

THROUGH
Different Eyes



Understanding young children living with
Fetal Alcohol Spectrum Disorder



Artwork: Adam Duncan–Biripi Man, Artist, Early Childhood Educator, Consultant.

Acknowledgement of Country

Early Childhood Australia and NOFASD Australia acknowledge the traditional owners of Country throughout Australia and their continuing connection to the land and community. We pay our respect to the continuation of cultural, spiritual and educational practices of our First Nations people and to the Elders both past and present.

This artwork depicts the complex relationships and support structures that are vital in providing effective and compassionate care for children and families living with FASD. It represents the connections between families, children, professionals, advocates and the broader Australian community.

Introduction

Early childhood educators support and advocate for children at an age when brain development is at its most rapid. This role includes the responsibility to ensure each child has the best possible opportunities for a positive childhood and a successful future. More than that, our role needs to focus on young children's belonging, being and becoming.

Educators who understand a wide range of potential reasons for developmental delays and have the relevant skills and strategies to support a diverse range of children are well positioned to provide each child the support and opportunities they need to flourish. In early childhood education and care, inclusion is foundational to our work. It is enshrined in our regulations, and we have experience supporting specific interventions and differentiated programs and processes.

Fetal Alcohol Spectrum Disorder (FASD) awareness in Australia is still gaining ground, although FASD was first formally identified in English-language literature in a 1973 study by Jones and Smith. However, due to the complex process involved in a formal diagnosis and the fact that the only cause of FASD (prenatal exposure to alcohol) can stigmatise mothers, FASD has often been misunderstood and misrepresented.

This guide aims to provide clear, current, factual and evidence-based information about FASD and help build awareness of the wide range of characteristics that may be associated with FASD.

The guide is designed to assist those working with children aged 0–5 years, where a child has been diagnosed with FASD or where observations of a child's development and behaviour—combined with information from family members—suggest FASD may be present and warrant further assessment by trained professionals.

Importantly, this is an identification guide, not a diagnostic tool. Its purpose is to contribute to the process of identifying the underlying cause of developmental delays and behaviours in some children by increasing the understanding of FASD in the early childhood profession, including its effects and likely prevalence in the community.

This guide also provides best-practice strategies for parents or carers of, and people working with, children who are falling behind in reaching developmental milestones in terms of age-appropriate behaviour, learning goals, physical expectations, socialisation and emotional development.

Our hope is that educators who use this identification guide will be better informed and therefore more confident in developing appropriate strategies to support children and their families in cases where Fetal Alcohol Spectrum Disorder (FASD) is either diagnosed or suspected.



Supporting families



Educator tips

Here are some helpful strategies for supporting children with FASD and ensuring inclusive environments:

- Find out what works for different children. Get to know each child and their interests.
- Provide additional time for tasks.
- Be consistent with the language and resources you use to support development.
- Even if the child is not looking at you or doesn't acknowledge you, it's okay; they are often still listening. Visual aids, visual tools and icons can be helpful.
- If you are stressed and trying to get the child to finish a task, set achievable goals, such as putting shoes on, and work with them on that. If your goal is too broad, this can cause stress. This is something other children and educators will pick up on.
- Focus on positives. By using positive language, you will help the child feel they are successful in their interactions, and they may be willing to try tasks again, particularly if they are not successful the first time. This, in turn, supports and fosters their sense of belonging because it communicates that even when the day is difficult for the child, they are having their needs met, perhaps with different accommodations.
- Make inclusion resources you use to support children with FASD available to all children. This will ensure everyone feels included and reduces stigma.
- Redirection is important as it will help the child focus on the goal you are working towards.
- Young children with FASD will often use alternative methods to communicate how they are feeling when they are stressed. For example, they may cover their ears or eyes if overwhelmed by sound or light. It is essential to take a step back and consider how behaviour is being used to communicate and make adjustments to meet their needs. This might mean making changes to the environment.
- Even if a child only plays with a resource or programmed activity for a short time, it is still a valuable educational experience. Intentionally creating a large number of brief experiences over time will have a positive impact and help them succeed in their learning journey.
- Ensure the physical environment and daily routines are predictable and consistent. This is especially important if staff rostering is not consistent. It is important that children can count on the same materials and spaces being available to them, with slight variation to keep them curious.

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Symbols that you will encounter throughout this guide:



Educator tips



Video:
Expert voice



Case studies



Video:
Acted scenario



Tools and resources



Video:
Parent's story



Expert voice



To access all videos within this guide scan the QR code.

What is FASD?

FASD is caused when a developing fetus is exposed to alcohol. It is a complex disorder that can affect children in a wide range of ways, in combination with the many other factors that can influence any individual child's outcomes.

Alcohol can cause damage to an unborn child at any time during pregnancy; the level of harm is dependent on the amount, frequency and timing of alcohol use. Other factors that can influence the effects of FASD include the genetic characteristics of both the mother and child, the stage of the pregnancy when alcohol was consumed, the physical and mental health of the mother, other substance use and external factors, such as exposure to stress, violence or other trauma.

Leading health authorities and researchers across the world advise **there is no safe time for and no safe amount of alcohol that can be consumed if you are pregnant, are planning a pregnancy or could become pregnant.** Alcohol can cause damage to any system of the developing fetus, and in recent medical research literature, over 400 different diagnoses and problems have been associated with FASD.

The symptoms of FASD include significant cognitive, behavioural, health and learning difficulties, including problems with memory, attention, cause and effect reasoning, impulsivity, receptive language and adaptive functioning difficulties. All of these are internal brain problems that are not necessarily apparent, which makes it difficult to diagnose immediately. Studies have shown that these symptoms become evident in early childhood. Five years of age is the most predictive age for diagnosing FASD although a recent study has shown that diagnosis can be made on children as young as nine months old (NOFASD Australia, 2020).

Children who are struggling or experiencing developmental delays are likely to benefit from additional support. The earliest possible diagnosis of any disorder or disability will allow the most appropriate platform of support to be implemented.

However, **it is very important not to label a child as being on the FASD spectrum without a formal diagnosis;** for educators to do so is unethical and inappropriate. Most behavioural characteristics that may be observed in children with FASD can also be caused by at least one other disorder or condition. Two key defining features of FASD are that it is permanent and follows exposure of the fetus to alcohol, but as the official diagnostic guidelines note:

The diagnosis of FASD is complex, and ideally requires a multidisciplinary team of clinicians to evaluate individuals for prenatal alcohol exposure, neurodevelopmental problems and facial abnormalities in the context of a general physical and developmental assessment (Bower & Elliott, 2016, p. 4).

The role of the early childhood educator is to note, through carefully observing and documenting the learning and development of all children, potential developmental delays and characteristics that could indicate a possible disability or need for additional support. Educators are well positioned to provide families with positive support, evidence-based advice and referrals to the relevant professionals if they wish to pursue diagnosis.

The following video shows paediatrician Professor Elizabeth Elliott discussing some of the diagnosis pathways and characteristics of FASD and what educators need to know about FASD.



Video: Expert voice
Paediatrician video on characteristics



<https://bit.ly/3Qyh9yZ>

FASD may frequently:

- vary with age, in terms of characteristics and severity
- vary widely from person to person
- be overlooked, misunderstood, misrepresented and misdiagnosed
- overlap with characteristics of other disabilities.

Children with FASD:

- are not all the same
- may express very few of the common FASD characteristics
- often do not display any characteristics of FASD prior to preschool age, or characteristics are overlooked as 'developmental'
- may seem as though they have difficulty learning from mistakes
- sometimes have long plateaux between growth spurts.



For further information on FASD characteristics see:

www.nofasd.org.au/service-providers/research-library/ or www.nofasd.org.au/parents-carers-and-families/characteristics-across-the-lifespan/.



Case study: Educator experiences

Laura:

I was a teacher and educational leader in a wealthy suburb. As I look back and consider the families I worked with, I realise that I didn't ever consider FASD. I recognise that for so many years we just didn't have awareness of it as a possibility—children were just described as 'having a delay' and we didn't really think about recommending a formal diagnosis by a specialist.

Tessa:

I have worked in assisting roles in early childhood settings and government schools, providing support to families who were either seeking a diagnosis or, in many cases, already had one. I have found that children with FASD may present with different types of behaviours, from squealing to throwing or destroying resources, to running away.

Instead of seeing these behaviours as a form of communication, children were often negatively labelled as difficult or challenging.

From my experience, each child will express themselves differently when they are not coping.

