

# **FASD: The Invisible Disorder Filling Beds in Juvenile Facilities & Prisons**

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# Faculty and Disclosures



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No financial conflicts

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No financial conflicts

# Goals of Presentation



## Three Key Goals

- To provide an overview of Fetal Alcohol Spectrum Disorders (FASD), including the nature of the disabilities and the challenges to the individual, family, and community.
- To discuss the particular challenges of FASD for the person (adult or youth) involved in the legal system and the person's family, and the corresponding challenges for the legal system.
- To consider how the legal system can best assist individuals with FASD under its jurisdiction.

# **Relevance of Topic: Why FASD, and why *now*?**

Lyn Becker



## FASD is relevant for many reasons

- U.S. current “love affair” with alcohol & other drugs.
- 21<sup>st</sup> century focus on individual’s healthcare rights, individualized care, and quality of life.
- 1990s to present– increased attention to developmental and intellectual disabilities.
- Improved technology has increased researchers’ ability to identify critical information about FASD.



## FASD is relevant (2)

- Increased ability to identify persons with FASD has resulted in identifying patterns of behaviors that are highly concerning, from both an individual and a public health perspective.
- Increased ability to identify and more accurately calculate the costs of not addressing FASD, compared to the costs of addressing FASD.

## Commonly unrecognized bottom line

“Of all the substances of abuse – including cocaine, heroin, [nicotine, and marijuana] – *alcohol* produces by far the most serious neurobehavioral effects in the fetus.” (IOM Report to Congress, 1996).

## What we know

- 80% of children/youth live in foster or adoptive homes (70% in foster care and 10% in adoptive homes).
- International adoptions an even higher risk.
- 60% of children/youth have a disrupted school experience, such as suspension, expulsion, dropping out.
- 60% have some degree of ADD or ADHD.
- 95% have a mental health disorder.
- Most adults have severe depression, and about 25% attempt suicide.



## What we know (2)

- 24% of adolescents and 46% of adults with FASD have a substance use disorder.
- As many as 60% of individuals with FASD spend time in a juvenile detention center or a correctional facility.
- 49% engage in inappropriate sexual activity.
- 80% of adults cannot maintain consistent employment.
- 80% of adults require some type of dependent living arrangement.

## What we know (3)

- Prevalence of FASD in U.S. estimated at 2.4-4.8 per 100 children (CDC). Much greater among high risk groups.
- Leading form of developmental disability in the world, and 100% preventable.
- 20-30% of U.S. women have reported drinking at some point during pregnancy – usually first trimester (NIH).
- 8% or more of U.S. pregnant women binge-drink (4+ drinks at one time). High risk for FASD.

## Input from Canada (greater experience than U.S.)

“Studies have demonstrated that a disproportionate number of youth with FASD are incarcerated. *Youth with FASD have been found to be 10-19 times more likely to be incarcerated than youth without FASD.*”

“A study of young offenders with FASD revealed their *understanding of legal jargon, criminal procedure*, the nature and objective of proceedings *and the ability to participate in a defense and communicate with counsel were significantly deficient in 90% of participants, compared to young offenders without FASD.*”

*FASD and the Criminal Justice System*, CanFASD, Research Network, 2015

## CDC recommendations to women of child-bearing capacity

- If you want to drink and are sexually active, use reliable birth control, do not pursue a pregnancy.
- If you want to become pregnant, stop drinking before you start efforts to conceive, and remain alcohol-free through delivery.
- If you drink alcohol and find that you are pregnant, stop drinking immediately. If you cannot stop, get help from county drug and alcohol agency.

## FASD costly, in many ways

- Lifetime care for moderately affected person – \$1- 1.5 million +.
- Cost to individual in terms of quality of life – cannot be estimated.
- Lifetime care for highly affected person – can exceed \$2 million.
- Cost to individual in terms of quality of life – cannot be estimated.

## Need for a “people first” orientation

People with an FASD have special needs, but they are first and foremost “people.” They have a variety of personalities, positive attributes, talents, abilities, skills just like all other people.

In spite of all of the adversities they face, they can be successful in life.

## Some people with an FASD

- graduate from technical schools, career schools, colleges; complete career certification and/or licensing
- become skilled craftsmen and craftswomen
- obtain and retain employment
- do live independently
- marry and have children

## People with an FASD tend to have these positive traits

- Kind and caring
- Want to be helpful
- Pleasant mood
- Good with humor
- Want to please and make others happy
- Open to meeting new people, very accepting of people different from themselves
- Affectionate
- Most have an average or even above-average IQ





# **FASD Basics**

Gordon R. Hodas, MD

## SAMHSA's FASD Center for Excellence Defines FASD

An umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. Effects may include physical, behavioral, mental, learning disabilities with lifelong implications.

