



Clár Sláinte Náisiúnta do Mhná & do Naíonáin
Feidhmeannacht na Seirbhíse Sláinte, Aonad 7A, Áras
Dargan, An Ceantar Theas, Baile Átha Cliath 8
T: 076 695 9991

National Women and Infants Health Programme
Health Service Executive, Unit 7A, The Dargan Building,
Heuston South Quarter, Dublin 8
T: 076 695 9991

18th November 2021

Deputy Ward,
Dáil Éireann,
Leinster House
Dublin 2

PQ 51138/21: To ask the Minister for Health the services that are available for children and adults diagnosed with foetal alcohol spectrum disorders; and if he will make a statement on the matter.

PQ 51139/21: To ask the Minister for Health the clinical pathway to diagnosis for those suffering with foetal alcohol spectrum disorders; and if he will make a statement on the matter.

PQ 51140/21: To ask the Minister for Health the supports that are provided for persons with foetal alcohol spectrum disorders in Budget 2022; and if he will make a statement on the matter.

PQ 51141/21: To ask the Minister for Health the section of his Department responsible for the treatment of persons with foetal alcohol spectrum disorder, that is, mental health, neurology or other; and if he will make a statement on the matter.

Dear Deputy Ward,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

These four Parliamentary Questions you have asked are closely inter-related. They are concerned with the diagnosis, management, and services available for cases of fetal alcohol syndrome so I have set out below a high level outline of how this condition is managed currently.

Every woman presenting at this first antenatal visit at the relevant maternity service, is specifically asked by the midwife about their prescribed medication, alcohol and recreation drug use history and whether it has been discontinued during the current pregnancy. If a disclosure is made regarding the on-going use of drugs or alcohol in pregnancy, an automatic referral is made to the relevant medical social work department. The mother will then be met by a social worker during which an assessment will be undertaken from a psychological and social perspective. Where deemed necessary and appropriate, a referral is made to a dedicated Drugs Liaison Midwife or other equivalent professional based in the relevant addiction services that support the maternity service. In some cases, the mother may already be

known to these services, having accessed them previously for care and support. An individualized support and education plan for the mother is then created, with further links being made with community based addiction services and family support services as required, with the focus being on reducing alcohol and drug intake and ensuring that the woman is fully informed regarding the impact of substance abuse on the pregnancy and the risk for the newborn infant. Where specific risk thresholds are reached in relation to child protection, a referral is also made to TUSLA. Aids and supports provided can include referrals for stabilization and detox placement in pregnancy, all targeting minimising / eliminating where possible the risks to both the mother and the unborn infant.

After the birth, the infant is assessed by paediatric and neonatal staff. If an infant exhibits signs of withdrawal they are admitted to the relevant Neonatal Unit. The magnitude of the withdrawal symptoms is assessed using the Finnegan's Score. The infant is placed on medication where necessary. In many cases it can take a number of weeks for the symptoms to settle. Further to discharge, the infant is followed up in the baby clinic and if there are concerns about the infant's progress and development they are referred to the early intervention team. In addition, the mother is followed up by the social worker and public health nursing and TUSLA as required.

The frequency of fetal alcohol syndrome is difficult to determine. First there must be a clear documented history of alcohol use during the pregnancy. Second, the classical description is that of a low birth weight baby with a distinctive facial pattern, and subsequent hyperactivity and cognitive problems. This complete picture is rare in clinical practice.

There is debate around the reliability of the diagnosis of partial cases of fetal alcohol syndrome where there is a history of alcohol ingestion and the baby has some cognitive problems but no typical facial features. The other problem is that pregnant women with an alcohol problem may also be taking other recreational drugs. In these circumstances it is difficult to extract the specific effect of the alcohol on the baby from the effects of the other drugs.

In relation to staff training, the HSE offers a module called 'Hidden Harm'. This module outlines the impact of alcohol and drug use in pregnancy on babies. It is agreed by health care professions and social workers that the provision of repeated consistent advice about the risks of alcohol in pregnancy is of the utmost importance.

I trust this clarifies the matter.

Yours sincerely,



Mary-Jo Biggs, General Manager, National Women and Infants Health Programme