Children who need any sort of additional support regulating their emotions may express themselves through their behaviour. This is often due to stress or anxiety. It is important to approach situations such as this in a calm, warm and empathetic way. Sometimes the child may need additional time to cognitively process the events or situation.

Observing and recording information: A holistic approach

Observing and recording information is a key part of best-practice early childhood education and care that becomes particularly important when there is a concern about a child's development. Educators therefore are encouraged to take their time when documenting observations of potential developmental delays. In addition, educators must be supported to select an appropriate observation tool that will best capture developmental concerns. This section highlights some characteristics educators may observe in children with FASD.

Just as all children are different, with comparable but varying developmental trajectories, each child who has FASD is unique. As a **spectrum disorder**, there are many potential FASD characteristics and one child might display only a few while another might display many. Some of these characteristics are hard to detect, particularly in very young children and infants.

Historically, FASD diagnosis was based mainly on specific facial features in combination with a developmental delay. However, newer research confirms that only a very small percentage of children with FASD have these facial features, which are now often considered to be related to alcohol exposure at a particular stage of pregnancy.

These are key characteristics of FASD that an educator may observe and should document:

- The child is not growing and developing as expected. This includes physical, cognitive and social-emotional challenges:
 - o Physical: the child may be smaller in stature than other children of the same age. Babies may have a weak sucking reflex or low muscle tone. Children may also have a high sensitivity to sound, light or touch.
 - o Cognitive: the child may have developmental delays, use fewer than expected words for their age, appear not to learn from their mistakes or have challenges with memory or a short attention span.
 - o Social-emotional: the child may be interested in activities that are normally considered suitable for a younger age group, have difficulty with transitions and change and encounter challenges relating to peers and building friendships.
- The child has facial features that suggest FASD, which include a small face, narrow eye openings, a flattened groove between the nose and the upper lip and a short, upturned nose. These features are often not noticed until a child is two to three years old.

Note: these can be hard to see and only a very small percentage of children affected by prenatal alcohol have these distinctive facial features.

- The child may have sleeping challenges. Evidence suggests that up to 90% of children with a FASD diagnosis present with a sleep disorder, including difficulty falling asleep, frequent waking and difficulty staying awake during the day.
- Confirmation that some alcohol has been consumed at any stage of the pregnancy (including prior to the pregnancy being confirmed).

The observations you make can be useful to the assessment, diagnosis and planning process. This simple tool will help get you started:



FASD Checklist:

www.nofasd.org.au/wp-content/uploads/2018/05/FASD-checklist.pdf

The following video shows a range of approaches that may include problematic representations of situations you may have observed in your workplace. They are designed for you to reflect on past and present experiences for parents and families with diverse needs.



Video: Acted scenario

Teachers discussing deficit diagnosis



<https://bit.ly/3Qyh9yZ>



Early Childhood Australia and Early Childhood Intervention Australia Position statement on the inclusion of children with a disability in early childhood education and care:

www.earlychildhoodaustralia.org.au/wp-content/uploads/2014/06/ECA_Position_statement_Disability_Inclusion_web.pdf

The diagnostic pathway

It is of course not part of an educator's job to diagnose medical conditions, but early childhood professionals' early identification of any causes for concern plays an important role in the early identification of FASD. It facilitates timely and appropriate referral pathways, enabling additional support structures and early intervention strategies. Educators are encouraged to address any concerns about a child's development promptly, starting with professional discussions, before careful and sensitive conversations with parents or carers.

Early intervention can assist with inclusion and prevent secondary challenges arising, such as behaviours becoming habitual or mental health issues developing. Early diagnosis and interventions for FASD are linked with substantially better long-term outcomes for the child and the family that supports them.

A formal medical diagnosis of FASD can also help those working with the child to access additional support. It may also assist educators to understand certain learning and behavioural concerns and develop strategies to support each child and their family.

Research confirms the diagnostic process for FASD can be very challenging for families and primary caregivers due to the guilt and stigma that are often associated with the disorder. Stigma is a complex societal issue, and educators need to take particular care as they work in partnership with parents to consider their observations of the child and whether to seek assessment by a professional.

Steps leading to a diagnosis:

- Regularly record detailed information about concerning behaviour.
- Discuss concerns confidentially with senior staff to gain a second opinion.
- Make an appointment with parents or guardians and a colleague.
- Suggest an assessment and be willing to provide your observations if necessary.

Note: educators are advised not to suggest FASD (or any other disorder) as a diagnosis. The educator's role is to observe, document and share information to support the identification process and alert others to any potential need for further intervention.

'Early diagnosis and interventions for FASD are linked with substantially better long-term outcomes for the child and the family that supports them.'



Case study: A midwife's perspective

I have worked as a midwife for the past 30 years across several spaces. In my experience, in their first interview with a midwife, mums are consistently asked if they are smoking, drinking alcohol, taking recreational drugs or have done so in the past. This data is collected using simple tick boxes in their antenatal record booklet. I occasionally have had a mum admit to binge drinking prior to knowing they were pregnant, but we don't currently provide any information at this point regarding Fetal Alcohol Spectrum Disorder, regardless of what they answer.

As a midwife, I think it can be helpful to ask some direct questions, even if a mum chooses not to divulge information regarding alcohol consumption on first meeting; this, from my experience, opens the door for future discussions, and at a later stage they may feel comfortable discussing further.

I have also found that answering a questionnaire, for some people, can be easier than verbally responding directly to a question on the spot. We currently don't offer a questionnaire and it would be up to the individual midwife to ask questions. One thing for educators to be aware of is the fact that different midwives are going to ask different questions, and, in some cases, questions relating to alcohol consumption might be skimmed over, as there are often a multitude of questions asked at the initial booking.

All midwives know that when a mum does admit to drug-taking, she mostly understates actual amounts. Feelings of guilt and fears that their baby could be removed from their care come into play regarding whether they are willing to divulge their true history. Women often fear community service involvement rather than seeing it as a positive support to actually keep them with their babies.

Early questions need to be backed up with valuable, non-judgemental support. This is critical due to the need to maintain positive relationships with our clients, particularly ones that may be vulnerable. We display posters from Pregnant Pause recommending 'Dads, swap the pub for your bub' and have Pregnant Pause pamphlets, but there is an extensive amount of information provided and, for new parents, this can often be overwhelming.

While midwives are aware of symptoms that present in an affected baby, not everyone will have the experience or the specific training needed to be aware of babies that may be affected without the classic features on display.

The following video shows paediatrician Dr Heidi Webster discussing some of the diagnosis pathways and characteristics of FASD and what educators need to know about FASD.



Video: Expert voice
Paediatrician video on characteristics



<https://bit.ly/3Qyh9yZ>

The following videos show how we can talk to parents. It is confronting to be faced with the possibility of a child not coping with age-appropriate activities, social interactions or behavioural expectations. A professional, caring approach will help you work with parents to determine the best approach to assist the child.



Video: Acted scenario
Careful conversation approaches



<https://bit.ly/3Qyh9yZ>



United Nations Convention on the Rights of the Child:
<https://www.unicef.org.au/our-work/information-for-children/un-convention-on-the-rights-of-the-child>

Case study: A parent's perspective

I love being a parent. For many years of my life it was all I wanted to be. Finding out we were pregnant is one of my happiest memories. The journey for us has been a bit different than expected. Although I didn't drink a lot during my pregnancy, I was told by my friends a couple of drinks wouldn't hurt, and I remember my mum saying she drank with me and I was fine. So, while I wasn't a regular drinker, it's fair to say I had a few drinks every now and then.

James was a happy enough baby. He preferred to sit next to me rather than on me and he was a terrible sleeper, but I thought this was just normal. My friends said it was probably teething and their children had also gone through stages when they didn't sleep. There was always something about the way James developed that concerned me, but when I brought it up during his standard check-up appointments, I was told everything was fine.

The feeling didn't go away.

A few months later, James started at his early learning service. This started with a meeting with the lead educator in James' room. James was 16 months old at the time. There was a long orientation process, which gave us time to work together, go through the detailed enrolment forms and share our family journey with James so far. This included my history. I shared with them all of the things that had been concerning me for some time: he would get upset when his routine needed to change, he was a fussy eater, he would only sleep for 10 minutes at a time, he would get tired quickly and he would get startled by noises easily and need to be taken out of the room to calm down. He was also behind in his physical development and was still crawling and not really wanting to do any standing. Although it was hard hearing it all in one go, another part of me was relieved. It wasn't just me.

