

**Fetal Alcohol Spectrum Disorder - Implications for Children in Out
of Home Care (OOHC) and the Importance of Accurate Identification
and Diagnosis**

A Literature Review

Executive Summary

The central aim of this literature review is to shed light upon the importance of FASD assessment and diagnostic referral for children who have been, or it is suspected that they have been, exposed to alcohol prenatally within OOHC settings.

The Project Brief

To develop a suite of prevention and awareness resources specifically tailored to Priority Groups identified in the FASD national awareness campaign contract for pregnancy and breast-feeding women. This includes people working in, and supporting, children in the out-of-home-care sector.

Many children with FASD continue to go undetected and subsequently, untreated in OOHC. This manifests as a considerable concern as FASD is the leading cause of intellectual disability, behavioural and learning problems and without proper diagnosis there are significant implications for providing people with FASD with accurate and timely interventions and supports. There are high rates of misdiagnosis and missed diagnosis rates in children with FASD who are in OOHC and without diagnosis it is more difficult to provide proper supports and interventions for those impacted by FASD. A delayed FASD diagnosis is linked with the development of secondary disabilities, and only early and accurate interventions can help mitigate the risks of these secondary effects

When there is inadequate screening and diagnosis for FASD the implications on the OOHC sector include: inappropriate case management, inadequately trained and supported foster caregivers, ineffective parenting practices and/or behavioral interventions that exacerbate the child's condition, other inappropriate labels attached to the child's symptoms, availability of appropriate educational supports for the child will be compromised, greater risk of placement breakdown or multiple placements resulting in poor outcomes for the child, inappropriate medications may be prescribed, increased risk of developing secondary issues that lead to serious medical, social and legal consequences for the child, the family and for society and the child's chances of reaching their full potential will be severely compromised.

There are also issues surrounding ageing out of care for children with FASD. Many children with FASD do not achieve successful independence and they are set up for failure if they have not been diagnosed and are expected to “learn from their mistakes”, “try harder” and “follow instructions” when the unrealised cognitive impairment prevents them from doing this.

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1. Introduction

About FASD and the OOHC Sector

Fetal Alcohol Spectrum Disorder (FASD) is a complex worldwide health and social concern that is currently under-recognised and consequently, underdiagnosed (Reid, 2018). Within Australia there remains no accurate measure of FASD prevalence (Reid, 2018), however, as asserted by Montag (2016), it is estimated that 5% of the general population is affected by FASD. FASD is a lifelong disability that results from prenatal alcohol exposure (Chatterley-Gonzalez, 2010). Individuals with FASD are impacted at varying degrees and the way the disability manifests itself differs (Rutman, 2013). Individuals with FASD have primary effects which include poor executive functioning, impairments in memory, challenges with conceptualisation and understanding of abstract concepts, issues in language and comprehension skills and difficulties with affect regulation (Rutman, 2013). As a result of primary effects individuals with FASD are susceptible to secondary effects such as mental health issues, involvement with the law, risky sexual behaviours, and troubles in schooling. Primary and secondary effects are interrelated and are directly linked to the individual's quality of life and ability to thrive (Rutman, 2013).

FASD is particularly concerning when the out of home care (OOHC) sphere is considered. Children often enter OOHC due to unfavourable circumstances, this may include parental substance use, neglect, or abuse (Lange et al., 2013). This factor greatly increases the likelihood of prenatal alcohol exposure in children within the OOHC population (Lange et al., 2013). Additionally, most children with FASD will not be raised by their biological parents but rather will be raised in care (Williams, 2018). This concern is exacerbated by the high rates of misdiagnosis and missed diagnosis found in the OOHC sector. Children with FASD are often taken from their adoptive or birth homes and placed into child welfare systems, mental health, and justice systems (Chatterley-Gonzalez, 2010). Youth in care with FASD experience a myriad of challenges, they are often misunderstood and misread by society which can lead to these youths finding themselves in troublesome situations (Chatterley-Gonzalez, 2010). As a result of this misunderstanding people with FASD can be perceived as

having behavioural problems, reluctant to comply or unmotivated. Subsequently, the people around them use traditional interventions that can be harmful and inappropriate for those with FASD (Chatterley-Gonzalez, 2010). This can potentially perpetuate feelings of failure or feelings of “not trying hard enough” and exacerbate secondary problems for those impacted by FASD (Chatterley-Gonzalez, 2010). The major issue here lies with the fact that many in care with FASD are not recognised or identified, this is then further exacerbated by the “invisible” nature of the disability (Chatterley-Gonzalez, 2010).

