allied health services to promote clear identification of risks and appropriate interventions.
>
> Many of the cases of concerning parental alcohol use showed a pattern of repeat notifications. In each case the presenting issues were addressed to provide immediate safety to the children, but the underlying issues such as long term addiction were not significantly resolved.
>
> Denial of concerns by parents, in particular those that are intoxicated or known to consume risky amounts of alcohol, needs to be treated with caution and if necessary seek verification with notifier.

There were also examples of where DCF built on a family's motivation to change and address the safety concerns of their children. For many families the involvement of DCF in their lives is a powerful motivator for change. It is important to note that parental motivation is not enough, wrap-around responses including day to day support, specialist addiction support, parenting skill development, practical measures such as "no alcohol" signs and ongoing monitoring of the parents' progress towards agreed goals are required to ensure the children's safety.

Conclusion

As expected, the Study found the children who were exposed to alcohol and who were FASD affected are disproportionally represented in child protection systems across Australia. The study found that in the Northern Territory the rate of children with FASD was higher for children from town camps and remotes communities than urban settings.

Recognition of FASD prevention generally focuses on high alcohol misuse. The issues of alcohol consumption and poverty and disadvantaged are closely intertwined. It is clear that the poor maternal nutrition, high rates of smoking, stress, homelessness and exposure to violence that are associated with low socioeconomic status (SES) increases the risk of FAS and FASD. This is further compounded by the cumulative effect of intergenerational maternal drinking.

The Study found that child protection responses to families with high alcohol use or children who might be FASD affected is not focused or coordinated at this stage. Responses to FASD and the high levels of alcohol consumption require coordinated and targeted interventions from a range of agencies and organisations including health services, education, drug and alcohol treatment services, family support services as well as child protection. The supports need to not only address the families' addiction and substance misuse issues but also provide supports to improve their parenting skills to ensure the safety and wellbeing of their children.

The study also recommended:

- development of a standardised assessment tool would assist with earlier identification of FASD or FAS which is critical to ensure the needs of these children are met, particularly when the children are in out of home care;
- improvements in the way information about children's foetal alcohol exposure or FASD diagnosis is shared and recorded as well; and
- support to DCF staff, carers and family support workers to better respond to children and families affected by high levels of alcohol use and FASD.