The lead educator mentioned to me that they were not in a position to make any sort of diagnosis, but recommended, given everything I had shared with them, that it might be worth getting James assessed. She also said she would help to write up observations of everything she had noticed from her professional perspective. The service had a good relationship with a paediatrician and offered an introduction.

After the assessment process was finished, James was diagnosed with a global developmental delay. With a plan in place for James to undergo further assessments, FASD was mentioned as a possibility. This wasn't what I expected. I guess it's fair to say we are still getting used to it, but having the strategies to support him, and these being used by the centre and at home, has made such a difference.



Supporting parents



Case study: An educator's perspective on informing educators to reduce the stigma and judgement

I worked in a service located in an area of low socio-economic status. We supported families and children who experienced trauma. We were aware of using trauma-informed practices to support the children and families. One child, Aidan, had been with us for a year, and although we had noticed some things about his behaviour, we were also aware that his family had a history of domestic violence and trauma. When Aidan was three, he was diagnosed with FASD. Due to fear of being judged, however, his mother, Charlotte, did not disclose this to us. We were informed by his caseworker, who worked closely with us to ensure there was continuity of care between the service and home.

When we spoke about Aidan's learning and development, Charlotte never did disclose his FASD diagnosis. However, she did make us aware of other concerns he had been assessed for. To support her, we made sure that we were transparent with her and continually worked to ensure we had a growing reciprocal relationship.

Following Aidan's diagnosis, we worked closely with our family and community worker to ensure we were providing the best support for Charlotte at home and using the same strategies within the service. On advice, I investigated some of the specific attributes and required supports to be put in place for children who have a FASD diagnosis and shared these with the staff. One thing we quickly became aware of was the capacities of each of the educators as a team. We underwent specific training in supporting children who are neurodiverse, including specific professional learning regarding building partnerships with families that are inclusive and non-judgemental.

No blame, no shame

A core principle in our work with children is, 'Respectful, responsive and reciprocal relationships are central to children's education and care' (ECA, 2016). Respect for all children and their carers or parents is particularly important when discussing any aspect (or potential aspect) of FASD.

Sadly, as noted on page 6 (see 'A midwife's perspective'), FASD carries a negative stigma, unlike many other diagnosable conditions. Many mothers feel shame and are reluctant to disclose information regarding any consumption of alcohol during their pregnancy. Careful consideration of language, along with great respect and awareness, must always be exercised when approaching the topic of FASD.

Use objective, factual language—for example, describe the child's body movements and voice—and focus on the skills we aim to build as educators rather than labelling the child or describing more subjective characteristics like their personality. The following language guide has been produced in an effort to promote the dignity of those with FASD and their families.



Language guide:

www.nofasd.org.au/service-providers/language-guide/

This video is of an actor reading a story of lived experience from a parent who has a child with FASD.



Video: Parent's story

Actor sharing a parent's story



ECA Code of Ethics:

<https://www.earlychildhoodaustralia.org.au/our-publications/ece-code-ethics/>

Prevalence

There is a lack of data on the prevalence of FASD in Australia, and estimates of its occurrence vary. Research in Canada suggests that 4% of the general population is affected by FASD. Higher rates exist in foster care and correctional systems when compared to global rates (Popova et al., 2019). Global rates vary by region and country (e.g. 0.8% globally, 2% in the World Health Organisation's European region, with high rates in South Africa [11%], Ireland [5%] and Croatia [5%]) (Lange et al., 2017). Because of this prevalence, it is vital that early childhood educators recognise the signs and seek early intervention.

It should also be kept in mind that FASD occurs in many different communities, affects children from a wide range of backgrounds, and is not confined to cases of heavy alcohol use or addiction. Wherever there is alcohol consumption in pregnancy, there is a risk of FASD.

Misdiagnosis

FASD is a complex disability with many characteristics that overlap with those of other conditions. This can add to the complexity of a formal diagnosis and is another reason why educators should take particular care as they seek further information. Research (Chasoff et al., 2015) suggests that many children are misdiagnosed with other neurodevelopmental disorders, such as autism spectrum disorder, and so careful recording, documentation and referral pathways are vital. Careful diagnosis is important: avoid jumping to FASD as an explanation for behaviours of concern and instead consider it among a range of possibilities for further investigation. It is also important to note that children with FASD may receive a dual diagnosis.

The ethical considerations of diagnosis

We all have strengths and weaknesses. Regardless of a diagnosis, the educator's role in seeking out and building on each individual's strengths is especially important when a child's behaviour is concerning. This is an important part of our *National Quality Standard* and our learning frameworks. While it is not possible to change the way a child's brain is 'wired', it is certainly possible to provide an environment that removes, or reduces, the barriers that make it more difficult for a child to engage successfully and meaningfully with their educational program.

In supporting families through the process of seeking diagnosis by a multidisciplinary team of professionals, early childhood educators should take care to uphold the inclusive education principles that are set out in the *National Quality Standard* and widely accepted as best practice in our profession (Cologon, 2015).

It is important that educators do not accidentally adopt a deficit model of disability; instead, we should remain committed to inclusive practice. Families may find it reassuring to know that with or without a diagnosis, educators can respond to and plan for each child's learning and development in many of the same ways as they would for any child with a disability or developmental delay.

A diagnosis is not a solution in itself, nor is it a simple process, but it can be very beneficial in paving the way for earlier and more targeted intervention. Research (Lange & Thompson, 2006; De Beer et al., 2010; Paul & Roth, 2011; Brown & Subel, 2013) suggests that early intervention enables better, more proactive management and referrals to various specialists as needed. If FASD is diagnosed, educators are advised to take an optimistic outlook, keep focusing on the child's strengths and communicate clearly that there is no reason why children living with FASD cannot have a positive, productive future.

Invisible disorder disability?

Early childhood educators are often the first to recognise matters for concern about a child since they observe children in a group environment and in play contexts. For example, a common early observation of children who are later diagnosed with FASD is an ongoing inability to cope with situations that do not trouble their peers. The value of such observations may not become clear until much later, and so educators are advised to document them carefully.

FASD has been called an 'invisible disorder' because it is often undiagnosed or unnoticed. Many children with FASD do not appear physically different to others. They might have a positive, friendly personality and use excellent, expressive language. However, they may struggle unnoticed in a range of areas: understanding and following instructions (processing), managing time, thinking ahead, organising (executive functioning), remembering, filtering social interactions, sensory processing, anger management, anxiety, retaining information and dealing with pain or frustration. In a very young child with FASD, everyday life is often overwhelming, and meltdowns—as opposed to tantrums—can frequently occur as a result (see page 20 for more information about this).

Caring for a child with a neurodevelopmental disorder like FASD is challenging, but understanding how the brain of a child with FASD functions can help educators adjust their approach while maintaining high expectations of every child. It is important to understand their behaviour objectively, in the context of the disorder. Keep in mind the mantra, 'It is not that they won't; they can't.' This mindset will go a long way to changing how you 'see' FASD. Educators have an ethical responsibility to ensure that every child is included and that every attempt is made to remove barriers to inclusion.

Taking a whole-of-service approach

The key for a service-level approach to FASD is to avoid judgement, which contributes to the stigma, to respectfully engage with the child and family and focus on inclusive practices that support engagement and learning. Provision of information and resources about FASD is helpful, but must be done in a sensitive way.

It is suggested that a whole-of-service approach can be most beneficial to support neurodiverse children such as those with FASD. This could include:

- training for all staff
- a focus on high-quality practice
- continuity of the educator team
- support for children to form responsive and positive attachments with primary caregivers
- using a strengths-based approach
- scaffolding children's learning to promote successes
- creating opportunities to help children gain functional skills
- encouraging and supporting active participation in learning experiences
- welcoming and predictable environments that promote safety and trust
- supporting and focusing on actively teaching social-emotional skills
- supportive and culturally aware family engagement
- addressing the wellbeing of early childhood educators to avoid stress.

A strong orientation program is helpful as families settle into the service and children transition between rooms. For children with FASD and their families, this orientation process may need to be slower and more extensive in order to build confidence and trust.

This video is of an actor reading a story of lived experience from a parent who has a child with FASD.



Video: Parent's story
Actor sharing a parent's story

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**Families sharing stories
of lived experiences**

My reflections

<https://bit.ly/3Qyh9yZ>



Case studies: Infants and preschoolers

FASD in the nursery

Annie is a nine-month-old baby who has just been accepted into a service in Queensland. Sarah, her mum, is quite anxious and does not feel ready to leave Annie and go back to work. Sarah has concerns about how Annie will settle, as she has not taken a bottle well and Sarah has had trouble creating a sleep routine for her. Sarah often describes Annie as being irritable and unsettled for no obvious reason.