2. Literature Review Aims and Search Strategy

Aims and Objectives

The central aim of this literature review is to shed light upon the importance of FASD assessment and diagnostic referral for children who have been, or it is suspected that they have been, exposed to alcohol during the term of their mother’s pregnancy. Where it is known that family alcohol/drug issues have been the driver of children coming into care, the possibility of FASD must be investigated. In addition, intake processes when children come into care should include exploration of the pregnancy to obtain information about alcohol exposure or possible exposure at the earliest possible opportunity.

Children with FASD often come from complex home environments and may require removal from home and permanent care by the state (Pelech et al., 2013). Thus, without assessment and diagnosis children with FASD in OOHC are highly vulnerable to placement disruptions, inadequate supports/interventions, and development of secondary effects (Pelech et al., 2013).

Literature Review Search Strategy

This literature review was conducted using two databases: Google Scholar and the La Trobe University Library. Literature was explored to attain a holistic range of sources that discussed and explored the implication of FASD on the OOHC sector. Literature identified through this was screened by the titles and abstracts and other relevant sources were retrieved from reference lists of relevant literature.

The databases were searched using a combination of the terms: “FASD”, “Out of home care”, “missed diagnosis”, “misdiagnosis”, “prevalence”, “assessment”, “diagnosis”, “child welfare”, “child protection” and “foster care”.

Inclusion and Exclusion Criteria

Literature was included if it referred to FASD, the OOHC sector and issues regarding FASD diagnosis and the implications of this. All articles which were not peer reviewed were excluded. Ensuring the sources used in this literature review were of high quality.

Results Yielded

From searching Google Scholar and the La Trobe University Library, 21 pieces of literature were selected as pieces which embody the aims and objectives of this literature review. The full texts of these pieces were assessed and carefully reviewed to generate themes which best highlight FASD and the implications of the disability on the OOHC sector.

3. Discussion of Themes

Rates of Misdiagnosis and Missed Diagnosis

Many children with FASD continue to go undetected and subsequently, untreated in OOHC. This manifests as a considerable concern as FASD is the leading cause of intellectual disability, behavioural and learning problems and without proper diagnosis there are significant adverse implications for interventions/supports (Chasnoff et al., 2015). Children and youth are placed in care often due to various adverse circumstances; this could include parental substance use, child abuse/neglect and incapacity of parents to provide adequate care (Popova et al., 2014). As Popova et al., (2014) states, such circumstances increase the likelihood that a child was prenatally exposed to alcohol. Hence, the risk of FASD in children in OOHC is likely high. A salient theme which emerged throughout much of the

literature was the rates of misdiagnosis and missed diagnosis which are explored below.

The high rates of FASD are reiterated by Bakhireva et al., (2018) who state, FASD may be 10-15 times more prevalent among children in OOHC compared to the general population, yet many of these children go undiagnosed or misdiagnosed. Consequently, these children are at great risk of not receiving adequate supports and interventions leading to poorer life outcomes (Bakhireva et al., 2018). A study by Chasnoff et al., (2015) assessed the rates of misdiagnosis and missed diagnosis of FASD among a population of 547 foster and adopted youth who were referred to a mental health centre. The population group underwent a multidisciplinary diagnostic evaluation, results found that of the 156 children who met the criteria for FASD, 125 had never been diagnosed as impacted by prenatal alcohol exposure, resulting in a missed diagnosis rate of 80.1% (Chasnoff et al., 2015). Of the 31 children who had been recognised priorly as affected by prenatal alcohol exposure, 10 of these children's FASD diagnosis were changed (still within the spectrum) indicating a misdiagnosis rate of 6.4% (Chasnoff et al., 2015). A study by Colom et al., (2021) aimed to find the prevalence of FASD in adopted children in Russia and Ukraine. Colom et al., (2021) found that of the 162 children assessed 50% met the diagnostic criteria for FASD, 20.4% met the criteria for FAS, 17.2% had partial FAS, 1.2% had had alcohol-related birth defects and 11.1% had alcohol-related neurodevelopmental disorder. Moreover, within the 81 children where alcohol exposure was not confirmed, many exhibited signs which would meet the FASD criteria, however, could not be confirmed due to unknown maternal alcohol consumption history (Colom et al., 2021). Another study conducted by Tenenbaum et al., (2020) found that within a population of high risk children in an adoption centre, 20.2% had been prenatally exposed to alcohol and among the children that there was confirmed alcohol exposure, nearly half met the diagnostic criteria for FASD.

