

# MANAGING FETAL ALCOHOL SPECTRUM DISORDER IN THE PUBLIC SCHOOL SYSTEM: A NEEDS ASSESSMENT PILOT

Gal Koren<sup>1</sup>, Ellen Fantus<sup>1</sup>, Irena Nulman<sup>1,2</sup>

<sup>1</sup>The Hospital for Sick Children, Motherisk Program, Toronto, Canada;

<sup>2</sup>University of Toronto, Toronto, Canada

## ABSTRACT

### Background

Published data and Canadian population reports suggest that approximately 1% of students in Toronto may have learning problems related to Fetal Alcohol Spectrum Disorders (FASDs). It is therefore imperative to understand how the needs of affected students are being met by various practitioners in their school environment. To date no comprehensive follow-up studies on FASD-affected children, families and educators in Toronto public schools are available. Documentation of school experiences associated with FASDs is needed to aid in developing appropriate and efficient intervention models for FASDs.

### Objectives

Identify and document needs as related to school capacities and education practitioner capabilities with respect to their abilities to support children diagnosed with FASDs.

### Methods

A qualitative approach using semi-structured interviews was utilized for this exploratory pilot study. Twelve practitioners from various disciplines, all of whom work for Toronto public schools participated.

### Results

Participants represented approximately 3500 students enrolled amongst their schools and classrooms. Only one respondent reported having worked with a child diagnosed with an FASD during their career. Education practitioners commonly report a lack of knowledge of FASDs and how to appropriately plan for affected children.

### Conclusions

Practitioners need additional supports in order to address FASDs in their schools. As this is the first pilot study on FASDs in the Ontario school system, further study is warranted.

**Key words:** fetal alcohol spectrum disorders, fasd, education, special needs, intervention, inclusion

*"...Every child has the right to childhood experiences which promote the chances of developing into a healthy, well-adjusted and productive adult".  
(1999, Toronto City Council Resolution)*

Early intervention has been reported to minimize negative outcomes associated with delayed development seen in children diagnosed with FASDs.<sup>1</sup> Evidence has also consistently demonstrated that early diagnosis of an FASD is a strong predictor of favourable

outcomes in affected children.<sup>2,14</sup> However, whether or not early diagnosis has assisted educational practitioners in developing and delivering appropriate interventions to their affected students is unknown. While previous research provides some insight into the

ameliorating potentials of early intervention with FASDs, to date few initiatives have documented FASDs in the educational context.

FASDs currently affect 1% of Canada's population<sup>3</sup> and are the leading cause of mental retardation, developmental, and cognitive disabilities in Canada and the western world - ahead of Downs Syndrome and Cerebral Palsy.<sup>4</sup> It is estimated that approximately 300,000 Canadians are affected with an FASD<sup>5</sup>; and of those affected, 30,000 reside in the Greater Toronto area.<sup>6</sup> It is perhaps not surprising then that 1% of all students in Toronto are believed to have learning disabilities related to FASDs.<sup>7</sup> The societal financial burden associated with FASDs is also astonishingly high - as evidenced by a recent publication that estimated the annual costs of FASD per affected individual in Canada to be \$21,642 - or \$5.3 billion in total.<sup>8</sup>

Despite its prevalence FASD is often referred to as a 'hidden' disability, owing to the common absence of overt physical characteristics (e.g. facial dysmorphism) in affected individuals.<sup>9</sup> It is also not uncommon for children diagnosed with an FASD to demonstrate weak adaptive skills (including social, emotional and self-regulation skills), as well as reduced cognitive functioning due to their disorder.<sup>10</sup> However, regardless of a child's outwardly presentation, it is believed that irreversible brain damage underlies a diagnosed child's inability to achieve academic and developmental milestones on par with typically developing peers.<sup>11</sup> With these presentation measures considered, it is hypothesized that schools are overwhelmed by overt special needs while more 'invisible' disorders (such as 'mild' organic brain damage associated with FASD) may be missed or mistaken as behaviour issues. This outlook, if true, has the potential to offset even the best intentioned intervention services for FASD affected children, as they are likely to be mislabeled based solely on academic assessments, or overlooked altogether due to the 'invisible' nature of the disorder. It is of utmost importance for schools to consider this and develop appropriate intervention services.

The Motherisk Program in Toronto provides counseling and clinical services for families and practitioners regarding exposure to known or suspected teratogens that may cause abnormalities

in the developing fetus. In 2009, the Motherisk programs FASD Clinic initiated a needs assessment pilot project aimed at reflecting some key issues relating to managing FASDs following diagnosis. The first phase of the needs assessment focused on local public school capacities and teacher capabilities to address the needs of children diagnosed with an FASD. This portion of the needs assessment was completed by interviewing a variety of practitioners (see Methods for participant information) who deliver educational services to children in the school setting. In addition to understanding what education practitioners may need in order to provide appropriate academic supports for diagnosed students, it is expected that this exploratory study may also demonstrate what actions are currently plausible to enact in the school setting in order to improve the quality of life for children affected with FASDs.

