


Supporting children and young people with Fetal Alcohol Spectrum Disorder (FASD)



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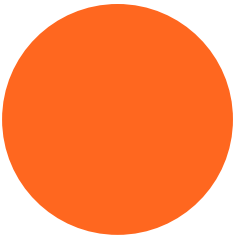
The Centre for Excellence in Therapeutic Care acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians and owners of this land. We pay our respects to their elders past and present and to the children who are their leaders of tomorrow. We acknowledge their history and living culture and the many thousands of years in which they have raised their children to be safe and strong.



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Desired Outcomes



This workshop will help you:

- identify the key features of FASD
- recognise the possible effects of prenatal alcohol exposure over the lifespan
- Identify the range of behavioural and emotional presentations of FASD and the overlap with trauma
- identify features of appropriate support, intervention and planning
- reflect on opportunities to apply learnings with residential space



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Agenda

- **Introduction, acknowledgement, welcome and poll – who is with us today?**
- **Case study – introducing Nate**
- **Introduction to FASD**
- **BREAK @ 11:00-11.10am**
- **Nate's case study through a FASD lens**
- **Break out room**
- **Comments, questions and close**



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Case study – introducing Nate (14)

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Nate's background

- Parental substance use, mental health issues and family violence
- Child protection pre-birth report, family homeless, violence, older siblings in permanent care
- Nate born withdrawing from opiates
- Placed with MGM, mother in the home, IVO against father
- Nate seemed well cared for, appeared attached to MGM
- FV incident, father incarcerated when Nate 6 mo
- mother using substances, placed Nate at risk
- Order breached at 18 months, Long term care with MGM
- Placement ended age 3 due to MGM's health

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Nate's early childhood

- Difficulties adapting to kinder routine
- Social skills delay, difficulty expressing himself
- Hitting, biting, aggression
- Delayed toilet training
- Hard to understand speech
- Emotionally dysregulated, impulsive
- At home, hurt the dog, needed constant supervision
- Didn't appear to listen or follow instructions
- Psych assessment at 5 – language delay, ADHD, repeated 4 yr old kinder
- Multiple placements between 3 - 4 ½.



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Reflective questions

What is going on for Nate?
How can we understand his behaviour?
What does he need?



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Nate's primary school years – at school

- Difficulty sitting still, focusing, some improvement with Ritalin
- Emotional and physical outbursts, aggression
- School exclusion
- Difficulty with social skills, conflict with other children
- Struggling academically, made some gains with reading, challenged by maths

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Nate's primary school years – at home

- Behaves like a much younger child
- Lying, stealing items, not showing remorse
- Gets fixated,
- Doesn't often show empathy or appreciation
- Doesn't sustain attention for long, except gaming – gets obsessed
- Conflicts with other children, can be verbally abusive or hit others
- Carers avoiding many situations – loud, noisy, over stimulating
- Can be loving and affectionate with carers, worries if someone gets hurt, helpful around the house

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Supports/interventions

- Psychology, child psychiatry, play therapy, equine therapy
- Social skills groups, speech pathology, tutoring
- Child mental health services – diagnosed Attachment disorder, anxiety, ODD
- Supervised contact with siblings, respite, camps
- Carers trained in trauma-informed care, Tuning into Kids, parenting supports, life story work
- Tried activities – can't sustain them. Asked to leave camp (hurt animal)
- Sexting at school, accessing porn. Restricted to half days at school
- Incident at home – aggression, threats, property damage – placement breakdown



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Reflective questions

What is going on for Nate?
How can we understand his behaviour?
What does he need?



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Nate at 14, in residential care

- In his 4th unit in 2 years, conflicts with other residents
- Attending specialised learning unit but rarely goes
- Challenges around boundaries and routines, sleeping, showering
- Fixated on x-box, gets aggressive
- Significant damage to the unit
- Difficulty sharing attention of staff with other residents
- Behaviour upsetting to other residents
- Unrealistic hopes for future as a rapper



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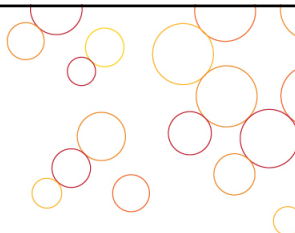
Nate at 14, in residential care

Currently:


- Drawn towards 16 year old resident Andy
- Started going out, staying out late, come back alone, substance affected
- Has been assaulted
- Preoccupied with revenge, talking about stabbing someone
- Asked 13 year old girl to be his girlfriend



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How can we understand Nate's behaviour?
How would you advise the youth workers to support him?




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The child protection worker contacts you and says Nate's younger brother (Tyson, 6) has been diagnosed with FASD.



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A presentation slide with an orange background. The text "What is FASD?" is written in white on the left side. On the right side, there is a cluster of overlapping circles in shades of orange, yellow, and red. In the bottom right corner, there is a logo for the Australian Childhood Foundation and the Centre for Excellence in Therapeutic Care, with the text "Delivered in Partnership with Southern Cross University" below it.

What is FASD?

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A presentation slide with a dark red background. A large white circle is centered on the slide, containing the text "FASD is: a neuro-developmental disorder caused by exposure to alcohol during a pregnancy". On the right side of the slide, there is a pattern of overlapping circles in shades of orange, yellow, and red. In the bottom left corner, there is a logo for the Australian Childhood Foundation and the Centre for Excellence in Therapeutic Care, with the text "Delivered in Partnership with Southern Cross University" below it.

