

# What specific characteristics of FASD need to be taken into account in family court and in the child welfare system?

1. Common – A high prevalence of prenatal alcohol exposure has been reported among children in care – so the risk of having an organic brain disorder in this population is high. The CW system needs to recognize that it is so common in presentation that we should be convinced to rule it out rather than be convinced to include it!
2. Complicated – children placed in care have unique risk factors for development “without” the complications of FASD. Critical case management errors occur because the system fails to consider the possibility of FASD in the child, its attendant long-term ramifications and also fails to consider the possibility that the parent(s) may be compromised by this birth defect as well.
3. Expensive – complexity of care that is influenced by the developmental trajectory – most expensive care is for individuals with FASD who fall in the 11-15 age group – followed by 6-10 year olds – followed by the least expensive care for birth to 5 years.  
\*\* The cost of FASD (Popova.Lange.Burd.Rehm)
4. The common, complicated and expensive also plays out intergenerationally! Children not served developmentally in the CW system come back to the system with children of their own. Children who may also have an FASD with parents who may only be able to care IF they receive and accept support.

# This presentation will focus on current problems in the system with proposed solutions:

## THE ISSUES:

- The child protection system – as it is working now - stops us from doing what really needs to be done – especially with birth mom
- The system sees children and often their parents as “bad” rather than hurt
- There are few child welfare agencies where training to the complexities of FASD occurs
- We separate birth mother from children with FASD – and we don’t see her again until she brings us another child to take care of – legal structure restrains us.
- There are few models of collaboration within child welfare agencies that share and respects the principle that children coming into care is a failure of the community and not of the mother or the family
- We fail to address the developmental needs of children and youth in care while we navigate the court system to secure the legal authority necessary to “do the work”.
- “Being a good guardian” for children with FASD is not understood in the child protection systems. WE need to create environmental supports to prevent secondary trauma, placement instability and optimize safe participation in a meaningful life
- What happens to children and youth with FASD when their parents fail to cope?

# Why do children and youth come into care or return to care?

- Their biological parents are unavailable due to addiction and/or mental health problems
- The needs of these children often exceed the caregivers (birth/adoptive/foster/kinship) ability to care
- It is not unusual for their caregivers to be misunderstood and/or accused of inappropriate care as they struggle to manage their developmental needs

# Also...there are many court based dilemmas

- Issues of “informed consent” – this is a disability characterized by information processing deficits. It is hard to determine what is understood.
- Transitions required to serve children past the age of majority - Children and youth with FASD’s are often oppositional to plans and rarely benefit from the wisdom of community or government advocates.
- Currently there is lack of training on FASD for judges, lawyers and child welfare workers in their core curriculum.
- Information on what to base decisions is often incomplete, fragmented, not coordinated and coming from multiple sources. A collaborative and timely model across many systems is needed.

# Case Management – specific to FASD - is vital for the following reasons:

- Frees us to focus on the developmental needs of these children and youth and not only in the management of the legal authority.
- Creates a focus on the birth mom that supports prevention to further children with this disability being born
- Allows for the care to be specific to the needs of the family and placement stability
- Focuses intervention plans to the medical and developmental needs
- Creates a collaborative response to education, medical needs, placement stability priorities etc.

# Would we create improved outcomes for children and youth with FASD if we developed practice standards in Child Welfare?

- Early identification
- Appropriate service planning - A collaborative and timely model across many systems is needed.
- Specialized training to agency staff, families and caregivers
- Focus all intervention on the need to increase placement stability
- Focus intervention on the reduction in the incidence and severity of secondary disabilities
- Plan for meaningful and effective transitions to adult services
- Work in collaboration with all service partners



**COLLABORATE  
OR  
DIE**

Debolt

There is evidence and consensus among experts that collaboration among relevant service providers is effective

- increases the circle of influence
- provides “training” and advocacy to the best practice intervention principles
- expands skills and knowledge beyond the case managers capacity – elements of “collective wisdom”
- collaboration can support a willingness by the community to see child protection as everyone’s responsibility



# Purpose of Creating “Strategic Alliances”

- rise above “core business” to work towards common goals
- will be mutual benefit
- shared risk
- “collective wisdom” – complimentary knowledge, skills and abilities
- creates elements of equality – reciprocity
- strength in numbers
- Facilitate complex problem solving
- No one group has all the answers – FASD has perplexed us for 40 years!
- The “world cooperates with a made up mind”! A common purpose creates movement

# How do we do this???

- begin with significant purpose and trust
- be clear about shared goals
- be clear about the cost of not doing this well – the cost of “non-involvement”
- create opportunities for shared learning
- identify tangible and achievable strategies – early success will move the group forward
- understand that collaboration is a process and not an event

# What do we do!

Prevent children and youth from coming in to the care of the child intervention system in the first place!

Means what?

Women mothering under duress – pregnant and parenting – with addictions/homelessness/family violence - require specialized care.

Children with FASD living in adoptive/foster/kinship families often present with behavior that challenges the permanence of the placement.

Recognize that the needs of individuals with FASD often “exceed the caregivers ability to care”.

# What do we do!

- Child Welfare – by default – receives referrals of children with FASD – they come to us because of their cascading vulnerabilities. The legal lens of “hurt not bad” is the best framework for practice.
- Valuing the prenatal experiences of children being referred for service as much as the post natal experiences.
- Valuing the developmental assessments in the birth to school age period and consider that, as expectations increase, so might the developmental needs
- There is a predictable developmental trajectory that needs to be anticipated and supported. There is a very good reason why the needs increase as they age.....there is no anticipation of need and no “getting ready” for the needs occurring in the system.

# What do we do!

Ensure placement stability. Research has led to recommendations that include supporting stability in the child's life through engaged casework supervision.

We know anecdotally and through research that if we do 4 things then we can stabilize and support placements:

- train caregivers BEFORE placement
- Coach them to the principles of promising practice & FASD
- Provide respite – “even when not asked for!”
- Support to the grief and loss that is common with caregiving and disabilities – “help them to give up what they wish this was to take on what it is!”

# Simply put.....Child Welfare can.....

1. See this as a public health issue
2. Shift the value from legal authority work to casework that understands the developmental trajectory of FASD – “be a good guardian”.
3. Heighten awareness of the value of early intervention with focus on working with birth mothers and the components that support placement stability
4. Train their intervention case workers to specific competencies that support FASD informed practice including collaboration.