### “FASD” = alcohol-related neurodevelopmental disorders

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol Related Neurodevelopmental Disorder (ARND)
- Alcohol Related Birth Defects (ARBD)



# Fetal Alcohol Syndrome



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Normal brain of baby 6 wks old

Brain of baby same age with FAS

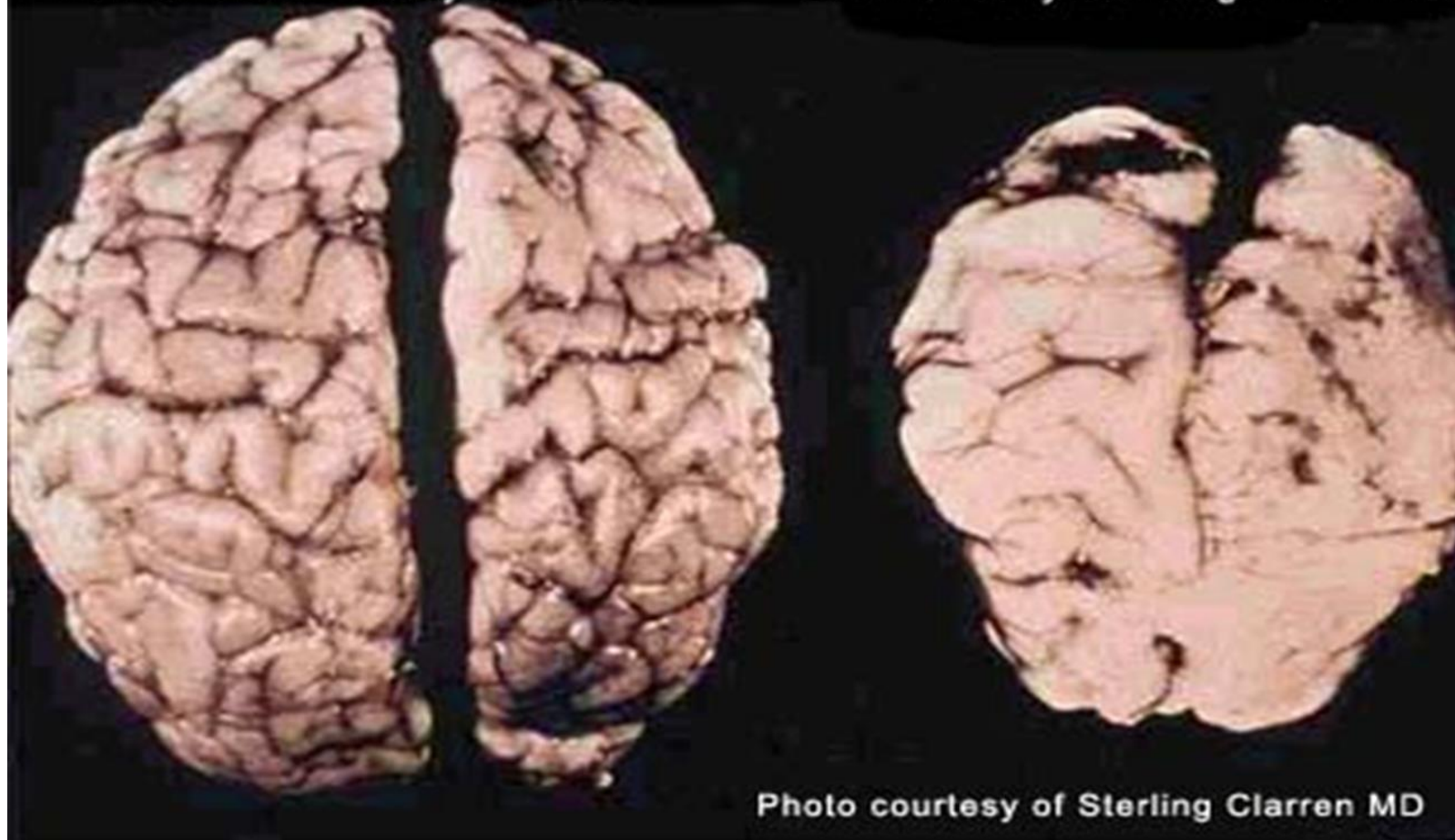
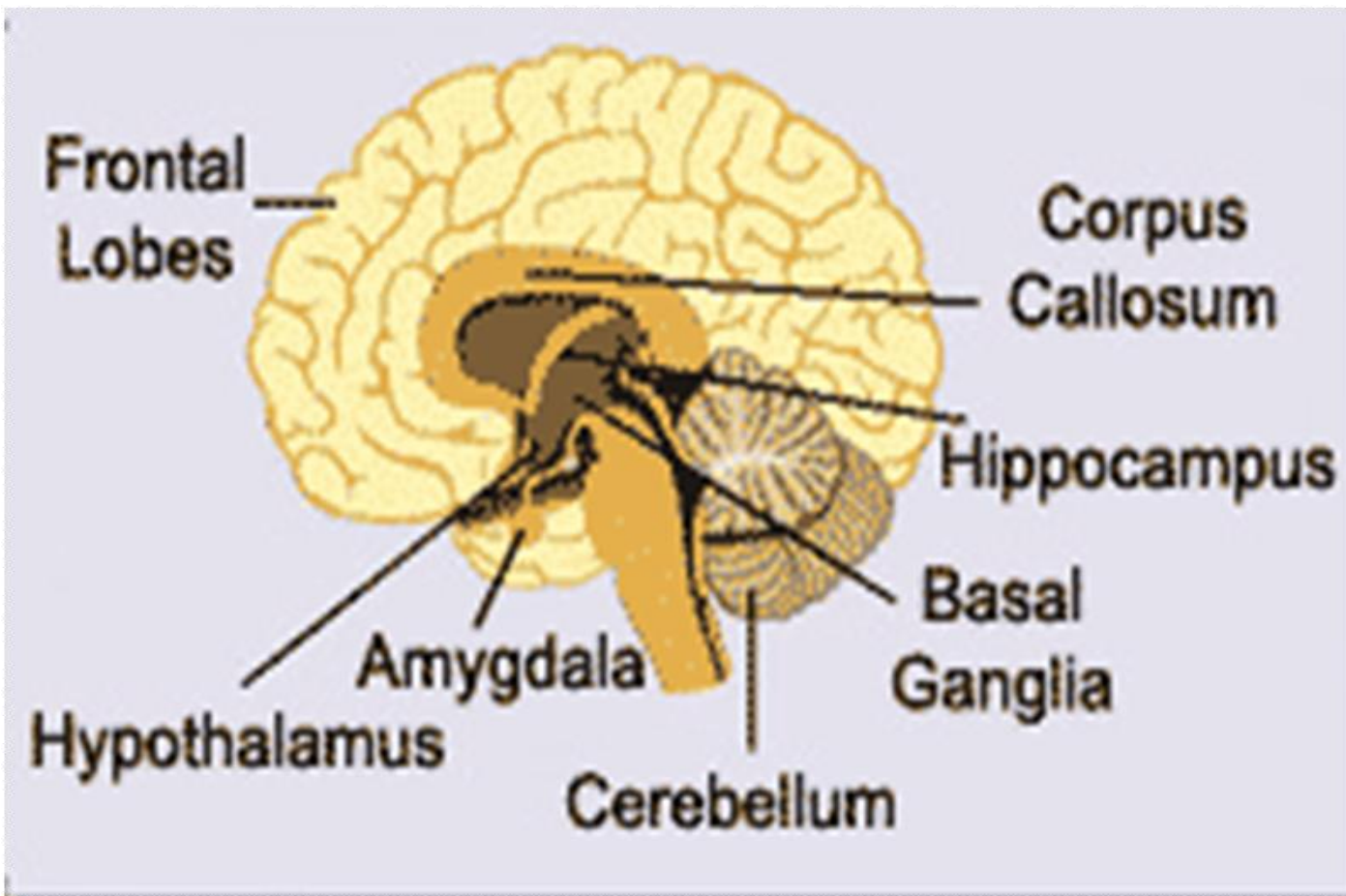