FASD is:
a neuro-developmental disorder
caused by exposure to alcohol
during a pregnancy

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FASD is:
a neuro-developmental disorder
caused by exposure to alcohol
during a pregnancy

**It affects about 1:100 people
in Australia**



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Prenatal alcohol exposure can cause:

- birth defects
- abnormal brain development
- functional impairments
- facial features occur in about 13% of cases



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Greatest impact of prenatal alcohol exposure is to the brain

cognition memory
attention
language social skills
planning communication
making choices



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Features of FASD include:

Developmental delays

- speech, language, social skills
- cognitive impairment may be present, but often isn't

Learning difficulties

- difficulty with reading, maths, abstract concepts
- difficulty learning and remembering routines
- problems with planning and sequencing



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Features of FASD include:

Behavioural characteristics

- difficulty controlling impulses
- may not show empathy
- may not take responsibility for their actions
- difficulty controlling frustration and anger
- difficulty identifying consequences of their actions

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Challenges for carers and professionals

- FASD often looks like the effects of trauma, or what we think of as trauma
- making sense of FASD as a disability
- may say they understand when they don't
- good verbal skills mask underlying impairments
- "talk better than they think"
- show insight at times, but can't follow through
- doesn't seem to make progress

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What carers say

“He presented as being a lot more competent than he actually was because of his verbal skills. Despite his speech not being clear, his written verbal skills were really quite excellent and he was quite creative, you know, he used to write stories, he had good computer literacy from an early age and music.”



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What carers say

Without a plan or advance warning my son loses it. It's impacted on every part of his development – and he struggles.

They get put in the too hard basket at school.

I don't get him to sleep till 2 or 3 in the morning, then he wakes up at 6am.



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What carers say

There is no cause and effect – they don't understand the consequences.

They can switch from abuse and anger to loving in an instant and they don't remember what happened.

I am on standby every hour of the day to respond.

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What carers say

When I finally found out (when she was 17) what was wrong, as much as it was a really difficult thing to deal with in the beginning, I could finally breathe. I knew what the problem was. I knew I had to re-adjust my expectations.

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Every child is unique, but there are patterns

- different dose, timing
- different amount of exposure
- different genetics
- mother's health, age, diet all have an effect
- post-birth environment has an impact
- trauma exacerbates the effects of FASD

Each child has unique strengths and abilities



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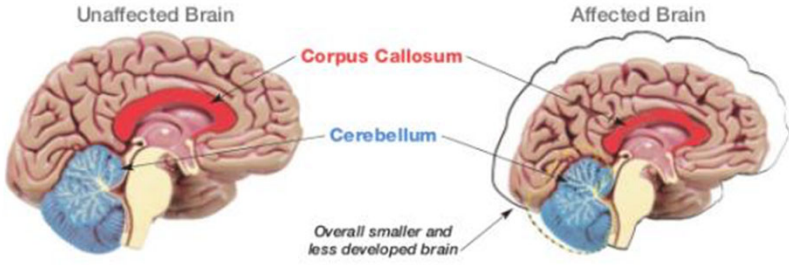
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How does alcohol affect the developing brain?

- Alcohol is a teratogen
- More harmful than other illicit substances
- Affects the fetus in many different ways – development of cells, blood flow to placenta, development of neural pathways
- Can change the structure of the brain
- Brain functions show the impact

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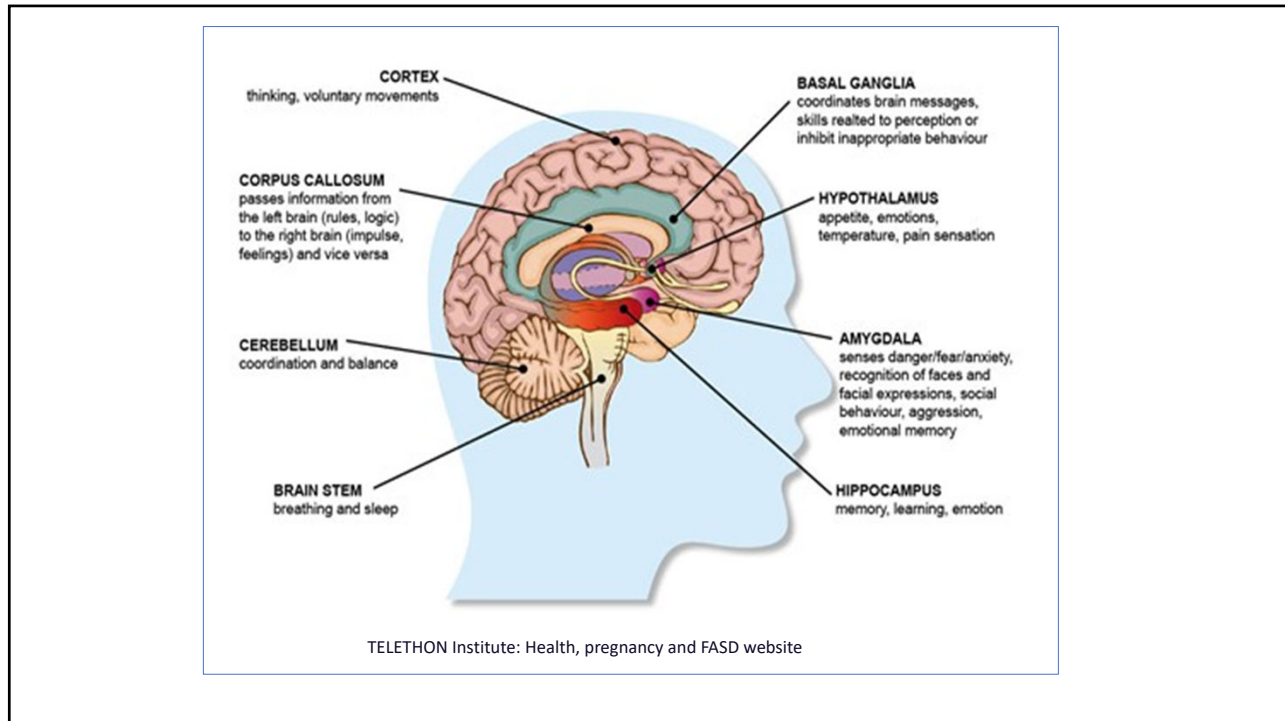
Brain Structures Most Sensitive to Prenatal Alcohol Exposure