The service has a detailed orientation process, in which the director and team leader have a meeting with new families to ensure they have a holistic picture of the child and family. This information includes, but is not limited to, the family's pregnancy and birth history, cultural background, development, routines, comforters, interests, likes and dislikes and any other specific concerns or additional support needs. This process also helps the family understand how babies are supported within an early learning context and how the rights of the child are supported in the service philosophy.

Upon finishing the meeting, the centre director provided Sarah with a welcome pack, which included multiple parenting fact sheets from partner organisations and strategies for supporting behaviour. The director also invited Sarah to attend fortnightly parenting meetings the service hosts with a maternal and child health nurse.

The director organised for Annie to have an extended orientation process to support Sarah and Annie in developing relationships with the educators, building upon the information provided to them in the meeting. After several weeks, Annie formed a strong attachment to the nursery team leader, Olivia. Olivia noticed Annie still had a little trouble weight-bearing, would sleep better if the room was dark and quiet, was often not interested in taking her bottle when it was offered to her and preferred pureed food over other food. Olivia communicated these observations to Sarah.

After several weeks of attending the parenting meetings, Sarah asked for a meeting with the lead educator and centre director. Sitting down together, Sarah burst into tears, saying she knew being a mum was going to be hard, but it was so much harder than she expected. She felt like she was a bad mum and couldn't believe she had done this to her baby. She said that it was her fault that Annie was so unsettled and that she wished she could turn the clock back. After reading through the pamphlets given to her and recalling a few things the maternal and child health nurse had said, Sarah explained she was beginning

to have some concerns about Annie's development and disclosed that she had had several drinks a week during her pregnancy with Annie and was feeling worried that Annie might have FASD.

Seeing that she was feeling concerned, the centre director suggested regular meetings to support both Sarah and Annie. The centre director expressed to Sarah how well she was doing and because, it was not their place to diagnose Annie, offered her the contact information of a child health nurse who would be able to help them with paediatricians and the assessment process.

FASD in the preschool

Ryder was three when he arrived for his first orientation visit at our service. I had been given the background about Ryder from our director: I knew he was in foster care and had a FASD diagnosis, and the family had to leave their previous service due to a lack of support and understanding about the complexity of Ryder's needs. As he came into the room, he was full of energy. I watched him as he moved quickly from one activity to another, not focusing on one thing for more than a few minutes and seemingly being unaware of how other children were playing with the resources. I suggested to Brooklyn, his foster mum, that we go outside to chat about how best to support Ryder and herself, so that he could play and start to get to know the space.

We headed outside, which seemed to be a welcoming option for Ryder. Brooklyn had a stack of documents to share with me. I asked her to tell me a bit about Ryder, his story, her story and where they were up to now. Brooklyn was very open. She explained that she had taken on Ryder as an emergency-care case, but due to their quick bond, he was now staying with

them permanently. Ryder still had regular visits with his birth mother. For two weeks following these visits, he would need more support, as he found this transition between the two homes difficult. Brooklyn explained she had been to two other services before coming to us and said she was excited about the inclusive environments, the ways each of the educators engaged with and supported the children and the philosophy she observed when she came for her tour.

Ryder was small for his age but didn't have any significant obvious difference in his facial features when he was born. He had been diagnosed with FASD and, about two months earlier, ADHD. I listened as Brooklyn spoke about the strategies they were using, such as giving an instruction or direction, allowing time for him to focus, giving him time to run around, letting him sleep in a dark, uncrowded room with music playing and giving him visual cues for his routine to provide predictability. He was a fussy eater and would only eat white food, he had good language and was able to communicate, but he needed support to understand social situations and his own feelings. He really liked trains, cars and building cities, at which he was very skilled.

We gave Ryder time to play and become familiar with the different environments and meet the other educators in the room. We decided not to make his visit too long so he would not become too overwhelmed. We set out a long orientation plan that went over four to five weeks, depending on how he formed relationships in the space. As part of the orientation process, Brooklyn and the director met to write an individual learning plan for Ryder, which included all stakeholders of the multidisciplinary team to support him within our service context.

An inclusive approach requires that all staff focus on supporting all children to be involved in all aspects of learning (Cologon, 2015). To enable this, individual educators play a key role and all staff have a responsibility to support every child's learning.



Supporting children

What can educators do to support children with FASD?

Educators are well placed to support children who present with delays in their overall development or have a diagnosis of FASD. Through quality programs and observations of individual children, educators will begin to form a holistic picture of each child, including their physical, social-emotional and cognitive development, and their strengths, interests and abilities, while working in collaboration with the child, family and carers. As educators begin to form this whole picture of each child, it may become obvious that some are not tracking in the same way as their peers.

The aim of this section is to provide educators with practical strategies they can put in place to best support all children in their learning environments, including those who may have a FASD diagnosis.

Inclusive practice in action

The suggestions in this resource aim to support educators, children who have been diagnosed with FASD and children who educators feel may need further assessment for FASD. Educators are further encouraged to maintain inclusive practices. Many of the adjustments that can be made to support children with FASD, such as changes to the learning environment, will benefit all children. With this in mind, educators are encouraged to consider the individual needs and rights of all children when making changes in the learning space.

Relationships with families

Parents, families and caregivers are the experts on their children, of course, which is why educators need to build open, respectful and reciprocal relationships with them as a foundation for all other elements of early childhood education and care. Building these relationships starts at enrolment and continues through orientation and starting at a service. Here, frequent communication and opportunities to build trust lay a foundation for respectful interactions and supportive relationships.

It is important that educators, as a way to reflect on their observations, professionally discuss with senior colleagues or service leaders any concerns about a child's development or behaviours that may require further assessment. It is also beneficial to use a team approach when taking these concerns to families. Hold conversations in a space that is private and non-confrontational, using respectful and non-judgemental language and focusing on the strengths of the child as much as areas of concern.

When working with the parents and carers of children with a FASD diagnosis, it is imperative that educators consider each family's specific situation and the complex issues that may arise, should they seek additional support for their child. Any concerns need to be communicated with care, respect and empathy. To best support children who have been diagnosed with FASD,

It is essential to build respectful, reciprocal relationships first.

There are many ways to do this, including:

- enrolment interviews where families are encouraged to share their perspectives about their child—including the pregnancy, birth and infancy and the child's interests and strengths or any areas families are concerned about
- orientation practices that allow time for both families and educators to get to know each other slowly so that trusting relationships are developed
- daily conversations or chats on arrival and departure, where stories are shared about the child from both families' and educators' perspectives
- where possible, sharing information through parent information nights, social events for families or informal gatherings where families, children and staff get to know each other better
- using respectful communication practices (including verbal, non-verbal, formal and informal) with families, which respond to cultural and other aspects of diversity or difference.

When these relationship-building practices are enacted, it will be easier for educators to respond to individual differences and specific situations.

early childhood educators should work in collaboration with their parents or carers to access in-depth knowledge of each child's strengths, interests and skills.

Invite parents or carers to have an advocate or supporter with them in meetings, ensure all team members treat them as equals, and avoid any practices that will undermine that trust. For example, arrange the room in a roundtable configuration, create a shared agenda, keep to time, be clear and kind, and end on a positive note.

This video is of an actor reading a story of lived experience from a parent who has a child with FASD.



Video: Parent's story
Actor sharing a parent's story

THROUGH
Different Eyes

**Families sharing stories
of lived experiences**

A strong partnership



<https://bit.ly/3Qyh9yZ>

Individual learning plans and behaviour support plans

Individual learning plans and, in some cases, behaviour support plans can be useful tools for educators and services to ensure that each child is a part of an inclusive learning environment. These plans support inclusive practice since they recognise each child as a unique individual who may present with challenges different from other children's. An individual learning plan should consider the reasonable adjustments that need to be made for children who may be on the pathway towards a FASD diagnosis or those who have already received one.

In developing plans, educators will need to work with their colleagues and children's families, as well as external professionals such as paediatricians, to implement successful individual learning plans for children who require additional support, including those with a FASD diagnosis.

Each individual plan should outline measurable and observable goals and priorities for learning, taking into account the child's individual needs, strengths and abilities, as well as their cognitive, linguistic, physical and social-emotional development.

The following video outlines measurable and observable goals and learning plans for children who require additional support.