Ultimately, these studies indicate and confirm that FASD has been severely underdiagnosed within this particular population (Bakhireva et al., 2018; Chasnoff et al., 2015; Colom et al., 2021; Tenenbaum et al., 2020). Diagnosis has the potential to avoid the adverse life course that is common for people with FASD who go through life without a diagnosis, which includes social and behavioral problems that

maybe prominent throughout their lives (Williams, 2018). Emphasising the importance of identifying, assessing and diagnosing children with FASD within the OOHC sector to provide appropriate interventions/supports (Tenenbaum et al., 2020).

Importance of Accurate and Timely FASD diagnosis

As stated by Bax et al., (2015), accurate and timely identification of FASD is fundamental to providing interventions, services and preventing secondary characteristics. Children with disabilities who go through life without a proper diagnosis are at a high risk of not receiving early interventions which can aid in improving life outcomes significantly (Bakhireva et al., 2018). Without diagnosis it is more difficult to provide proper supports and interventions for those impacted by FASD. A delayed FASD diagnosis is linked with the development of secondary disabilities and only early accurate interventions can help mitigate the risks of these secondary effects. (Bakhireva et al., 2018). This is reinforced by Williams (2018), who suggests that incorrect and delayed diagnosis of FASD has a profound impact on the correct treatments and medications to prevent secondary disabilities. Williams (2018), also asserts that diagnosis can improve self-advocacy and agency of those impacted by FASD and combined with appropriate supports/interventions can pave the way for a successful life.

In order to reach their full potential children impacted by FASD need continuous support in areas of their lives, including the physical, social and emotional domains (Burns et al., 2020). This continuous support cannot be achieved without accurate and timely diagnosis. The overrepresentation of children with FASD in OOHC and the high rates of missed/misdiagnosis result in children with FASD being more vulnerable to abuse, neglect, substance abuse and overall poorer life outcomes (Burns et al., 2020). As research has made evident, children with FASD function

better and are susceptible to less adverse life outcomes when they have a stable living environment, have structure, are not exposed to violence, and have their basic needs met (Burns et al., 2020). The importance of stability is reiterated in a study by Koponen et al., (2009), who found that the caregiving environment during the early years of life directly influenced the social and emotional development of children with FASD. Moreover, for children with FASD it is crucial to have stability within their lives to nurture their potential and combat against neurological difficulties (Pelech et al., 2013). There are significantly higher rates of placement disruptions for children with FASD, this is substantial as there is a direct link between placement stability and the likelihood of developing problematic secondary conditions such as school troubles, mental health issues, involvement with the law and substance use issues (Pelech et al., 2013). This is reinforced by Rangmar et al., (2016), who states that psychosocial outcomes for individuals with FASD are contingent on their environmental circumstances.

Children with FASD are often misdiagnosed with learning disabilities, ADHD, or other diagnoses. Although these may align with the child's behaviour, they do not fully encompass the needs of a child with FASD. Additionally, inaccurate diagnosis leads to incorrect interventions, these interventions seldom work as they do not align with the manifestations of the disability (Petrenko et al., 2014). Accurate and timely diagnosis of FASD in children in OOHC has been recognised as crucial to good practice, as assessment and diagnosis pave the way for identifying needs and providing adequate services and supports (Badry et al., 2014). Hence, professionals within the OOHC sphere must be aware of the consequences of prenatal alcohol exposure as early intervention, supports and a stable living environment are fundamental to the prevention of secondary disabilities (Knuiman et al., 2015). This is reiterated by Colom et al., (2021), who state that there is a critical need to draw more attention to FASD, particularly within the OOHC sector, efforts must be made to train professionals within these sectors on FASD assessment and diagnosis. In order to be able to provide the tailored supports, services and resources needed for those with FASD (Colom et al., 2021).