Brain Structure	Function	Prenatal alcohol exposure may result in problems with:
Corpus Callosum	Communicates motor, sensory and cognitive information between the two hemispheres of the brain	Storing and retrieving information, problem solving, attention and verbal memory
Cerebellum	Processes input from other areas of the brain to coordinate motor and cognitive skills	Controlling movements, maintaining balance and fine motor skills



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Animal studies

Normal mouse

Alcohol-exposed mouse

Dr Kathleen Sulik, University of North Carolina

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Structural changes visible on MRI

Figure 1: T1-weighted structural magnetic resonance imaging scans of four children demonstrating significant variability in brain structure among children with fetal alcohol spectrum disorders relative to an unexposed child. (A) Typically developing 10-year-old male, unexposed child. (B) 11-year-old male child with partial fetal alcohol spectrum disorders. (C) 7-year-old female child with fetal alcohol syndrome (FAS), and 14-year-old male child with FAS (D).

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Timing and dose make a difference

Age of Embryo (Weeks)	Organ System	Major Congenital Anomalies (Red)	Functional Defects & Minor Congenital Anomalies (Yellow)
1-2	Central Nervous System (C.N.S.)	Yes	Yes
3-4	Heart	Yes	Yes
4-6	Upper Limbs	Yes	Yes
4-8	Lower Limbs	Yes	Yes
4-8	Eyes	Yes	Yes
5-8	Teeth	Yes	Yes
6-8	Palate	Yes	Yes
7-8	External Genitalia	Yes	Yes
8-16	Ear	Yes	Yes

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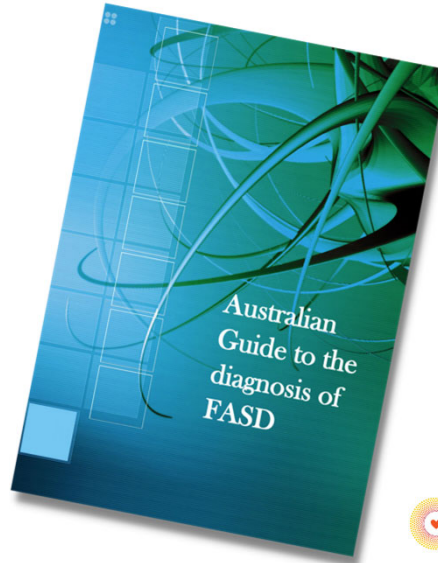
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FASD Diagnosis

- Prenatal alcohol exposure
- Severe impairment in 3 or more brain domains
- Facial features may or may not be present

2 diagnostic terms

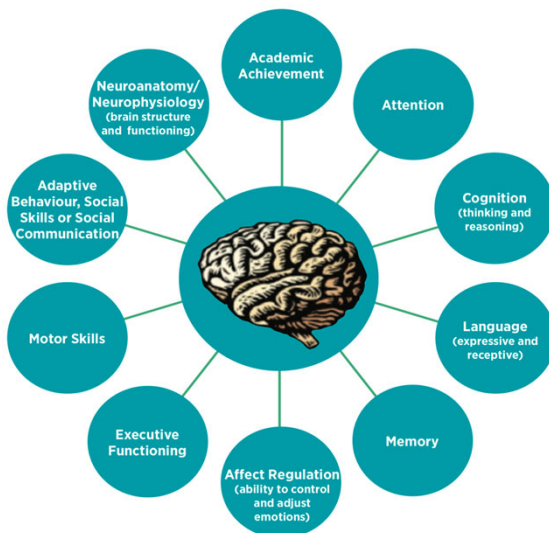
- FASD with 3 sentinel facial features
- FASD with < 3 sentinel facial features



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Brain domains assessed



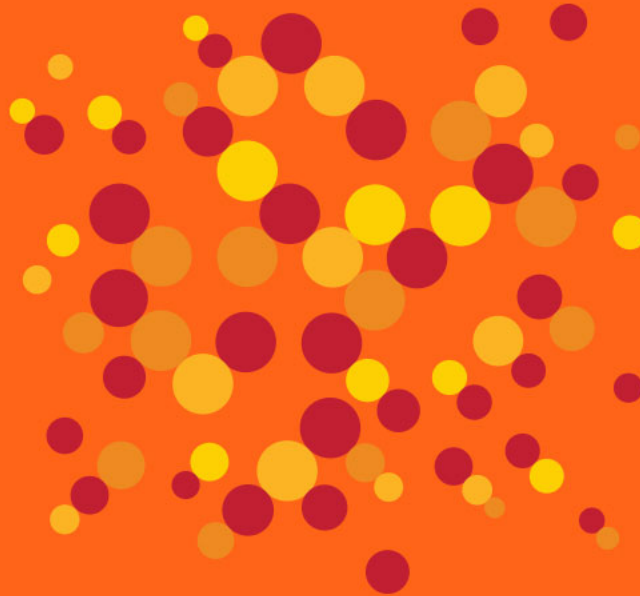
Requires input from:

