

FASD | ONE

Fetal Alcohol Spectrum Disorder
Ontario Network of Expertise

Education Essentials For Students With FASD: Setting Them Up For Success

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that describes the range of effects that can occur in an individual who was prenatally exposed to alcohol with the most common and serious result being life-long damage to the brain. Understanding that the permanent brain damage from alcohol use in pregnancy causes the behaviours commonly found in students with FASD reduces confusion and frustration for educators and is the basis for developing effective support and intervention strategies for students who have or are suspected of having FASD. One way to effectively support students with FASD is the neurobehavioural approach developed by Diane Malbin. It is explained on the reverse side of this page.

Fetal Alcohol Spectrum Disorder (FASD) is a permanent, brain-based, usually invisible, physical condition with behavioural symptoms. As with any other physical condition, identification and provision of appropriate accommodations are required in order for each person to be able to reach their full developmental potential. Symptoms of FASD vary widely, and can impact on: adaptive functioning, communication, attention, reasoning, memory, sensory processing, cognition, impulsivity and executive function. No two students with FASD are the same. Variability reflects the part(s) of the brain affected. Fortunately, many of the educational interventions and supports that have been developed for FASD will also work for other neurodevelopmental disorders and show promise for simplifying many current educational challenges created by the thousands of students exhibiting brain-based behaviours.

Starting Points for Educators

- ✓ All students with FASD have strengths. Build on their individual strengths rather than focus on deficits.
- ✓ All staff and volunteers at school and in after school programming need to have ongoing and consistent FASD training in order to understand these children differently and operationalize successful interventions.
- ✓ Adjust expectations for students with FASD to create a “good fit”. All will need a variety of accommodations and some may require modifications. Individual Education Plans (IEPs) should reflect a student’s individuality.
- ✓ Adaptive functioning assessments, ideally the Vineland, are much more reflective of the student’s true abilities. IQ scores are not a good indicator of the student’s useable intelligence, strengths or abilities.
- ✓ Remember, their brains work, but differently from what is seen as “normal”. A student’s learning difficulties are NOT a reflection of your skills as an educator.
- ✓ Dysmaturity means social and emotional development is often half their chronological age (e.g., developmentally 6 at 12 years of age). Adaptive functioning assessments, eg. the Vineland, clarify students’ actual developmental level of ability and are important for understanding their brain-based behaviours.
- ✓ Students with FASD all have good and bad days – a good day does not mean they have mastered a skill.
- ✓ Activities based on a student’s strengths should always be available. Withholding them is not instructive.
- ✓ Understanding all aspects of a child’s functioning helps clarify behaviors. Neuropsychologists, Occupational Therapists, and Speech-Language Pathologists are important neurobehavioural team members.
- ✓ Some students with FASD may do well in an integrated classroom with on-going support.
- ✓ Evaluate environments for sensory input. Children are often easily overstimulated and slow to settle. The less “incoming data” the better for students with FASD. Provide non-punitive quiet areas.
- ✓ A student with FASD needs one or two “go-to” adults in the school who understand FASD well for when they are overwhelmed, exhausted or need a break. Ensure at least one adult is always available.
- ✓ A student with FASD who genuinely feels liked, safe and welcome at school will be more successful.
- ✓ Provide ongoing support. Start accommodations without a diagnosis. If it looks like FASD, it probably is – Think FASD First. This is brain-based behaviour. Providing effective FASD supports will not harm any student.
- ✓ These are students with a disability; think they *can’t*, not they *won’t* (Diane Malbin).
- ✓ Always use person-first and respectful language. These are students with FASD not FASD students/kids.
- ✓ FASD is a permanent, physical disability that you can’t fix but a condition which you can significantly help with continued, consistent and appropriate or “good fit” supports.
- ✓ Think of appropriate supports as a wheelchair for the brain, a wheelchair that will always be needed. Therefore, focus on building interdependence for life, not independence after graduation.
- ✓ Regression will take place if supports are removed. This is a life-long disability. Supports must remain.
- ✓ Parents and caregivers of children with FASD are usually experts and must be equal members of your school team supporting students with FASD (and other neurobehavioural disorders).

For specific FASD education resources, contact the FASD ONE Education Action Group
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Understanding and Application of a Brain-Based Approach

By Diane Malbin | www.fascets.org

Research has found factors other than prenatal alcohol exposure, such as genetics, illness, trauma/sustained abuse; oxygen-deprivation at birth and head injuries may also cause brain structural changes and functional deficits with associated neurobehavioural symptoms. Diane Malbin refers to this entire spectrum as Fetal Alcohol/Neurobehavioural conditions (FA/NB). The following is based on p.5 of www.fascets.org © publication Malbin, D. (2011) FA/NB Conditions: Understanding & Application of a Brain-Based Approach, 3rd Edition (Permission received)

Twelve Points regarding Fetal Alcohol/Neurobehavioural (FA/NB) conditions – The Logic Model

1. Alcohol, drugs, traumas and other events affect the physical structure of the developing brain. Physical changes mean people with brain-based conditions have a usually invisible, physical disability with behavioural symptoms. Recognition of FA/NB is synonymous with recognition of brain damage. The brain is the source of all behaviours.
2. FA/NB encompasses a wide spectrum of neurobehavioural symptoms associated with other brain-based conditions (e.g., injury, illness and exposure to teratogens).
3. People with FA/NB are a “hidden” population, not recognized in the DSM V and often diagnosed with ADHD, LD, PDD, ODD, Autism, Emotional Disturbances, Sensory Processing Disorders, and others.
4. People most at-risk for psychosocial problems are those who have no observable physical characteristics. This is the majority.
5. FA/NB is an invisible brain-based physical condition with behavioural symptoms.
6. Actual cognitive abilities of people with this physical disability are at odds with Learning Theory-based assumptions about brain function.
7. Interventions in all systems based on the principles of Learning Theory are often incompatible with neurobehavioural characteristics, or differences in brain function (e.g., Behaviour modification or Cognitive therapies/strategies). Good strategies but are a poor fit for people with FA/NB.
8. Well-intended but inappropriate and ineffective interventions implemented over time have been associated with chronic frustration and the development of debilitating secondary characteristics in children and adults with FA/NB. Poor fit = challenging behaviours.
9. An emerging neurobehavioural theoretical foundation systematically links brain function with behaviours and supports a shift in understanding, reframing the meaning of presenting behaviours – from “won’t to can’t” – and redefining both the nature of the problem and the focus for interventions in a manner consistent with research.
10. This shift in thinking is the basis for providing appropriate environmental accommodations to these individuals in all settings, preventing deterioration and maximizing realization of developmental potential. This principle of providing environmental accommodations for people with Fetal Alcohol/Neurobehavioural conditions is the same as for other physically handicapping conditions – (e.g., for individuals who are blind, paraplegic). Good fit = problem prevention = improved outcomes.
11. Children, parents and professionals, all systems and strata of communities and cultures benefit from shared understanding and a common language that enhances communication and helps establish and sustain an informed, community-based, continuum of care.
12. Adequate accommodations at home, school and in the community provide appropriate levels of support, over time. An informed community-based continuum of care assures conceptual consistency and congruent accommodations in all settings. This is associated with fewer challenging behaviours, stronger relationships, and improved outcomes. Change is indicated at the level of individuals, families, practice, programs, institutions, policy and law.