Photo courtesy of Sterling Clarren MD

# Fetal Alcohol Syndrome



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## FAS/FASD & affected brain parts

- Frontal Lobes

- Functions, especially re prefrontal cortex *executive functioning*: Judgment, impulses, self-control (behavior), self-regulation (emotions), planning, problem-solving, working memory, self-monitoring, motivation, time perception
- Loss: Any or all aspects, executive function



## FAS/FASD and the brain (2)

- **Parietal lobes** (behind frontal lobes)
  - Functions: Interpreting sensory information, understanding spatial relationships, touch perception, math skills, planned movements inc. writing.
  - Loss: Problems with math, intentional actions, poor sensory processing.



## FAS/FASD and the brain (3)

- **Corpus callosum**
  - Functions: Connects right & left hemispheres of brain, coordinated information processing information, enabling regulation of behavior.
  - Loss: Processing problems – e.g., left brain unable to stop behavior in right brain, despite person's understanding of the rule.





## FAS/FASD and the brain (4)

- **Cerebellum**

- Functions: Motor control, balance, coordination, movement; socialization, language.
- Loss: Impairment of motor control, memory, and behavior.



## FAS/FASD and the brain (5)

- **Basal ganglia**
  - Functions: Spatial memory, working toward goals, switching behavioral modes, predicting likely behavioral outcomes.
  - Loss: Understanding of time, perseverating, inability to work toward goals or predict outcomes.



## FAS/FASD and the brain (6)

- **Hippocampus** (part of limbic system)
  - Functions: Memory, learning, emotion, connects sensory input to motor output.
  - Loss: Memory problems, academic & other learning problems, may appear uninterested or inattentive.



## FAS/FASD and the brain (7)

- **Amygdala** (part of limbic system)
  - Functions: Central to emotion responses; senses danger, fear, anxiety; emotional memory; social behavior; recognition of faces and facial expressions; aggression.
  - Loss: Over- or under-responses of behavior and emotions; poor emotional memory.



## FAS/FASD and the brain (8)

- **Hypothalamus (part limbic system) & brain stem**
  - Functions: Controlling appetite, emotions, temperature, pain sensation; fight or flight response; ability to sleep.
  - Loss: Dysregulation of physiological functions, including arousal and sleep; primitive responses during stress.

## FAS/FASD and the brain (9): Additional effects

- Not only are brain parts smaller, also fewer ridges on brain and physical damage to cells
- Functional damage – to how cells carry out specific roles
  - Cell reproduction
  - Cell pruning.
  - Cell differentiation.
  - Cell connections to other cells.
  - Release of neurotransmitters.