Implications for the OOHC Sector

FASD places a huge demand on child protection, foster care, and social service systems (Kambeitz et al., 2019). As Kambeitz et al., (2019) assert, the high rates of preventable problems for those with FASD are compelling, children with FASD are 9 times more likely to be placed in foster care and 19 times more likely to come into contact with juvenile correction services. Moreover, children with FASD are not only overrepresented in OOHC but also come into care at an earlier age and stay longer (Williams, 2018). Furthermore, data from the Canadian FASD Database was analysed to compare outcomes of youth with FASD in OOHC and those living with their biological family, adoptive family or other family members (Burns et al., 2020). The results highlighted that youth with FASD in OOHC showed significantly higher rates of sexual abuse, physical abuse and had higher rates of difficulty with the law (Burns et al., 2020). Thus, providing a compelling cause to strive for accurate/early diagnosis in order to provide preventative measures and adequate services/supports (Kambeitz et al., 2019).

Professionals who work within the OOHC play a central role in the lives of children with FASD (Burnside & Fuchs, 2013). These professionals are in the position to handle living accommodations, school enrolments, health care services and mental health services (Burnside & Fuchs, 2013). The supports received within these areas are essential to managing the primary and secondary effects of the disability (Burnside & Fuchs, 2013). Hence, the lack of diagnosis within this area is problematic as the lack of routine screening efforts results in many going undiagnosed. As stated by Olson et al., (2009), successful outcomes for individuals with FASD are contingent on the quality of the care giving environment and are influential in the prevention of secondary disabilities. Children with FASD who have struggled with ineffective interventions due to misdiagnosis or missed diagnosis often have challenges with behavioural change, and the more delayed a diagnosis the greater likelihood of development of secondary disabilities (Petrenko et al., 2014).

When FASD is not screened for, assessed and diagnosed within the OOHC sector it has negative implications on the facilitation of an early diagnosis, which is associated

with the provision of timely supports, combats secondary effects and improves quality of life (Lange et al., 2013). Within the OOHC sector adequate screening, assessment, and diagnosis of FASD can: aid in establishing appropriate placements, reduce the likelihood of failed placements and placement breakdowns, allow for foster or adoptive parents to be better equipped/informed to meet the needs of FASD and increase understanding/awareness in both foster/adoptive parents and those employed in the OOHC sector (Lange et al., 2013).

When there is inadequate screening and diagnosis for FASD the implications on the OOHC sector include: inappropriate case management by the agencies involved, inadequately/inappropriately trained, and supported foster caregivers, ineffective parenting practices and/or behavioral interventions that exacerbate the child's condition. Other inappropriate labels may be attached to the child's symptoms, availability of appropriate educational supports for the child will be compromised, there can be greater risk of placement breakdown or multiple placements resulting in poor outcomes for the child. In addition, inappropriate medications may be prescribed increasing the risk of developing secondary issues that lead to serious medical, social, and legal consequences for the child, the family, society, and the child's chances of reaching their full potential will be severely compromised.

Thus, there is a dire need to improve support for FASD in OOHC (Petrenko & Alto, 2017). As stated by Durkin et al., (2016), very few professionals within this realm understand FASD, can recognise FASD or know how to effectively work with youth with FASD, yet they are critical to the prevention of secondary disabilities for youth prenatally exposed to alcohol. Hence, FASD training should be of high priority within the OOHC realm, to combat against the severe ramifications and implications that may arise within the OOHC sector.

Ageing out of Care

Youth who age out of care are often thrust into the world without the skills to live a successful life, often confronted with issues of homelessness, mental health problems, substance abuse, involvement with the law and unemployment (Chatterley-Gonzalez, 2010). This is particularly true for youth impacted by FASD,

who are pushed out to fend for themselves with little support and little advocacy on their behalf (Pepper et al., 2019). This presents as a dual challenge as these children must navigate the world with their disability and deal with the immense responsibility of ageing out of care which is often not consistent with their abilities (Burnside & Fuchs, 2013). Young people with FASD are far less likely to live independently without intensive, comprehensive support. Appropriate support from early adolescence until the mid-20s at the very least is vital to successful transition to adulthood. This is substantiated by Williams (2018), who suggest that transitions into adulthood should be accompanied by extending care and a long transitional phase. However, many with FASD do not ever achieve successful independence and they are set up for failure if they have not been diagnosed and are expected to “learn from their mistakes”, “try harder” and “follow instructions” when the unrealised cognitive impairment prevents them from doing this (Chatterley-Gonzalez, 2010).