Video: Expert voice
Individual and support plans



<https://bit.ly/3Qyh9yZ>

Behaviour support plans and individual learning plans should be living documents that are developed in consultation with all stakeholders and will be a part of supporting the child to meet their goals. Here we need to remember that small steps are important and, where possible, should incorporate the child's agency and child-led learning goals. They should explain the behaviour observed, the behaviour educators would rather see and the response. They should assign accountability for implementation and evaluation and act as records to ensure continuity of learning.

Meetings to discuss individual learning plans are an opportunity for parents, educators, service managers and related support services to come together and work towards providing an inclusive and holistic educational program with achievable goals. As you set the goals within the plan, ensure that resources and strategies are clearly outlined to ensure consistency. Too often, goals are changed frequently without measure or monitoring. Ensure that goals are short-term and measurable.

Defining dysmaturity (adapted from the New York State FASD Interagency Workgroup, 2010)

Common characteristics of FASD include difficulty understanding consequences, poor short-term memory and a desire for instant gratification. Often, alternative techniques are required to encourage children with FASD to cooperate with others. It is also important to remember that dysmaturity is common in those with FASD.

Dysmaturity refers to children who function socially, emotionally and cognitively at a much lower developmental level than most others of their chronological age. A five-year-old with FASD, for example, may be developmentally more like a two-year-old.

Dysmaturity is distinct from immaturity, which suggests a person has the capacity to catch up with others of the same chronological age.

In developing individualised plans or setting goals for a child with dysmaturity, educators are advised to make them specific, measurable, achievable, relevant and time-bound:

- For example, the child sits for two minutes during a group experience; this can be built up to the goal incrementally over the year.
- Use phrases such as, 'They stayed on task for five minutes, twice a day.'
- Take into account the child's development and learning style.
- What do you have time to assist with and what does the child have capacity for? For example, asking a child to pack up after destroying an activity may not be a realistic goal for the child, whereas supporting the child to pack up with an educator may be more realistic and provide an opportunity to feel a sense of achievement when they complete the task.
- Set a realistic timeframe for when you would like to see the goal achieved.

Inclusive learning environment

There is always a great deal of planning and preparation when educators design learning spaces. There are many things to consider: the age of the children, the input and agency children have over their own spaces, budget, resources and the perspectives of the educators themselves on the structure of the space. According to Arthur et al. (2020), learning environments should foster each child's sense of agency, balance flexibility and facilitate peer relationships and support for social and emotional learning. Environments should provide opportunities for quiet experiences and appropriate resources for challenging and engaging activities, as well as the option to choose from a diverse range of resources that support children's various interests and cultural backgrounds.

In line with inclusive practice, a learning environment aims to support all children equally. There are, however, some considerations specific to FASD that should be taken into account in planning.

Providing a range of different areas, spaces and opportunities for different sensory experiences is likely to meet the needs of many children, including those with FASD. Having a plan to support different children at different moments of the day, or in different spaces, is another good idea. Also, consider how routines can be made accessible and predictable to all children, perhaps by providing a visual schedule of the day.

Through putting strategies like this into place, educators will be able to provide children with a rich and inclusive learning environment.

Infants (0–2)

For infants, designate spaces to support each area of development. Suggestions include spaces to promote fine and gross motor activities, such as surfaces to practice standing, pillows to support feeding and resources to promote motor development; and spaces for social-emotional learning, including space for educators and babies to sit together, such as areas to read books and share meals together. Additionally, some children who experience FASD may prefer learning environments with soft lighting and reduced noise.

Toddlers (2–3)

For toddlers, provide resources designed to ensure success. This could include resources such as shape-sorters and puzzles and materials that encourage sensory exploration, such as different textured blocks and balls to explore and play with. Adding fabric to book corners can make it easier for children to turn the pages. One of the more common aspects of FASD for educators to consider is that children with FASD are often interested in exploring resources that are more suitable for a younger age group, and it helps if certain aspects of the environment reflect this.

Preschoolers (3–5)

As above, careful consideration of resources is needed. Additionally, assistive technology is something that educators may want to consider including in their learning environments and programs for preschoolers, since they can be helpful in supporting a child's ability to actively participate in the program. While careful use of technology is important, children with FASD may benefit from assistive tools like those that help with communication and scheduling. For any whole-group activities, such as story times, ensure there are options for children to access multi-sensory supports, such as fidget toys or tactile rugs. Use visual guides to help support the routine of the day, for example, a visual timer, such as an hourglass, for supporting transitions and resources that help children identify and understand their own feelings and how they may look to others.

Again, all of the environmental considerations mentioned above must be supported by strong relationships between educators and children.

Supporting individual children

Understanding various aspects of FASD can help educators plan to support the learning and development of all children. Although not a complete list, the following aims to provide a helpful reference for educators to use when creating observation records if they are concerned a child may have FASD and needs further assessment or are supporting a child who has a FASD diagnosis.

Newborn infants who have FASD tend to sleep poorly due to a melatonin imbalance, which leads to disturbed sleep patterns. They may be irritable and hypersensitive to touch, light and sound. In addition, infants with FASD may be poor feeders, which can lead to them struggling to put on weight and growing up to be smaller in stature than their peers.

It is recommended that educators support all children to establish predictable routines and be open with each family about what these look like for their child, in order to ensure continuity between home and the service. Methodically recording observations and discussing them with colleagues first allows educators to have evidence-based, non-judgemental conversations with families later.

Early intervention may be beneficial for any infant, toddler or preschooler who is observed to have persistent, ongoing developmental concerns. A whole-of-service approach is required to support parents and carers, and particularly mothers, who may have been on a very emotional journey up to this point for reasons previously mentioned. Some parents find the challenge of parenting a child with FASD overwhelming and a whole-of-service approach can also help them to build their own skills.

Older children with FASD will often present with more readily identified and specific signs than infants typically do. Educators should be aware of, and record, instances where they observe any behavioural concerns or developmental delays, especially in terms of speech and physical growth. Characteristic behavioural manifestations of FASD may become apparent at this stage, such as hyperactivity, poor judgement, inability to predict consequences of actions, excessive friendliness, difficulties with sequencing, poor short-term memory and learning difficulties.



ECA Statement on the inclusion of every child in early childhood education and care:

www.earlychildhoodaustralia.org.au/wp-content/uploads/2014/01/Statement-of-Inclusion-2016.pdf

Another indicator of FASD in babies, toddlers and preschoolers is increased stress reactivity. This means the child may overreact to stressful situations, such as separations, or experience increased anxiety.

Even in the absence of a definitive diagnosis, educators can adjust their approach and use targeted interventions in response to particular behaviours. The table below outlines specific behaviours that can be presented by children, the age groups in which these are most common and suggested interventions. Educators should note, however, that these issues can occur across all age groups, and the suggested interventions are broadly applicable.

Age	Reported issues	Support interventions
Infants	Sleep disturbances, e.g. waking a lot.	<ul style="list-style-type: none"> • Ensure the sleep environment is conducive to the child's needs, in terms of lighting and noise levels, for example. • Play music or white noise. • Check if there are patterns or images on the wall; some can cause overstimulation. • Check the child's clothing for tags as they may be causing heightened sensory reactions. • Check to see if the child is being irritated by soaps used on bedding. • Check to see if they need a heavier blanket while sleeping, keeping in mind this needs to be done within safe sleeping guidelines. • Check to ensure there are not smells in the room that might be causing the child to become overstimulated and wake up frequently. • Consider whether the child has a consistent and predictable sleep schedule with an accompanying routine.
Infants	Decreased or increased sensory response, e.g. to light, sound levels.	<ul style="list-style-type: none"> • If fluorescent lighting is used, consider changing it as this can cause children to have headaches. • Use natural light whenever possible. • Utilise both your indoor and outdoor environments for routines and play, providing spaces with variation in light and sound.
Infants	Weak sucking reflex and general trouble with feeding.	<ul style="list-style-type: none"> • Offer different toys for infants to explore, including toys that babies can put in their mouths. • Provide supportive contact, for example, putting your hand on their skin when they are eating or drinking. • Work with individual support services to ensure different strategies are being accessed to support this area of development.
Toddlers	Trouble learning motor skills, particularly with unfamiliar movements.	<ul style="list-style-type: none"> • Use dance and movement activities: incorporate moving to music into the program on a daily basis with action songs such as 'Heads, shoulders, knees and toes'. • Provide resources for the child to climb into, out of, over, under and through, such as A-frames, tunnels, hoops and stepping stones. • Act out stories with physical actions and unfamiliar movements, such as 'Going on a bear hunt'. • Encourage activities to support upper body strength: pushing and pulling heavy items, climbing on monkey bars and playing with wheelbarrows, bikes, cars, trucks and balls.