- Paediatrician
- Psychology/Neuro-psychology
- Speech Pathologist
- Occupational Therapist
- Social Worker

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FASD across the lifespan



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A neuro-behavioural approach

The environment influences the way some FASD symptoms affect a child or young person.

Primary symptoms reflect the brain injury, eg:

- Poor memory
- Difficulty paying attention
- Hyperactivity
- Slow learning pace

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A neuro-behavioural approach

The environment influences the way some FASD symptoms affect a child or young person.

Primary symptoms reflect the brain injury, eg:

- Poor memory
- Difficulty paying attention
- Hyperactivity
- Slow learning pace

Secondary effects emerge when there is a poor fit between the person and their environment, eg:

- Frustration
- Anger
- Overwhelmed
- Depression
- Self harm



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Without appropriate supports:

The likelihood of negative long term outcomes increases, including risks of

- Being in trouble with the law
- Mental health problems
- Drug and alcohol problems
- Homelessness
- Dropping out of school
- Living in violent relationships
- Having children taken into care



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Infants

- Prematurity
- low birth weight
- withdrawal from substances
- slow to reach milestones
- slow growth
- irritable
- over-sensitive to stimulation



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Preschoolers

- slow to speak
- fine and gross motor difficulties
- clumsy, poor balance
- delayed toilet training
- feeding issues
- sleep problems
- emotional outbursts
- familiar with strangers
- social skills delay
- don't understand danger
- take longer to learn routines
- oversensitive to sensory input
- anxiety



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In Primary School

- not keeping up academically
- repeat mistakes, don't learn from mistakes
- difficulty following instructions
- doesn't seem to listen
- over-active, over stimulated
- misreads social cues
- difficulty making and keeping friends
- easily distracted
- doesn't complete tasks
- can be rigid



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In Primary School

- not keeping up academically
- repeats mistakes, doesn't learn from mistakes
- difficulty following instructions
- doesn't seem to listen
- over-active, over stimulated
- misreads social cues
- difficulty making and keeping friends
- easily distracted
- doesn't complete tasks
- can be rigid
- can't generalise rules and expectations
- loses belongings
- doesn't tell the truth
- say they understand when they don't
- takes risks
- gets obsessed
- may want to be in control
- can't see things a different way
- seems oppositional
- escalates quickly
- anxiety continues



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As expectations of the child increase...

- self-regulation
- managing social situations
- learning
- independence
- responsibility for self care

...it becomes harder for the child to meet them

- child becomes more frustrated, dysregulated
- consequences for aggression become more serious



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Young people

- academic difficulties continue
- disorganised
- needs prompting for self care
- can't remember routines
- seem immature, shows off - annoys others
- lying - confabulation
- stealing - difficulty with ownership
- wants independence but struggles when unsupervised
- seems oppositional
- difficulty shifting thinking



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Risks increase with age

- low self esteem
- school refusal
- running away
- excluded from school
- self harming/depression
- drug and alcohol use
- placement breakdown
- victim of assault
- injuries to self - accident or intentional
- risk of exploitation



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In adulthood

- make agreements but don't follow through
- miss appointments
- don't engage with services
- lacks insight
- doesn't seem to make progress
- can't keep a job
- makes poor choices and doesn't learn
- lacks parenting skills/children in out of home care
- anxiety, depression, other mental health issues
- victim of violence
- drug and alcohol issues
- homeless



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FASD is often missed because

- The child's symptoms can look like trauma
- No-one has asked about prenatal alcohol exposure, or information is missing
- Professionals aren't aware of FASD – psychology, childcare, school – so it's not raised
- Lack of clarity about who/how to diagnose
- Cost/funding/availability/access
- **People are not sure if the diagnosis will make a difference**

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Trauma and FASD: what's the difference?

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Trauma has been associated with

- Cognitive and language delay
- Problems with memory
- Pattern of dysregulation
- Hyperarousal, hypervigilance, reactivity, even when there is no threat
- Dissociation, inattention, zoning out
- Difficulties processing emotional information
- Lack of cognitive flexibility
- Behavioural regulation problems
- Sensory integration issues
- Forgetfulness, not paying attention, disorganised thinking
- Sleep problems
- Sense of bodily dislocation



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SIDEBAR 1.