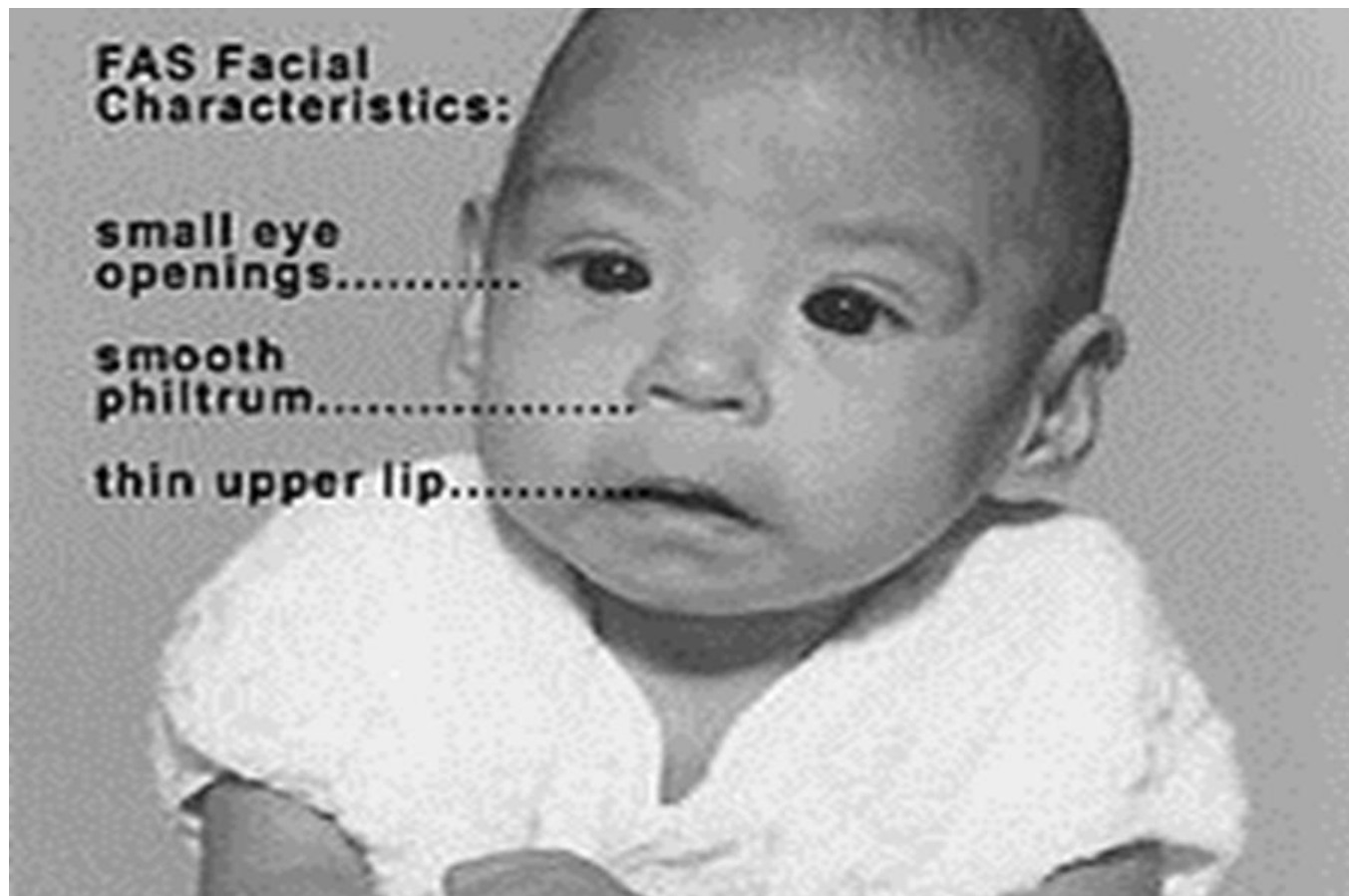
## Fetal Alcohol Syndrome (FAS) – The “Syndrome” commonly presents with the following characteristics

- Three facial abnormalities (facial features develop 4-8 weeks):
  - Smooth philtrum (groove between upper lip and nose)
  - Thin vermilion (upper lip)
  - Small cerebral palpebral fissures (eye openings)
- Growth retardation: height, weight, head circumference.
- Neurodevelopmental involvement: cognition, intelligence, attention, behavior, memory, processing, mood, attachment, motor skills, eye-hand coordination and other.

# Fetal Alcohol Syndrome



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## Alcohol-Related Neurodevelopmental Disorder

*ARND* refers to various **neurological abnormalities** linked to prenatal alcohol exposure. These include:

- Decreased head size at birth
- Structural brain abnormalities, as described
- Functional and cognitive impairments
- Behavioral abnormalities

However, physical appearance is **normal** – facial features of FAS are **absent**.