Age	Reported issues	Support interventions
Toddlers	Increased activity, e.g. a child who does not like staying in the same place for too long.	<ul style="list-style-type: none"> • Through observations and conversations with families, find out the child's interest and set up experiences for them to explore it each day for a few minutes. • Provide educator support where needed to encourage the child to stay engaged, reducing involvement as they build stamina with activities.
Toddlers	Reduced fine motor skills. The child might avoid using toys that require fine motor control.	<ul style="list-style-type: none"> • Play games where children pick up small items or collect different things that interest them. • Play with playdough, plasticine or other materials that promote children squeezing, poking, pulling, cutting and rolling. • Provide resources that support sorting or moving things from one place to another. • Try art activities that encourage fine motor actions such as painting, drawing, cutting or sticking. • Provide the opportunity to use spray bottles with water; these can enable the development of skills such as gripping and build hand strength.
Preschoolers	Cognitive difficulties may arise, including poor short-term memory.	<ul style="list-style-type: none"> • Play games with repetitive actions to encourage working memory and promote social interaction, such as sorting games, memory games and simple board games (physical and digital). • Play familiar games that require turn-taking. • Use props and play dramatic games.
Preschoolers	Short attention span, e.g. moving from one activity to another without maintaining focus.	<ul style="list-style-type: none"> • Speak to the family to find out what the child's strengths and interests are to promote engagement with the resources and program. • Use both indoor and outdoor environments, providing intentional resources as well as open-ended play. • Provide timers to promote turn-taking. • Offer educator support where needed to encourage the child to stay engaged, reducing involvement as they build stamina with completing activities.
Preschoolers	Delayed receptive language. This means they may have issues with understanding and following instructions.	<ul style="list-style-type: none"> • When giving the child information or an instruction, allow them time to take in and process the information. The amount of time will be different for each child. • Use visual aids to reinforce information. • Use consistent language.

Sensory needs

Sensory needs are linked to a child's neurological threshold and the ways in which they process and organise information and respond to their environment. Information coming to a child from the environment triggers how their nervous system activates within different thresholds. **While some children may seek certain sensory activities and resources, others will work hard to avoid them.** For example, water is often soothing to a child who is 'sensory seeking', and they may often want to spend a lot of time washing their hands. Alternatively, another child may be 'sensory averse' and become distressed if you ask them to wash their hands after a nappy change. If you observe these situations, it may be beneficial to obtain support, such as from an occupational therapist, to develop strategies as a team to support the child and find appropriate ways they can continue to engage in sensory learning while avoiding overload.

Other ways to support children with varying sensory needs include having quiet spaces available for children to access when they need a break or are feeling overstimulated; ensuring the learning spaces are not too overstimulating; putting up large canvases with several layers of material on them or large wall hangings to absorb sound; and utilising the different spaces available within your learning environment.

Attachment

Many children with FASD often experience insecure attachments to their primary caregivers in the first few years of life, and this may continue as they enter the early learning environment. A primary-carer model is something for educators to consider, particularly if the child has experienced trauma. Educators can support children to form secure attachments by ensuring that care and empathy are key components of engaging with the child, particularly when they are experiencing difficult moments throughout the day. If the educator is feeling anxious or frustrated with the child, they are going to pick up on this and as a result may begin to develop insecure attachments. A solid attachment with a primary carer in the early years is associated with having secure, healthy relationships later in life, while poor attachment with a primary carer corresponds to higher risk of ongoing emotional and behavioural challenges. Connection-first language is recommended, such as, 'I can see you want to ... but I can't let you ... so let's wait together.'

This video is of an actor reading a story of lived experience from a parent who has a child with FASD.



Video: Parent's story
Actor sharing a parent's story



Executive functioning

Early childhood educators are familiar with the concept of executive functioning. **It is important to note that children who experience FASD frequently demonstrate challenges with executive functioning and may have difficulty:**

- following instructions
- predicting and assessing risk
- following through with complex tasks
- sequencing, understanding, using working memory
- having a sense of time or following a schedule.

The following shows a video from an expert sharing what executive functioning is and how early childhood professionals can support children with FASD to develop these skills.



Video: Expert voice
Executive functioning



<https://bit.ly/3Qyh9yZ>

Anxiety

Anxiety is another common attribute of children living with FASD, and this may look different for each age group and each individual. For example, babies and toddlers may be unusually startled or distressed by loud noises. Toddlers may become afraid of the dark or unfamiliar people, whereas preschoolers may experience anxiety due to being teased, trapped or scared of heights. Educators need to be aware of what heightened anxiety looks like for each individual child, what triggers it and how long these distress reactions are likely to last.

To support children experiencing anxiety, it is often helpful to recognise and acknowledge their emotions. It could also help to try relaxation techniques, such as breathing exercises, yoga or listening to music; creating a visual schedule; or simply supporting the child (with gentle, reassuring words and actions) to move themselves to a place where they feel safe. Such practices will support educators in teaching the child how to regulate their own emotions. Whatever strategies educators adopt, it is important that they are evidence-based and built into individual learning plans using consistent language.



Be You fact sheet on anxiety:
www.beyou.edu.au/fact-sheets/mental-health-issues-and-conditions/anxiety



Case study: An educator's perspective on transitions

Educators in the toddler room noticed that every time we began our transitions from play to packing away, Kennedy would become increasingly agitated. If anyone came into the room during this time, she would closely watch the door and attempt to get out. The educators were starting to find this time very stressful because they were trying to guide the other children, but it would not be long before all the children would follow Kennedy's lead and stop packing away.

We wanted to continue to support the children to pack away, but it was becoming too difficult. Kennedy was in the process of being assessed for FASD, and we were having weekly meetings with her family and our centre director. During one of these meetings, her mother suggested we try playing a fun song using speakers as a cue, as Kennedy was very interested in music. This would be consistent with what was happening at home as they used musical cues on a device or singing to help her with routines such as brushing her teeth or having a bath.

We built this into her plan and kept a record each day of how well this strategy worked. After a few weeks, we had some success and it is something we are going to keep trying.

Transitions and navigating change

Transitions include any and all kinds of change, including events such as arrival at the service and movement between activities or spaces. While transitions can be challenging for any child, they are likely to be especially difficult for those with FASD. Big changes that include exposure to new people, new rules to learn and a new social context to understand can be particularly difficult. Educators supporting the child need to ensure they are considering how they are planning for any changes and allow for time and other supports as needed. This applies to a range of scenarios, such as moving to a new environment; morning and afternoon transitions between home and the service; or changes related to people, visual guides, routines, weather and clothing expectations.

Relationships with peers

It may be difficult for children with FASD to understand cause and effect—a critical cognitive skill that affects many other areas of development. This particular area of development affects their social interactions, challenges their ability to build strong relationships, and increases the incidence of risk-taking behaviours. For example, children with FASD or another developmental disorder may not understand that touching another child or interrupting play causes other children to become upset.

Educators are encouraged to spend time with peers building on advocacy for the inclusion of the child with FASD or suspected FASD. This means having conversations about strengths and what the child brings to the group. Explicit teaching of social and emotional skills through the use of puppets, mirrors and turn-taking games can provide children with experiences to refer back to when they are engaging in maladaptive behaviour; for example, 'Remember when Kookaburra had a sad face because the Wombat took his worm?' It takes time for children to develop empathy and recognise emotions in themselves and others. Explicit teaching, conversations and being aware of situations where empathy can be further explored can help develop these social-emotional skills. Engaging in conversations about individual children's strengths promotes inclusion and will help all children, including those with FASD, strengthen their relationships with others.

Behaviour

Given the complexities of FASD in young children and the different ways it affects children at different stages of their development, it is recommended that educators become aware of behaviours commonly associated with FASD. Research indicates that children who have FASD often have difficulties with academic performance, due to problems with not only cognition and executive functioning, but also emotional regulation.

It is helpful for educators to look at behaviour as a form of communication. This means asking the question, 'What is this behaviour telling me?' In many instances, if you attempt to ask children directly what the problem is, they do not know or are unable to communicate this verbally. Often, this is because they are reacting to something they are feeling or a particular situation, or they are overstimulated.

It is therefore beneficial for educators to take observations and track behaviour, using tools such as the Antecedent, Behaviour, Consequence (ABC) observation strategy. Being aware of particular triggers for children will help you understand their different behaviours and what they are trying to communicate through them. So, for example, you might notice a child's behaviour becoming concerning. Educators should discuss their observations about the child with each other and with the family, tracking the behaviour to see if there is a pattern forming and considering what supports to put in place to minimise any associated risks. This should also be documented in the child's individual learning plan.