Domains of Impairment in Children Exposed to Complex Trauma

I. Attachment	IV. Dissociation	VI. Cognition
Problems with boundaries Distrust and suspiciousness Social isolation Interpersonal difficulties Difficulty attuning to other people's emotional states Difficulty with perspective taking	Distinct alterations in states of consciousness Amnesia Depersonalization and derealization Two or more distinct states of consciousness Impaired memory for state-based events	Difficulties in attention regulation and executive functioning Lack of sustained curiosity Problems with processing novel information Problems focusing on and completing tasks Problems with object constancy Difficulty planning and anticipating Problems understanding responsibility Learning difficulties Problems with language development Problems with orientation in time and space
II. Biology	V. Behavioral control	VII. Self-concept
Sensorimotor developmental problems Analgesia Problems with coordination, balance, body tone Somatization Increased medical problems across a wide span (eg, pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)	Poor modulation of impulses Self-destructive behavior Aggression toward others Pathological self-soothing behaviors Sleep disturbances Eating disorders Substance abuse Excessive compliance Oppositional behavior Difficulty understanding and complying with rules Reenactment of trauma in behavior or play (eg, sexual, aggressive)	Lack of a continuous, predictable sense of self Poor sense of separateness Disturbances of body image Low self-esteem Shame and guilt
III. Affect regulation		
Difficulty with emotional self-regulation Difficulty labeling and expressing feelings Problems knowing and describing internal states Difficulty communicating wishes and needs		

Complex Trauma in Children and Adolescents
 Cook, Alexandra; Spinazzola, Joseph; Ford, Julian; Lanktree, Cheryl; Blaustein, Margaret; et al. *Psychiatric Annals*; Thorofare Vol. 35, Iss. 5, (May 2005): 390-398.

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Most studies of trauma's impact on brain development don't control for FASD or prenatal alcohol exposure

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frontiers in HUMAN NEUROSCIENCE REVIEW ARTICLE
published: 19 March 2012
doi: 10.3389/fnhum.2012.00052

Neuroimaging of child abuse: a critical review

Heledd Hart* and Katya Rubia

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Childhood maltreatment is a stressor that can lead to the development of behavior problems and affect brain structure and function. This review summarizes the current evidence for the effects of childhood maltreatment on behavior, cognition and the brain in adults and children. Neuropsychological studies suggest an association between child abuse and deficits in IQ, memory, working memory, attention, response inhibition and emotion discrimination. Structural neuroimaging studies provide evidence for deficits in brain volume, gray and white matter of several regions, most prominently the dorsolateral and ventromedial prefrontal cortex but also hippocampus, amygdala, and corpus callosum (CC). Diffusion tensor imaging (DTI) studies show evidence for deficits in structural interregional connectivity between these areas, suggesting neural network abnormalities. Functional imaging studies support this evidence by reporting atypical activation in the same brain regions during response inhibition, working memory, and emotion processing. There are, however, several limitations of the abuse research literature which are discussed, most prominently the lack of control for co-morbid psychiatric disorders, which make it difficult to disentangle which of the above effects are due to maltreatment, the associated psychiatric conditions or a combination or interaction between both. Overall, the better controlled studies that show a direct correlation between childhood abuse and brain measures suggest that the most prominent deficits associated with early childhood abuse are in the function and structure of lateral and ventromedial fronto-limbic brain areas and networks that mediate behavioral and affect control. Future, large scale multimodal neuroimaging studies in medication-naïve subjects, however, are needed that control for psychiatric co-morbidities in order to elucidate the structural and functional brain sequelae that are associated with early environmental adversity, independently of secondary co-morbid conditions.

Keywords: child abuse, maltreatment, fMRI, DTI, PTSD, executive functions, prefrontal cortex, limbic system

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Comparison of children with PAE and PAE+ trauma

The combined effects of prenatal alcohol exposure and childhood trauma: findings from a four-year research project at the University of Salford.

By pcook Oct 14, 2019

By Alan Price, PhD

Foetal alcohol spectrum disorder (FASD) is the range of conditions that can be caused by prenatal alcohol exposure (PAE). People with FASD can have a wide range of physical and mental difficulties, especially with planning, attention, impulsivity, coordination, social communication, emotional arousal, and memory. These difficulties can impact daily living, school, work, social relationships, and long-term health and wellbeing. In the UK, it is estimated that at least 3%, and possibly up to 17% of the population would qualify for a diagnosis on the foetal alcohol spectrum, although the majority will never be diagnosed. FASD has been known about for several decades but does not yet receive appropriate attention in schools and universities, meaning that many doctors, teachers, social workers and other professionals are not trained to spot the signs of FASD. This can leave children and adults with FASD struggling with the academic and social demands of everyday life without the support they need. Unsupported, people with FASD are more likely to be excluded from school, lose their job, struggle with addictions, and be convicted of a crime. FASD is thought to be especially common in looked after and adopted children and care leavers. Many of these individuals also have histories of traumatic experiences such as abuse or neglect in early childhood, which are also known to lead to developmental difficulties similar to those seen in FASD.

<https://hub.salford.ac.uk/salfordpublichealth/2019/10/14/the-combined-effects-of-prenatal-alcohol-exposure-and-childhood-trauma-findings-from-a-four-year-research-project-at-the-university-of-salford-by-alan-price-phd/>

“... children with both PAE and a history of trauma appear to function similarly to children with just PAE and tend to have more severe difficulties than children with just trauma. Therefore, the difficulties seen in children with both of these exposures seem to be primarily caused by PAE rather than childhood trauma.”



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Children with FASD over-represented in OOHC

Prevalence of FASD among children in child care system – orphanage, foster care, child welfare system internationally

- 23%

Lange, S., Shield, K., Rehm, J., & Popova, S. (2013). Prevalence of fetal alcohol spectrum disorders in child care settings: a meta-analysis. *Pediatrics*, 132(4), e980-995.