*NOFAS: <http://www.nofas.org/resource/CAP.aspx>*

## ARND is “invisible”

- With a “typical” appearance and no distinguishing facial features, ARND becomes “an invisible disorder.”
- ARND is the most common form of FASD.
- Further complication: Facial features of FAS often less evident by adolescence, so some adults with FAS also have an invisible disability.
- Consequences:
  - Individuals with ARND, and some with FAS, may be missed.
  - In contrast, mental health disorders that are comorbid with ARND are identified, with the primary neurodevelopmental disorder overlooked. Missed opportunities, and wrong therapies.



September 03, 2012 1:00 am • BY SCOTT FITZGERALD, The Southern

## Risk factors for alcohol use by a pregnant woman

- History of trauma/adversities during childhood.
- History of placement in foster care.
- Violence and abuse during adulthood.
- History of family substance abuse, including alcohol.
- FASD by biological mother: Often multi-generational.
  
- Note: FASD *not* limited to poor or minority families:
  - Alcohol use during pregnancy occurs among *middle & upper class females* and *all races and ethnicities*.
  - Occurs among *high school and college students*.

## Risks for adopted children and those in foster care include combinations of the following

- In-utero exposure to *alcohol*, resulting in FASD.
- Exposure to *other substances* in utero.
- *Genetic predisposition* to psychiatric disorders, leading to co-occurring psychiatric disorders.
- *Maternal stress* during and/or after the pregnancy.
- *Attachment* problems.
- *Maltreatment* following birth: physical or emotional neglect, physical abuse, sexual abuse.
- Overall, FASD 10-15 times more prevalent in foster care.

# Possible Co-Occurring Disorders



- Attention Deficit/  
Hyperactivity Disorder
- Depression
- Bipolar Disorder
- Schizophrenia
- Substance use disorders
- Medical disorders (i.e. seizure disorder, heart abnormalities)
- Sensory integration disorder
- Reactive Attachment Disorder
- Posttraumatic Stress Disorder
- Traumatic Brain Injury
- Anxiety Disorder
- Auditory processing disorder

# FASD Effects – Two Types



- Primary effects – Due directly to *in-utero exposure* to alcohol and its impact on in-utero development of infant, including brain development. Not reversible.
- Secondary effects – Due to the *impact of the ARND or other FASD* on child and family, and from adversities faced by the child and family – not from direct effect of alcohol.
- Goals: *Managing* primary effects of FASD, *building skills*, and *preventing*, whenever possible, secondary effects.

# FASD *Primary* Effects



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- Variable IQ – most children have normal IQ.
- Decreased *adaptive functioning* is key.
- Hyperactivity and impulsivity.
- Difficulty with sensory regulation.
- Physical sensitivities, especially sleep.
- Comprehension (oral & written), and processing.
- Short-term memory & using information.
- Judgment, cause-and-effect, & learning from experience.
- Irritability and mood lability; easily overwhelmed.
- Academic limitations & learning disabilities, inc. problems with math & reading comprehension.
- Naïve and easily led: immature for chronological age.
- Often unaware of own limitations.



- Problems in school – academic, social, behavioral.
- Problems with attachment and bonding.
- At risk of childhood maltreatment – children very frustrating and “abusable.”
- Peer victimization – money, bullying, sexual abuse.
- Inadvertent, inappropriate sexual behavior. Poor judgment.
- Alcohol and other substance abuse. Drawn to alcohol.
- Psychiatric disorders, often Inpatient and RTF.
- *Involvement in legal system.*
- Problems with employment and independent living.

## Causes of FASD secondary effects (secondary adversities)

- Disrupted attachments.
- Failure to *identify* FASD.
- Inappropriate interventions.
- Adverse Childhood Experiences – parental impairment or absence, poverty, limited social support, other.
- Blaming and punishment – of individual and family.
- Cumulative frustration and exhaustion.

## Need to *address* FASD: Seven levels, from basic awareness to effective interventions

- *Basic awareness* – knowing that FASD exists.
- *Warning signs, “red flags,” & other indicators*
- *Screening.*
- *Assessment.*
- *Diagnosis.*
- *Effective individual interactions* with those with FASD.
- *Effective interventions & treatment.*

## FASD *warning signs*, young children

- Child, diagnosed with MH disorder as preschooler (ADHD, ODD, Bipolar), not respond to Rx over time.
- Child with unexplained behaviors & mental health issues, do not appear to make sense.
- Child with difficulty applying what has been learned, makes same mistakes over and over.
- Repeated poor judgment, self-control, self-regulation.
- Child responds only to “hands on” & visual learning, not respond to auditory approach.
- Child easily overwhelmed & fatigued by over-stimulation

## *FASD indicators, youth and adults* (Brown, 2014, FASD in criminal justice system: A review)

- Immaturity
- Impulsivity, in general and in relation to offenses.
- History of academic failure.
- History of adoption or multiple foster care placements.
- Early age of first legal offense.
- Inability to learn from past errors.
- (Apparent) lack of remorse.
- Misinterpreting social cues and common expressions.
- Difficulty with daily living and with employment.

## *FASD screening*

- Screens exist, are useful (Appendix 3).
- FASD screening is critical for everyone who enters legal system, along with trauma screening.
- Can be done in court setting or in jail, by trained social worker.
- Results of screening can lead to supports in court, can affect the disposition by court (e.g., diversion from jail).
- With incarceration, results can influence placement and unit assignment, manner of interaction by staff, and planning for aftercare.

