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WHEN TRAUMA IS NOT THE WHOLE STORY: THE SYSTEMIC FAILURE TO RECOGNISE AND SUPPORT FASD IN ADOPTION, FOSTER AND KINSHIP CARE

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Conventional therapies and support often fail to address the complexities of FASD, leaving many children at high risk for placement disruption.

FASD in the context of family law

Fetal Alcohol Spectrum Disorder (FASD) is a life-long neurodevelopmental condition which is more common than Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), and yet to date does not benefit from similar levels of social understanding, or clinical and educational provision.

FASD is the most severe of all neurodevelopmental conditions, aside from intellectual disability, in terms of its impact on functioning across the lifespan (Novick Brown & Greenspan, 2021; Novick Brown & Reynolds, 2021).In the UK general population, it is thought that roughly 3.6% of children may be born with FASD, compared with perhaps 2% for children with ASD – albeit that ASD diagnoses are currently increasing for a range of possible reasons – and this may be an underestimate (McCarthy *et al*., 2021). Some screening studies have suggested that the prevalence of FASD may be over 6% (McQuire C. *et al*., 2019), and a 2018 prevalence study by McQuire and Paranjothy at the University of Bristol proposed that up to 17% of children could have symptoms consistent with FASD.

FASD can result from any amount of prenatal alcohol exposure (PAE) at any point during pregnancy; there is no known safe amount or time to consume alcohol, and, consequently, advice from the UK Chief Medical Officers and NHS is to avoid alcohol entirely when planning and throughout pregnancy.

What does this have to do with family law specifically? While FASD affects children and families from all walks of life, some populations are at significantly greater risk of having alcohol-exposed pregnancies. This includes mothers within care proceedings. The percentage of children in care and adopted children who are thought to have, or to be at risk of, FASD, varies depending on the study. Lange *et al*. (2013) suggested a world prevalence of 17% for children in care, while Gregory *et al*. (2015), in a UK-based study in Peterborough, found that 27% of children in care met the diagnostic threshold for FASD. The same study reported a history of PAE in 55 out of 160 health assessments for children in care (34%), and in 34 out of 45 of children put forward for pre-adoption medicals (75% of those children). We can

therefore extrapolate from these figures that a significant proportion of children on the case loads of social workers, children's guardians and solicitors may be affected by this condition. Most will be undiagnosed.

Often, it is substance misuse which receives the greatest attention and is most likely to be documented in social care chronologies, including suspected or confirmed use of substances during pregnancy. There is a common misconception that drugs do the greatest harm to the developing fetus, and yet alcohol, a 'socially acceptable' and readily available commodity, is one of the most teratogenic substances of all. Conversely, with opiates like heroin, following an initial neonatal abstinence syndrome, the long-term neurodevelopmental implications of prenatal exposure are far less severe than those relating to prenatal exposure to alcohol (Behnke *et al*., 2013). Because this is not commonly understood, many babies and children within care proceedings may not have their PAE explicitly documented, which can result in them not receiving appropriate diagnosis post-adoption and later in their childhoods.