- Prevalence of FASD among children in care – meta-analysis
 - USA - 39%
 - Chile - 34%
 - Russian orphanages – 68%

Popova, S., Lange, S., Shield, K., Burd, L., & Rehm, J. (2019). Prevalence of fetal alcohol spectrum disorder among special subpopulations: a systematic review and meta-analysis. *Addiction (Abingdon, England)*, 114(7), 1150–1172.



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FASD – missed diagnosis in care

Random sample of 547 children in care who had undergone a medical behavioural or neurodevelopmental assessment, usually for 'behavioural problems':

- 156 children were assessed with FASD
- 125 had never been diagnosed

86.5% had either:

- Never been diagnosed
- Had been misdiagnosed

Chasnoff, I. J., Wells, A. M., & King, L. (2015). Misdiagnosis and Missed Diagnoses in Foster and Adopted Children With Prenatal Alcohol Exposure. *Pediatrics*, 135(2), 264–270. <https://doi.org/10.1542/peds.2014-2171>



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Prenatal alcohol exposure in children in care

Audit of children seen at UK community paediatric clinic between 2010-2013 where there was history of prenatal alcohol exposure

- 72 children diagnosed with FASD during this period
- 34% of children in out of home care had prenatal alcohol exposure
- 75% of children placed for adoption had prenatal alcohol exposure

Gregory, G., Reddy, V., Young, C., 2015. Identifying children who are at risk of FASD in Peterborough: working in a community clinic without access to gold standard diagnosis. *Adoption & Fostering* 39, 225–234. doi:10.1177/0308575915594985



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Significant numbers of children in OOHC in Australia have trauma + undiagnosed FASD

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FASD practice

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Key principles

1. Understand the brain and behaviour
2. Adapt and accommodate
3. Keep it simple, support and scaffold
4. Focus on strengths and reframe success
5. Manage risks



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1. Understand the brain and behaviour

- Assessment and diagnosis
- Read the detail! Understand the impact of the child's impairments
- Reframe behaviours as brain-based
- Notice when frustration/anger is overload/overwhelm
- If it's can't not won't - what can you do differently?
- Acceptance – FASD is a permanent disability – but a diagnosis can open doors



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1. Understand the brain and behaviour

When we see FASD, we can recognise that a young person:

- has been masking an impairment
- hasn't been understanding
- struggles to remember information
- gets angry when feels vulnerable
- needs reminders
- has difficulty with planning
- will need transport to get to appointments
- needs targeted skills training
- manages with support but can't manage when support ends
- might need ongoing support in areas of daily life to succeed and maintain gains



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2. Adapt and accommodate

- Physical environment
- Rules and expectations
- Simplify tasks
- Use visual supports
- Reduce expectations
- Identify what is helping or not helping in the environment
- Explicit teaching of skills



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Adapt our usual strategies

- understand limitations of cognitive-based and behavioural approaches
- identify when we are using methods that rely on cognitive skills - when we expect the young person to change their thinking
- focus on prevention of behavioural issues
- adapt positive behaviour support approaches
- consequences need to be natural, immediate and concrete
- reduce expectation that young person can apply their skills in other settings
- reduce expectation that young person can manage themselves
- applying these principles to OT, therapies
- avoid approaches that don't have evidence for FASD



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3. Keep it simple, support and scaffold

- Keep language concrete and simple
- Short sentences
- Check for true understanding
- Lots of repetition
- Structure and consistency
- Recognise disconnect between expressive and receptive language skills
- Provide support to use strategies - don't expect independence
- Supervision to reduce risk
- Anticipate challenges and plan ahead
- Consistency between home and school
- Supports may need to be long term



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4. Focus on strengths and success

- Lots of time doing things they are good at
- Create opportunities to use their strengths and talents to build self esteem
- Reframe what 'success' looks like
- Identify opportunities for future learning, work and create pathways
- Use NDIS funding to tailor supports
- Educate the young person about FASD

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Strengths

A small study exploring the school and life experiences of adults with FASD found that individuals derived strength from

- asking for help
- having FASD-informed teachers
- being involved in school activities that fit their interests and abilities and create opportunities for friendship
- participating with youth groups
- engaging in elder support
- reaching out to help others
- gaining self-insight through FASD diagnosis

Flannigan, K., Harding, K., & Reid, D. (2018). Strengths among individuals with FASD. *CanFASD*, September, 1–4.



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5. Manage risks

- Recognise when increased risks are due to impulsivity and executive function impairments
- Don't expect the young person to use strategies that rely on learning, memory, controlling impulses, making better choices
- Reduce expectation that the child or young person will be able to take an active role in keeping themselves safe
- Increase supervision
- Focus on relationships
- Change environments



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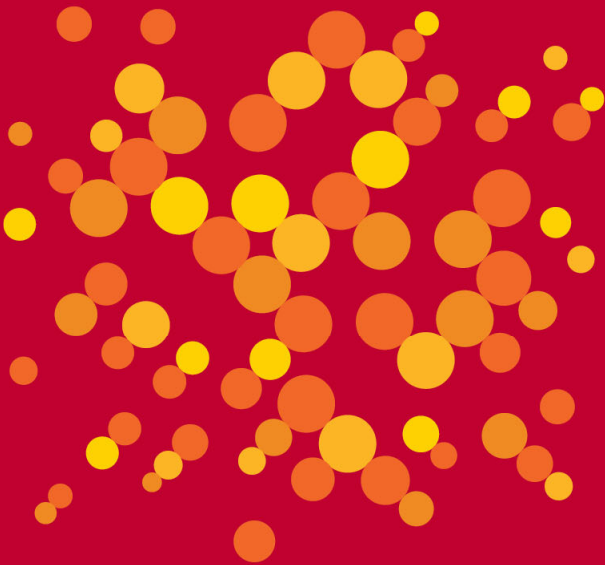
**10 Minute BREAK
(11:00 – 11:10 AM)**