## FASD *assessment* – three key areas

- *History*
  - Maternal history – alcohol/substances while pregnant
  - Atypical development of child
  - Underperforming student with behavioral concerns
- *Physical exam* – may have facial features and growth deficits FAS, or a hybrid FASD presentation
- *Psychological testing*
  - Standard tests very helpful – IQ tests, achievement tests, & adaptive functioning (see next slide for breakdown)

## Psychological testing – typical findings with FASD

- Overall IQ usually normal.
- *Verbal* IQ significantly higher than *performance* IQ.
- Overall IQ higher than achievement scores (WRAT).
- Overall IQ higher than adaptive behavior scores (Vineland).

When available, neuropsychological testing provides more detailed information to guide intervention.



## FASD-related *diagnosis* – of neurodevelopmental deficits

- Formal diagnosis comprehensive & multi-disciplinary – by MD, psychologist, at times others.
- In jail, FASD diagnosis a game-changer.
- Diagnosable part of FASD involves impairments in cognition, self-regulation, and adaptive functioning, in association with in-utero alcohol exposure and childhood onset.
- Diagnosable FASD is known as *ND-PAE* (neurodevelopmental disorder associated with prenatal alcohol exposure).
- Formal diagnosis on DSM-V & on ICD-10 – F88 with ICD-10.

*Other specified neurodevelopmental disorder: ND-PAE.*



## Caveat: Information on FASD is not enough

- Need a *paradigm shift*, altering one's understanding of the person with an FASD.
- Paradigm shift creates the opportunity to make a difference.
- Then better able to respond constructively to individuals with FASD involved in general.
- Better able also to respond constructively to individuals with FASD involved in *legal system*.

## The new paradigm

- It's not that these individuals *won't*, but rather that they *can't*. (Malbin).
  - Not lazy, and not “manipulative” – They have a *disability*.
  - Language *matters*: “William *has* a problem,” rather than “William *is* the problem.”
- Individuals with an FASD need greater support from parents/others to succeed – involves scaffolding, not “enabling” (Dubovsky).
- Parents/others as “external brain” for person.
- Importance of “goodness of fit”: When others understand the person differently, relationships improve, as does person.



## The new paradigm (2)

- Individuals with FASD usually not malicious, do not have negative intentions.
- When violating the law, usually don't intend to do so.
- Primary source of negative behavior = brain damage.
- Also social adversity (secondary effects).
- So *blaming* is not appropriate – not for child or adult with an FASD, and not for the family.
- Important to identify & use person's strengths.
- Important to make accommodations consistent with person's known deficits, including basic communication (Appendix 2).
- With intervention and support, person makes progress.



## The interface of FASD and the legal system

## The interface of FASD and the legal system

When an individual with an FASD comes into contact with criminal justice system, please remember the following

- Each individual was a victim long before he/she was a victimizer.
- FASD is not only a mental health disorder; it is lifelong, irreparable *brain damage*.
- Since FASD is a spectrum disorder, affected individuals will vary as to where they are on the spectrum.

## FASD and the legal system (continued)

- All human behavior is preceded by involuntary reflex or by thought, whether fully conscious or subconscious. Damaged intellectual capacity (brain) can not be expected to result in neurotypical thought. When thought cannot be neurotypical, the resulting behavior will likely not be typical.
- When you have experienced one individual with an FASD, you have experienced ONE individual with an FASD.
- FASD is a developmental, and sometimes also an intellectual, **DISABILITY**. Title II of Americans with Disabilities Act applies.

In order to stand trial, defendant must meet two criteria:

Criterion #1:

Culpability- Defendant's capacity to appreciate the wrongfulness of his conduct or conform his conduct to the requirements of the law, was significantly Impaired.

Individuals with an FASD often can not foresee the potential outcomes or results of their actions.



## Criterion #2:

Competency – Sufficiently mentally able to stand trial if one can understand the proceedings and can rationally deal with one's attorney.

People with an FASD can learn *just enough* to say “Yes, I understand,” but they often don't truly understand. Test the person's comprehension by asking various questions about the issue. Avoid yes- and no-type questions.



## Specific limitations that may get individuals with FASD into trouble

- Poor judgment in decision-making, cannot think of multiple options, limited thinking.
- Inability to think through cause-and-effect; doing the wrong thing without any intent to do harm, or awareness that harm could occur.
- Impulsivity, resulting in crimes like shoplifting (often things they don't really want or need).
- Heightened sensitivity to environmental stimulation: bright light, sounds, movement, tastes, smells can lead to state of hyper-excitability, uncontrolled anger, physical aggression.



## Limitations (2)

- Easily manipulated by others, becoming accomplices or the “fall guy” for real criminals.
- Demanding, loud, explosive at times.
- Inappropriate touching by males and females without understanding ramifications, can lead to criminal charges.
- Curiosity combined with poor judgment leads to criminal acts, i.e., playing with matches and starting fires that get out of control and appear to be arson.
- Socially inept, at times behaving 5-10 years younger than they are; tendency to associate with younger people with whom they feel more comfortable and accepted.