As identified by Burnside & Fuchs (2013), a protective factor which mitigates the risks of ageing out of care and becoming vulnerable to adverse outcomes is early diagnosis.

As Williams (2018) suggests, although FASD cannot be changed, the quality of life for youth with FASD can be increased through early intervention and appropriate ongoing supports. Early diagnosis is imperative in responding appropriately to the needs of the child and the disability (Burnside & Fuchs, 2013). An early diagnosis allows not only appropriate interventions early on but also capacity to understand how the needs of the child will change as they mature, to ensure they are able to develop coping skills and self-awareness which are fundamental to ageing out of care (Burnside & Fuchs, 2013). Again, emphasising the importance of professionals within the OOHC sector being aware of FASD, the needs of children with FASD and the importance of assessment and diagnosis in providing tailored and appropriate supports (Colom et al., 2021; Knuiman et al., 2015).

4. Discussion and Conclusion

In an attempt to explore the implications of FASD on the OOHC sector, literature was sourced from two databases. The literature was analysed, and four key themes emerged:

- Rates of misdiagnosis and missed diagnosis.
- Importance of accurate and timely FASD diagnosis.
- Implications for the OOHC sector.
- Ageing out of care.

Children who have been removed from their homes due to parental substance abuse are at greater risk of having FASD (Bakhireva et al., 2018). Hence, FASD is overrepresented within the OOHC sector yet, as made evident there remains starkly high rates of misdiagnosis and missed diagnosis (Knuiman et al., 2015). Children with FASD who go through life without a diagnosis, undiagnosed or with an inaccurate diagnosis are at great risk of experiencing poorer life outcomes. An early diagnosis of FASD has been associated with better long-term outcomes and mediates against the risks of secondary disabilities as well as issues surrounding ageing out of care. Additionally, an accurate diagnosis can prevent inappropriate interventions which fail to recognise the unique and varied nature of FASD as a disability, this is beneficial to both those with FASD and the OOHC sector. Thus, to conclude, this literature review has demonstrated that FASD is a major issue confronting the OOHC sector which has substantial implications that must be addressed for the benefit of those with FASD and those working within the OOHC sector (Pelech et al., 2013).

References

- Bakhireva, L. N., Garrison, L., Shrestha, S., Sharkis, J., Miranda, R., & Rogers, K. (2018). Challenges of diagnosing fetal alcohol spectrum disorders in foster and adopted children. *Alcohol (Fayetteville, N.Y.)*, 67, 37–43.
<https://doi.org/10.1016/j.alcohol.2017.05.004>
- Bax, A. C., Geurts, C. D., & Balachova, T. N. (2015). Improving Recognition of Children Affected by Prenatal Alcohol Exposure: Detection of Exposure in Pediatric Care. *Current Developmental Disorders Reports*, 2(3), 165–174.
<https://doi.org/10.1007/s40474-015-0057-3>

Burns, J., Badry, D. E., Harding, K. D., Roberts, N., Unsworth, K., & Cook, J. L.

(2020). Comparing Outcomes of Children and Youth with Fetal Alcohol Spectrum Disorder (FASD) in the Child Welfare System to those in Other Living Situations in Canada: Results from the Canadian National FASD Database. *Child: Care, Health and Development*, n/a(n/a).

<https://doi.org/10.1111/cch.12817>

Burnside, L., & Fuchs, D. (2013). Bound by the clock: The experiences of youth with FASD transitioning to adulthood from child welfare care. *First Peoples Child & Family Review*, 8(1), 40–61.

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

Chatterley-Gonzalez, A. (2010). *The Experiences and Needs of Young People with FASD: Silenced Voices from Youth in Care*. 144.

Colom, J., Segura-García, L., Bastons-Compta, A., Astals, M., Andreu-Fernandez, V., Barcons, N., Vidal, R., Ibar, A. I., Fumadó, V., Gómez, N., Russiñol, A., & Garcia-Algar, O. (2021). Prevalence of Fetal Alcohol Spectrum Disorders (FASD) among Children Adopted from Eastern European Countries: Russia and Ukraine. *International Journal of Environmental Research and Public Health*, 18(4), 1388. <https://doi.org/10.3390/ijerph18041388>

Durkin, K. M., Pryce, J. G., Smith, B. D., Cheng, T. C., Herzog, J. R., & Aliyu, M. H. (n.d.). *THE ROLE OF SELF-EFFICACY ON CHILD WELFARE WORKERS' FETAL ALCOHOL SPECTRUM DISORDER (FASD) TRAINING AND PRACTICE*. 136.