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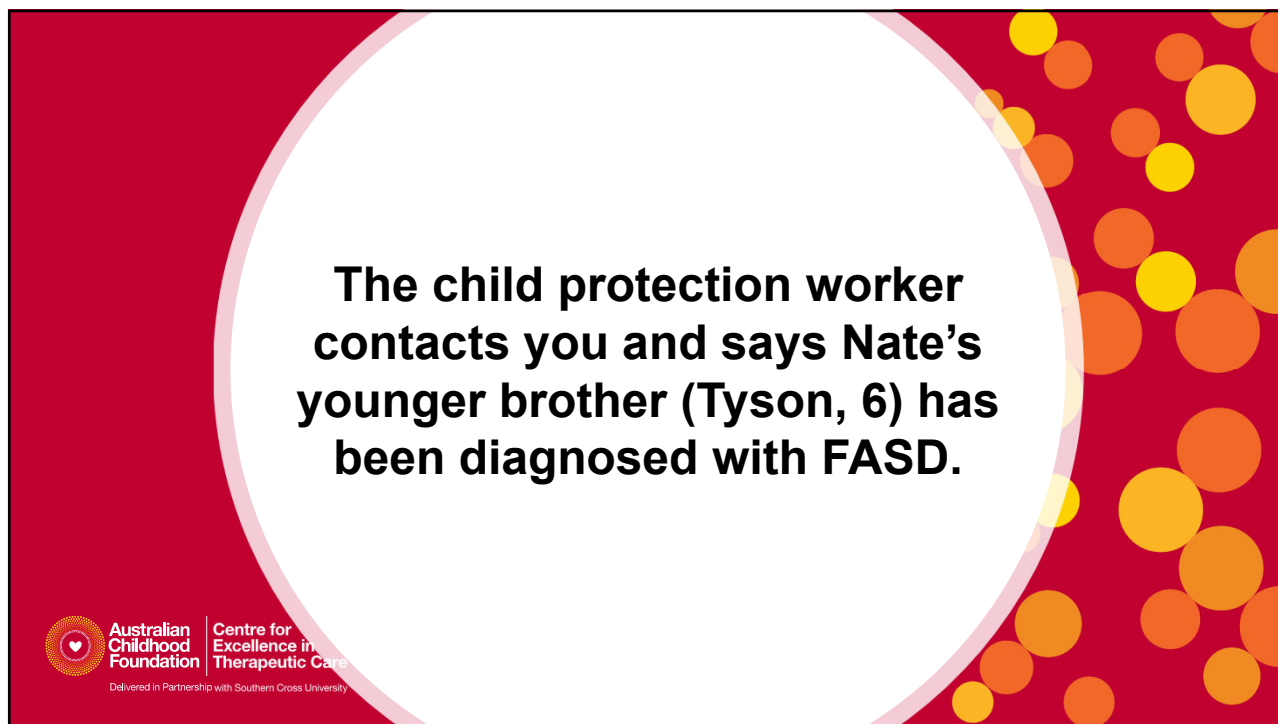
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**Case study –
returning to Nate**




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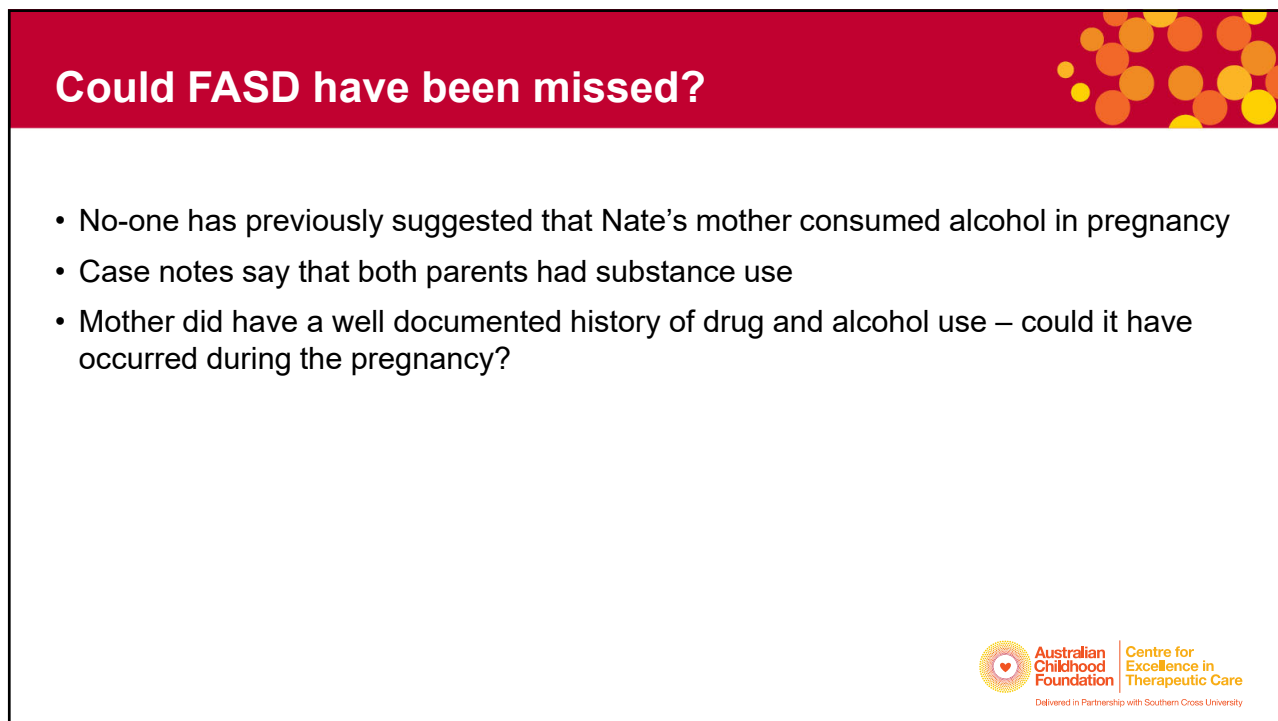
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The child protection worker contacts you and says Nate's younger brother (Tyson, 6) has been diagnosed with FASD.