## Limitations (3)

- Little inhibition, no filter on their words and/or actions.
- Overly friendly and hungry for new relationships, making them vulnerable to “the bad guys.”
- High need for acceptance.
- Easily frustrated.
- Confusing the order and sequence of steps of a process; cannot remember more than two steps at a time.



## Limitations (4)

- Difficulty taking cues from others, misreading other people and then responding inappropriately.
- Need more time to think things through, to respond to a question or request. This hesitancy in responding can be misunderstood as guilt or averting the truth.
- Difficulty with concept of time, and poor time management.



## Limitations (5)

- Repeated pregnancies for females.
- Difficulty dealing with change and transition, can make them seem uncooperative or adversarial
- Often easily distracted, missing important information or making others think they are blowing them off.
- Rigid in thinking, can be difficult for them to change their minds.
- Poor short-term memory: need frequent reminders, sometimes make up a story if they cannot recall exactly what happened.

## Things to keep in mind, when an individual with FASD is incarcerated/institutionalized

- Overly anxious about everything, in a constant state of inner turmoil.
- Tendency to focus on the negative, cannot see positives.
- Tendency to isolate self when overly anxious, over-stimulated by environment, feeling troubled; this is their way of managing stress and keeping themselves out of trouble.



## More to keep in mind, with incarcerated individual

- Each attempted coping response might be misinterpreted by corrections staff. For example, an inmate who isolates himself (*self-isolates*) might be viewed by staff as being suicidal when the inmate is actually doing what he needs to do to remain stable and comfortable.
- If *staff impose* further *isolation* to a suicide watch cell, inmate may de-stabilize and be thrown into panic and distress.



## Current work of PA FASD Task Force involves screening

The PA FASD Task Force is currently working on developing and/or approving screens to identify those individuals, from newborns to adults, who have – or are at high risk for – an FASD-related disorder. One of the screens is specifically for use with youth and adults who enter the legal or correctional system.

If the screen is positive, assessment should be done by a professional or a team of professionals with the training and expertise to do so.

## Need to document FASD, when present or suspected

If FASD is confirmed, it must be recorded on the individual's medical record. If not confirmed but reasonably suspected, a note should be written that it is suspected and why, or that it is under consideration. Since institutionalized individuals with an FASD may be transferred from facility to facility, **it is important that this information be recorded where it will be quickly noted.**

## Urgent need for staff training

Institutional **staff should be trained to work with individuals with an FASD**. Staff must recognize that FASD is a legitimate disability and that they should make reasonable accommodations in living and working situations. They must also recognize that a disabled person must be offered the same services as non-disabled individuals (ADA Title II).

## Need appropriate placement of individual with FASD in jail, and a focus on rehabilitation and aftercare

Inmates with an FASD must **be on an appropriate unit** such as a mental health unit or unit that is especially designated for intellectually disabled persons. The focus is on interventions (treatment) not punishment. It is inappropriate to punish a person for being intellectually incapacitated.

Individuals with an FASD might well **need additional time and effort in planning discharge and re-entry into the community.**



## Tools for Success, as Recommended by SAMHSA

1. Some courts have judicial officers who determine how youth with FASD should be treated case by case, using fairness as a guide but also with public safety and security in mind.
2. Obtain an assessment for FASD if it is suspected and not yet confirmed. Develop a multidisciplinary team approach with the offender including: his family/caretaker, case manager, direct service provider(s), probation officer, assigned mentor, healthcare provider, possibly school personnel.



## 3. Consider/address living situation

- Unstable housing/homeless
- Group or foster home
- Family with poverty, unemployment, substance use issues
- Lack of access to regular healthcare
- Food insecurity
- Aging out of eligibility for needed services



4. During sentencing, FASD disability should be considered as mitigating factor when considering incarceration.
5. Use of a Mental Health Court or other special court for intellectually disabled persons is strongly recommended. The Diversion Process is recommended for all but the most serious crimes.



6. Services and programs for adjudicated youth with FASD may better prepare them to function in life and be re-integrated into the community.
7. Use of “restorative justice” or restitution (has some limitations for a person with an FASD).
8. Community service.
9. Electric monitoring as appropriate.





10. Law enforcement may:

- divert juvenile offenders out of the juvenile justice system
- refer them to alternative programs designed for youth with an FASD or intellectual disability
- refer to juvenile probation for intake or detention



11. Use a longer period of monitoring
12. Assign a mentor [Note: Individuals with FASD need mentoring].
13. Place in foster care, treatment facility, or group home

<https://store.samhsa.gov/product/Tools-for-Success-Curriculum-Working-with-Youth-and-FASD-in-the-Juvenile-Justice-System/SMA07-4291>

## Beware – prolonged institutionalization/incarceration may exacerbate the risks

- Further increase the damage to the person's brain.
- Deepen their mental health disorder(s).
- Lead to deterioration in thinking and in behavior.
- Danger of suicidality.