Any behaviour support strategies that are included in an individual learning plan need to have several practical elements that guide educators in how to put support systems in place for the child to understand their behaviour. As most educators know well, getting into a power struggle with the child will often result in the behaviour escalating.

It is also important to keep in mind the developmental stage of each individual child. As stated previously, children with FASD often exhibit behaviour associated with much younger children. For example, a typical five-year-old can follow several instructions at once, take turns and engage with peers for long periods of time without adult assistance. It would not be unusual for a five-year-old with FASD, on the other hand, to only be able to engage in parallel play and follow one instruction at a time. They would be likely to have a shorter attention span than other children their age and less likely to be capable of taking turns.

This video is of an expert sharing how children with FASD often need additional support with their self-regulation and how this can be supported by educators using co-regulation.



Video: Expert voice
Self-regulation and co-regulation



<https://bit.ly/3Qyh9yZ>



Expert voice: Anne Kennedy

Tantrums

Behaviours such as tantrums—are not uncommon in children under three years of age and especially toddlers. Tantrums generally become less of an issue by the time children are about four, as they learn to manage their emotions and communicate more effectively with others. Some people describe tantrums as a ‘protest’ or ‘tactic’, which suggests the child has some control over the behaviour. For example, adults sometimes observe that a toddler will stop crying during a tantrum to check if anyone is watching them. There are several reasons why some young children have tantrums, including:

- their limited capacity for using words to communicate something they need or want or for telling adults how they are feeling
- being overwhelmed by strong emotions such as anger or jealousy
- difficulty coping when they are denied something or being overstimulated or tired.

Throwing a tantrum makes perfect sense to a toddler who is frustrated or overwhelmed because it gets attention and provides some relief from feelings they find difficult to manage. As young children learn how to communicate more effectively and how to regulate their impulses and emotions, there is less motivation or purpose for having tantrums.

Being able to control your emotions in appropriate ways (self-regulation) takes time to develop with support from caring adults who understand young children’s development. Educators working with toddlers encourage their capacity for self-regulation and manage tantrums when they occur in ways that respect children’s dignity, as the following strategies highlight:

- Acknowledge a child’s feelings using words they are not yet able to say: ‘I know you’re feeling cross because you want that toy Robby is playing with.’
- Offer to help: ‘I can wait with you until it’s your turn on the swing.’
- Provide comforting words and physical closeness: ‘Let’s breathe slowly together to help you feel calm again.’
- Play games with older toddlers that require some level of self-control, such as freezing when the music stops or waiting for the surprise action at the end of a song or rhyme.
- Engage in imaginary play with a child, letting the child direct you in the play with their words or actions. Regulating someone else is easier for a young child and helps them learn about self-regulation.
- Have regular time each day for slowing down and ‘chilling out’ in a quiet place, so that children learn about relaxing, and also as a way to reduce the likelihood of tantrums due to overstimulation.

Educators work in partnership with families to gain a deeper and shared understanding about young children and how best to support them when they find it difficult to manage their strong emotions. When tantrums continue beyond toddlerhood or if they become more serious and are difficult to manage, it can be a sign that the child has a disability such as FASD.

Meltdowns

While tantrums generally stop over time, there are some children who experience emotional disturbances that are beyond their control (involuntary) and caused by a disability such as FASD. These emotional disturbances can be described as meltdowns. The terms 'tantrum' and 'meltdown' are not used clinically, but are familiar to educators and parents.

Meltdowns may initially look like or begin in the same way as tantrums, but they are different. Meltdowns often go for longer, and the child's behaviour can be more extreme or intense than in tantrums, which is a sign of a child's lack of control over what they are doing. This lack of control is a key indicator of a meltdown. Educators may identify children experiencing meltdowns as being emotionally and socially immature. Meltdowns may occur for different reasons, such as when a child:

- lacks the social skills to do what is expected or appropriate in a particular situation or context
- is overwhelmed by too many choices
- finds it difficult to cope with rapid changes in routines or during transitions.

When educators learn to recognise the difference between a tantrum and a meltdown, they are able to respond more effectively. The ethical practices or strategies for responding to both tantrums and meltdowns are the same: respecting a child's dignity, being available as a support person for a child, keeping a child and other children safe and acting calmly and respectfully.

In addition to these ethical practices, educators can use the following strategies when gathering information about and responding to meltdowns:

- Observe closely to identify the trigger/s for the meltdown. Consider what happens before the meltdown begins, where it happens, and who is involved. Knowing about and reducing the trigger/s support intervening early to prevent or limit the scale of the meltdown.
- Work as a team in developing a response plan for meltdowns to ensure a coordinated, consistent response, which is reassuring for a child.
- Focus on a child's strengths and interests so that planned experiences, including routines, are appropriate.
- Recognise that a child's neurodevelopmental impairment may require adaptations to the program with a focus on play-based experiences that support social and emotional learning and wellbeing.
- Slow down when giving instructions or sharing information as this supports a child in processing the information and making meaning.

Working in partnership with families to build shared understandings about a child with FASD and the triggers that can cause meltdowns supports a more consistent, collaborative approach between home and an early childhood setting.

An educator's view on relationships with families

Many of the families that I observed did not have close relationships with their children, the school or the teachers at the beginning of the year. Throughout the year, we would need to work with the families as a team to build those relationships. We would often do this by sharing positive anecdotal evidence about their child's day, asking the families about strategies they were using at home and telling them what was working at school.

Checking in with the family and where they are up to is important for keeping the lines of communication open. Sharing positive stories about their child's day goes a long way because there is often a lot else going on, and sometimes hearing one more negative thing might be the last straw for them.

Next steps

The specific advice and information contained in this guide aim to support the identification of FASD in an early childhood setting, building on the fundamental practices that underpin high-quality early childhood education and care. Importantly, this includes educators building respectful and reciprocal relationships with children and families as a key starting point.

It is our hope that this identification guide, combined with further self-guided research and the advice of relevant accredited experts, will help to improve the practice of early childhood education and care. Most importantly, we hope it will improve the lives of children who have or are suspected of having FASD and reduce the stigma that is associated with this disability.

If you have concerns about a child's development, it is vital that you seek advice from your manager and work with inclusion support professionals, families and other parties that will make up the multidisciplinary team to ultimately support every child to gain access to, participate in and be assessed against outcomes outlined in the *Early Years Learning Framework* (DEEWR, 2009).

Through Different Eyes Resource Matrix

This resource matrix has been curated to support educators and services to deepen their knowledge of FASD and inclusive practices.

Organisation	Resource	Use	Link
Early Childhood Australia	Making Fetal Alcohol Spectrum Disorder visible	This blog post, in Early Childhood Australia's <i>The Spoke</i> , is designed to introduce early childhood educators to Fetal Alcohol Spectrum Disorder.	https://thespoke.earlychildhoodaustralia.org.au/making-fetal-alcohol-spectrum-disorder-visible/
NOFASD Australia	Social media: Facebook page	NOFASD Australia is the national peak organisation for individuals and families living with FASD. They are dedicated to building better lives for adults and children with FASD and their families through education, support and advocacy.	https://www.facebook.com/NOFASDAustralia
NOFASD Australia	Podcasts	NOFASD Australia's podcast series, 'Pregnancy and Alcohol: The Surprising Reality', features interviews with those who most understand FASD, including clinicians and researchers, parents and carers, and individuals living with FASD—all generously sharing their insights and experiences.	https://www.nofasd.org.au/education-training/podcasts/
NOFASD Australia	Website	NOFASD Australia is the national peak organisation for individuals and families living with FASD. They are dedicated to building better lives for adults and children with FASD and their families through education, support and advocacy.	https://www.nofasd.org.au
NOFASD Australia	Webpage	NOFASD Australia is the national peak organisation for individuals and families living with FASD. Challenges can be decreased if educators are able to recognise the common behaviours and features of a child with FASD. NOFASD has collated a variety of Australian and international resources for educators.	https://www.nofasd.org.au/service-providers/education/
People With Disability Australia	PWDA Language Guide: A guide to language about disability	This language guide supports educators to use inclusive language when working with people with a disability. It is essential that when educators use language and refer to anyone with a disability, they are aware of the meaning and historical significance of how words have been used to exclude children and adults living with a disability.	https://pwd.org.au/wp-content/uploads/2021/12/PWDA-Language-Guide-v2-2021.pdf
Be You	Mental Health Continuum	Most children and young people sit at the positive mental health end of the Continuum most of the time. In your everyday role as an educator, you help nudge them towards flourishing and reaching their full potential in the way you promote their social, emotional and academic development.	https://beyou.edu.au/resources/mental-health-continuum
FASD Hub Australia	Resources	A collection of Australian and international videos, websites, online toolkits, booklets and fact sheets. Use the filters on the left side of the webpage to refine your search by audience or topic.	https://www.fasdhub.org.au/fasd-information/resources/
Emerging Minds.	Research paper	This research paper by Dr Sara McLean offers a holistic picture of what Fetal Alcohol Spectrum Disorder is and how it relates to mental health.	https://emergingminds.com.au/resources/what-is-fetal-alcohol-spectrum-disorder-fasd/
Emerging Minds.	Research Paper	This research paper by Dr Sara McLean, looks at how FASD can impact children's development, mental health and behaviour.	https://emergingminds.com.au/resources/understanding-the-impacts-of-fetal-alcohol-spectrum-disorder-fasd-on-child-mental-health/
Emerging Minds.	Research paper	This research paper by Dr Sara McLean looks at how to support children living with Fetal Alcohol Spectrum Disorder (FASD).	https://emergingminds.com.au/resources/how-to-support-children-living-with-fasd/