- Kambeitz, C., Klug, M. G., Greenmyer, J., Popova, S., & Burd, L. (2019). Association of adverse childhood experiences and neurodevelopmental disorders in people with fetal alcohol spectrum disorders (FASD) and non-FASD controls. *BMC Pediatrics*, *19*(1), 498. <https://doi.org/10.1186/s12887-019-1878-8>
- Knuiman, S., Rijk, C. H. A. M., Hoksbergen, R. A. C., & Baar, A. L. van. (2015). Children adopted from Poland display a high risk of foetal alcohol spectrum disorders and some may go undiagnosed. *Acta Paediatrica*, *104*(2), 206–211. <https://doi.org/10.1111/apa.12822>
- Koponen, A. M., Kalland, M., & Autti-Rämö, I. (2009). Caregiving environment and socio-emotional development of foster-placed FASD-children. *Children and Youth Services Review*, *31*(9), 1049–1056. <https://doi.org/10.1016/j.childyouth.2009.05.006>
- Lange, S., Shield, K., Rehm, J., & Popova, S. (2013). Prevalence of fetal alcohol spectrum disorders in child care settings: A meta-analysis. *Pediatrics*, *132*(4), e980-995. <https://doi.org/10.1542/peds.2013-0066>
- Montag, A. C. (2016). Fetal alcohol-spectrum disorders: Identifying at-risk mothers. *International Journal of Women's Health*, *8*, 311. <https://doi.org/10.2147/IJWH.S85403>
- Olson, H. C., Oti, R., Gelo, J., & Beck, S. (2009). “Family matters:” Fetal alcohol spectrum disorders and the family. *Developmental Disabilities Research Reviews*, *15*(3), 235–249. <https://doi.org/10.1002/ddrr.65>
- Pelech, W., Badry, D., & Daoust, G. (2013). It takes a team: Improving placement stability among children and youth with Fetal Alcohol Spectrum Disorder in care in Canada. *Children and Youth Services Review*, *35*(1), 120–127. <https://doi.org/10.1016/j.childyouth.2012.10.011>

- Pepper, J., Watson, S., & Harding, K. (2019). "Well Where's he Supposed to Live?"—Experiences of Adoptive Parents of Emerging Adult Children With FASD in Ontario. *Journal on Developmental Disabilities, 24*, 66–80.
- Petrenko, C. L. M., & Alto, M. E. (2017). Interventions in Fetal Alcohol Spectrum Disorders: An International Perspective. *European Journal of Medical Genetics, 60*(1), 79–91. <https://doi.org/10.1016/j.ejmg.2016.10.005>
- Petrenko, C. L. M., Tahir, N., Mahoney, E. C., & Chin, N. P. (2014). Prevention of Secondary Conditions in Fetal Alcohol Spectrum Disorders: Identification of Systems-Level Barriers. *Maternal and Child Health Journal, 18*(6), 1496–1505. <https://doi.org/10.1007/s10995-013-1390-y>
- Popova, S., Lange, S., Burd, L., & Rehm, J. (2014). Canadian Children and Youth in Care: The Cost of Fetal Alcohol Spectrum Disorder. *Child & Youth Care Forum, 43*(1), 83–96. <https://doi.org/10.1007/s10566-013-9226-x>
- Reid, N. (2018). Fetal alcohol spectrum disorder in Australia: What is the current state of affairs? *Drug and Alcohol Review, 37*(7), 827–830. <https://doi.org/10.1111/dar.12855>
- Rutman, D. (2013). Voices of women living with FASD: Perspectives on promising approaches in substance use treatment, programs and care. *First Peoples Child & Family Review, 8*(1), 107–121.
- Tenenbaum, A., Mandel, A., Dor, T., Sapir, A., Sapir-Bodnar, O., Hertz, P., & Wexler, I. D. (2020). Fetal alcohol spectrum disorder among pre-adopted and foster children. *BMC Pediatrics, 20*(1), 275. <https://doi.org/10.1186/s12887-020-02164-z>

Williams, R. D. (2018). *Understanding Fetal Alcohol Spectrum Disorder (FASD) through the Stories of Nyoongar Families and how can this Inform Policy and Service Delivery.* 273.