## Intervention – Additional considerations

- FASD rarely occurs in isolation, so need to identify & address co-occurring disorders and sources of adversity:
  - D&A especially common.
  - Trauma responses.
  - Other mental health disorders.
  - Assess the relationships of staff with the individual. Adjustments can be made. Need to avoid preventable trauma.
  - Assess relationships of other inmates with the individual. May be positive, exploitative, or both.
- Need early aftercare planning – many supports and a safety net will be needed.
- Plan beyond only the individual with FASD – holistic approach: individual, family, and community.

## Role of psychotropic medication

- No psychotropic medication addresses core FASD deficits, or can reverse pre-existing brain damage.
- At times, medication for person with an FASD may be less effective or result in more side effects. Responses vary.
- However, meds quite helpful for ADHD and other medication-responsive MH disorders.
- In addition, meds may enable person be more “present,” benefit more from services, have improved quality of life.
- Pragmatic approach to meds and FASD in general: Do what you can, always listen, look for strengths, learn as you go.

# Contact Information



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- Lyn Becker: [clyn.becker@gmail.com](mailto:clyn.becker@gmail.com)

- NOFAS (National Organization on Fetal Alcohol Syndrome) Roundup & website. Google “NOFAS Roundup.”
- SAMHSA (2014): Treatment Improvement Protocol (TIP) 58: Addressing Fetal Alcohol Spectrum Disorders. HHS Publication No. (SMA) 13-4803.
- SAMHSA:  
[http://www.fasdcenter.samhsa.gov/documents/FASDGuide12\\_01](http://www.fasdcenter.samhsa.gov/documents/FASDGuide12_01)
- Chasnoff, I. (2011): The Mystery of Risk: Drugs, Alcohol, Pregnancy, & the Vulnerable Child. New York: Barnes & Noble.

## FASD Resources (continued)



- AAP (American Academy of Pediatrics) FASD Toolkit. Google “Toolkit – AAP.org”
- Malbin, D (2002): Trying Differently Rather Than Harder: Fetal Alcohol Spectrum Disorders. FASCETS.org/resources, to order.
- The Eight Magic Keys for Teachers:  
<http://www.fasdcenter.samhsa.gov/documents/eightmagickeys.pdf>
- National Screening Tool Kit - Canadian Association of Pediatric Health Centres: <http://www.caphc.org>



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## Trauma-informed approach to person, family, team – core TI principles:

- **Safety** – physical & emotional, the sine qua non (Fallot & Harris)
- **Trustworthiness** – honesty, transparency, consistency (Fallot & Harris).
- **Choice** – opportunities for participation & daily decision-making (voice and choice) (Fallot & Harris).
- **Collaboration** – working together and sharing power (Fallot & Harris).
- **Empowerment** – prioritizing competency, skill-building, validation, strengths-based responses (Fallot & Harris).
- **Cultural, gender, linguistic, (and developmental) competence** – part of any effective system of care or intervention (SAMHSA).

### Talking to & interacting with person with FASD: Practical approaches – Dubovsky

- Identify strengths and supports.
- Reduce stimuli in environment (visuals & sounds) – esp. room.
- Use soft lighting and colors, avoid fluorescent lights.
- Use consistent routines, schedules, calendar – visual.
- Check for true understanding.
- Repetition, without impatience, is key.
- Prepare person for change in routines, & for transitions
- Make use of role-playing, & model desired behaviors.



## Talking to and interacting (2)

- Keep it simple -- limit number of goals and plans.
- Break things down to one step at a time.
- Whenever saying, “you can’t,” also add, “but you can...”
- When rule is broken, help person understand & remember it.
- Consequences, when needed, are immediate, related to what occurred, and completed preferably within same day.
- Don’t assume that lack of follow through is due to lack of motivation.



## Talking to and interacting (3)

- Don't use child's preferred activities as reward, or remove these in response to a negative behavior.
- Don't assume generalization of skills to other situations, or that child will necessarily learn from experience,
- Goal is inter-dependence, not necessarily independence.
- Learn signs of person getting stressed or anxious, and identify 1 or 2 things that help person calm down.
- Create or identify a potential "chill out" space.
- Person-first language – A child with FASD, not "FASD-child."



## Talking to and interacting (4)

- Use literal language – no metaphors or idioms.
- Be careful with humor – may be misunderstood.
- Assist with key tasks: forms/applications, managing money.
- Promote wellness: exercise, balanced nutrition, respect for culture.
- Assist with key tasks: forms/applications, managing money.
- Remember importance of support and relationships.
- Alertness to trauma & other disorders. Trauma-informed

## Screening tools

- For adults: Life History Form (LHF). Adult version developed by Dan Dubovksy and colleagues
  - Includes specific screening questions for FASD in adults.
  - Includes modifications, when working with person with positive screen
  - Ask screening questions such that person with FASD will understand.Dan Dubovsky email: [ddubovksy@verizon.net](mailto:ddubovksy@verizon.net)
- For youth: FASD Screening and Referral Tool for Youth Probation Officers (2010)
  - Screening checklist: social factors + personal factors via formula.
  - Decision to refer for assessment, if screen deemed positive.
  - Contact Asante Center for FAS in Canada. [www.asantecentre.org](http://www.asantecentre.org)