ACECQA	Developmental milestones and the <i>Early Years Learning Framework</i> and the <i>National Quality Standard</i>	This resource links to the <i>Early Years Learning Framework</i> and <i>National Quality Standard</i> by offering examples of children's development. This resource is about enriching educator knowledge and should not be used as a checklist.	https://www.acecqa.gov.au/sites/default/files/2018-02/DevelopmentalMilestonesEYLFandNQS.pdf
Inclusive Education	Guide to FASD and learning	This website offers targeted strategies for teachers to meet the multifaceted needs of students living with Fetal Alcohol Spectrum Disorder (FASD).	https://inclusive.tki.org.nz/guides/fetal-alcohol-spectrum-disorder-and-learning/
Marninwarntikura Women's Resource Centre	Resource	This resource aims to address gaps in knowledge and skills faced by educators working in classrooms, playgrounds and other educational settings. It is designed to support schools, educators and community members to recognise, understand and work effectively with students with FASD and complex trauma.	https://cdn.shopify.com/s/files/1/1613/1919/files/FASD_2nd_Ed-2018.pdf?17909097525429957987
POPFASD	Booklet	This booklet is designed for caregivers and professionals who, in their everyday lives, encounter children and youth affected with FASD. Readers should be aware that this booklet provides strategies and suggestions for people who already understand FASD. For ease of reading, the child is referred to as female. The booklet contains 19 chapters, a glossary, other resources and online support.	https://edmontonfetalalcoholnetwork.org/wp-content/uploads/2019/02/strategies_not_solutions_handbook.pdf
POPFASD	Website	This website offers educational strategies for Fetal Alcohol Spectrum Disorder.	https://www.fasdoutreach.ca/resources/all/f/fetal-alcohol-spectrum-disorders-educational-strategies
The MEHRIT Centre	Website	The MEHRIT Centre is Dr Stuart Shanker's organisation dedicated to understanding how we all respond to stress in the same way: we thrive when it is positive, and we struggle when it is excessive. This website offers resources and fact sheets for families, educators and teachers to understand how the principles of self-regulation can be used to support inclusion.	https://self-reg.ca/
Center on the Developing Child, Harvard University	Webpage	Three core concepts in early development allow educators to explore how early experiences shape brain development. Healthy development in the early years provides the foundation for many different aspects of being a part of society.	https://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/
North Star Paths	Infographics	This collection of infographics and short videos is aimed at supporting teachers and educators by offering free resources and downloads to support inclusive practice.	https://northstarpaths.com/graphics-free-downloads/
Youtube	Video	How a child's brain develops through early experiences.	https://www.youtube.com/watch?v=hMyDFYskZSU
KU Children's services	Resources webpage	This collection of resources has been curated to support early childhood educators to access multiple perspectives of inclusive practice.	https://inclusionagency.nswact.org.au/resources?cap=27
ACECQA	Resource	Supporting children to regulate their own behaviour.	https://www.acecqa.gov.au/sites/default/files/2020-01/QA5_Supporting_children_to_regulate_their_own_behaviour.pdf

Glossary

Parents: For the purposes of this guide, the word parent is often used to describe a child's primary caregiver. This word is also designed to encompass a child's family, foster parent, guardian, caregiver and primary caregiver.

Fetal Alcohol Spectrum Disorder (FASD): Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol.

Characteristics: Typical or noticeable features of someone or something.

Diagnosis: The identification of something following an examination of the symptoms.

Inclusion: Considering all children's social, cultural and linguistic diversity (including learning styles, abilities, disabilities, gender, family circumstances and geographic location) in curriculum decision-making processes. The intent is to ensure that all children's experiences are recognised and valued. The intent is also to ensure that all children have equitable access to resources, participation and opportunities to demonstrate their learning and value differences (DEEWR, 2009).

Behavioural concerns: The escalated behaviours of a child that can impact their wellbeing and safety. This extends to their daily living skills and inability to self-regulate their emotions.

Stigma: A strong feeling of disapproval that most people in a society have about something.

Labelling: Defining a person in terms of their behaviour.

Multidisciplinary team: The mechanism for organising and coordinating health and care services to meet the needs of individuals with complex needs. The teams bring together the expertise and skills of different professionals to jointly assess, plan and manage care.

Deficit model: A perceived set of attributes and failures, such as a lack of learning, success or achievement, based on the deficiency of an individual rather than the limitations of a system.

Developmental delay: A delay in the child's development. This often means the child will be significantly delayed in multiple areas of their developmental milestones compared to their peers.

Neurodevelopment: Refers to the development or growth of the brain and other neurological parts of the body, such as the spinal cord and nerves.

Learning style: How an individual learns, including any supports or adjustments that will support the child to absorb, process and comprehend a concept or idea.

Anxiety: The body's physical response to a perceived threat that causes a pounding heart, rapid breathing, butterflies in the stomach and a burst of energy, as well as mental responses such as excessive fears, worries or obsessive thinking.

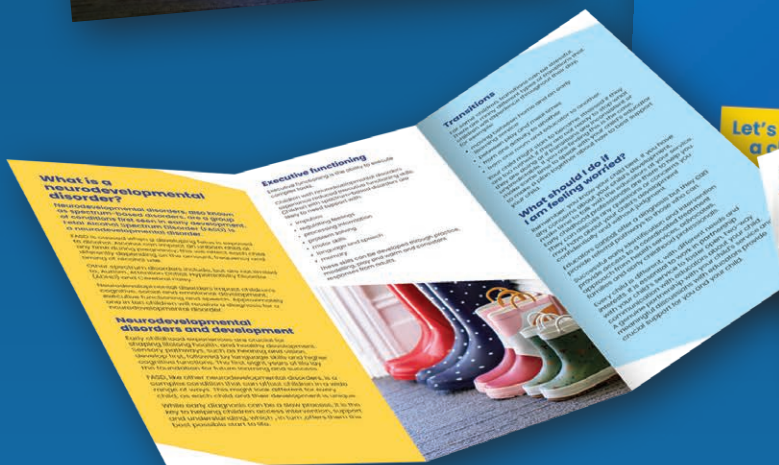
Neurological threshold: The personal range for noticing and responding to different sensory events in everyday life. If someone has a lower sensory threshold, they may detect more stimuli due to their sensitive neurological system.

Social skills: Refers to the ability to communicate in social situations, including using language appropriate for the audience and environment, listening to others, taking turns talking and noticing the non-verbal responses (or body language) of other people.

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Understanding young children living with Fetal Alcohol Spectrum Disorder



There are a range of materials developed and available including a Brochure, Poster, Guide for Educators, and online videos and resources. The guide and accompanying materials are designed to assist those working with children aged 0–5 years. The brochure can be shared with educators to provide an introduction to the Educator Guide. This guide also provides best-practice strategies for parents or carers of, and people working with, children who are falling behind in reaching developmental milestones in terms of age-appropriate behaviour, learning goals, physical expectations, socialisation and emotional development, the guide also provides web links to videos and additional online resources. The poster can be placed on the walls for families to view in order to assist starting conversations around children's development.

These materials can be accessed at:
www.earlychildhoodaustralia.org.au/through-different-eyes



To access all materials including videos scan the QR code.



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