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Could FASD have been missed?

- No-one has previously suggested that Nate's mother consumed alcohol in pregnancy
- Case notes say that both parents had substance use
- Mother did have a well documented history of drug and alcohol use – could it have occurred during the pregnancy?

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The case team makes a plan....

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Information gathering

- Child protection file review – some information relevant but it's unclear
- Paediatrician requests birth records – alcohol indicated
- MGM confirms she saw alcohol being consumed in pregnancy

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Prenatal alcohol exposure is confirmed...

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Further assessments?

- Needs speech, OT and neuro-psych – but Nate may not agree
- Paediatrician gets birth records – head circumference was **under 3%ile**
- OT assessment at the house – **fine motor skills** severely impaired
- **ADHD** already diagnosed – combined type, so goes to **Executive Function**
- Staff and teachers complete questionnaires – **Executive Function** and **Adaptive Function** severely below
- School psychologist reviews reports – reading ok, maths very low (**Academics**)
- Nate agrees to a short session with Neuro-psych who identifies impaired working memory (**Exec Function**) as well as strengths in Memory
- **Language impairment** previously assessed

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Diagnosis

Paediatrician reviews results and diagnosis Nate with FASD with <3 facial features.

Severe impairment in 6 domains:

- Neurology (small head circumference at birth)
- Academics
- Executive function
- Fine motor skills
- Receptive and expressive language
- Adaptive function/social communication.



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Reflective questions

What does this new diagnosis mean for understanding Nate's behaviour?

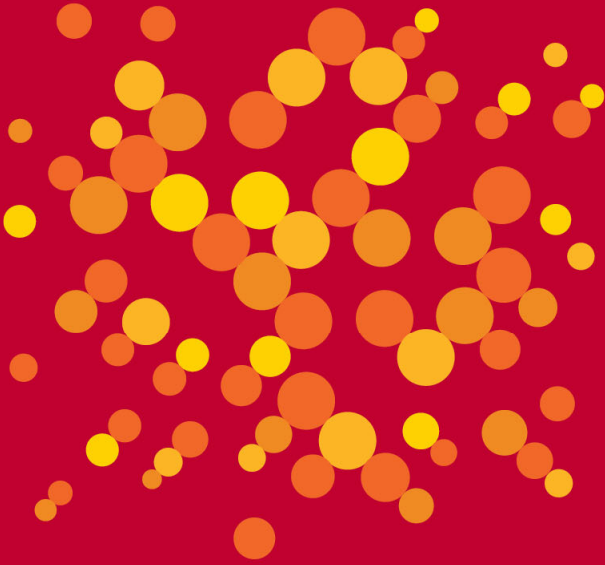
What does it change about our approach?

What would we do differently, to support him?



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Break out room




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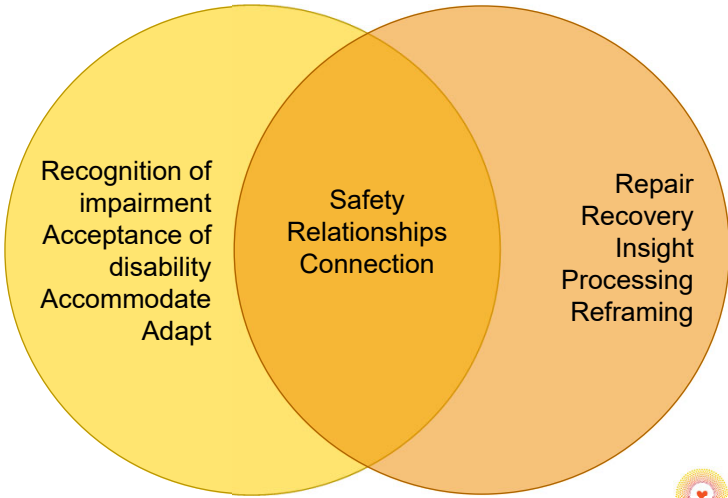


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FASD and Trauma informed approaches

Left Circle:


- Recognition of impairment
- Acceptance of disability
- Accommodate
- Adapt

Intersection:


- Safety
- Relationships
- Connection

Right Circle:

- Repair
- Recovery
- Insight
- Processing
- Reframing



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