The final portion of any FASD diagnosis provided by the Motherisk Program is a recommendations report, based on our clinicians' psychological assessments which are conducted as part of the clinical diagnostic process. The recommendations report is intended to be shared with the child's school with the aim of supporting their growth and development by complimenting teacher planning for that particular child. To date no clinical follow-up or educational initiatives have documented the intervention process experienced by children with FASDs, their families and the practitioners charged with their care (teachers, children's aid, special services, etc.). Reporting and acting on the current climate, capacities, and needs of our public schools to support children diagnosed with FASDs is required in order to better address the needs of these populations and apply appropriate interventions.

### **Education Practitioners as Key Informants on FASD**

It is a matter of fact that when you see a school-aged child, you can safely assume that few people, if any, will spend as much time with him or her as their teacher does. Teachers and other education related practitioners are charged with the critical task of supporting children's development and academic success. Aside from teachers' skills of

adapting or modifying their classrooms and teaching styles to suit students' needs, their observations in working with special needs children are integral to creating and implementing successful intervention strategies for FASD affected children specifically.

According to a Toronto District School Board report (2007), 80 to 100 students (of every 10,000) might have learning problems related to FASD.<sup>12</sup> It is hoped that due to the high reported incidence of FASDs in Toronto schools, education practitioners may contribute to the needs assessment with their first-hand knowledge of working with FASD affected children. Alternately, for practitioners who report little to no experience working with children diagnosed with an FASD, insights they may provide based on their experiences working with special needs students will be informative as to the public school environments abilities to adequately address special needs in the classroom.

## METHODS

A qualitative approach was used to gather anecdotal information relating to FASD in the public education system through semi-structured interviews with educators and other school practitioners. Participation was anonymous. Interviews were administered by our needs assessment team and guided by a questionnaire developed by the Motherisk FASD Clinic staff. Please see the 'Appendix' for a questionnaire summary. The duration of the interviews was approximately one hour and they were arranged through the school principals. All participants were offered an opportunity to share their perspectives and expertise on FASDs and special needs issues facing their schools.

Once the interviews had concluded, analysis of participant reports focused on extracting thematic information which would highlight or improve on clinicians understanding of:

- Capacities of schools to address FASDs through understanding their approach to special needs in general.
- Who are the key FASD stakeholders in schools?
- The usefulness of an FASD diagnosis for educators.

- How the medical community may provide educators support in lieu of Motherisk's goal to provide follow-up care to patients.

As this qualitative pilot study represented a relatively small number of participants, and was intended to serve a descriptive and exploratory role for future study, statistical analysis methodologies were not used. Future research efforts in this field are encouraged to consider utilizing a quantitative model and recruit a larger sample of participants.

## Participants

Twelve practitioners from various disciplines who work in providing services to children in attendance at Toronto public elementary and middle schools (kindergarten to grade eight) were interviewed. Practitioners consisted of staff from six public schools around Toronto; five randomly selected schools and one targeted school where several of our patients had attended in the past. Five schools were part of the Toronto District School Board and one was from the Toronto District Catholic School Board. A fairly wide socioeconomic demographic range was represented as the schools were spread amongst distinct regions of Toronto; 2 schools in downtown Toronto, 1 school in Midtown, 1 school in Etobicoke, 1 school in the Beach region, and 1 school in North York. In all, participating practitioners included 2 principals, 2 vice-principals, 2 materials and resource teachers, 2 school board psychologists, 2 primary grade teachers, 1 kindergarten teacher and 1 special education teacher in a multiple exceptionalities class. Practitioners who participated were recommended by the school principal or vice-principal. Participants were invited to discuss their understanding of what an FASD is and its presence in the school, as well as their other related experiences as experts who support children with special needs.

With exception to the kindergarten teacher who was a first year teacher, the participants involved are thought to represent a breadth of professional knowledge due to their many years working as education practitioners. The experience of the remaining participants was broad - ranging from seven to thirty-four years.

## RESULTS

### Special Needs in Toronto Public Schools

Our participants represented a large student base as well as range of experience and knowledge about the state of public education and special needs in Toronto schools. The six schools of focus represented approximately 3500 currently enrolled students, and approximately 400 identified special needs students.

It is difficult to assess how many special needs students there actually were as each school uses different methods to estimate their special needs student totals. In all schools, however, a guiding principle for special needs screening relies on whether or not the child requires support to access the curriculum. Formally identified special needs students will have an Individualized Education Plan (IEP) developed by their teachers. Quite often schools are developing an IEP for children who may require additional supports while not having yet been formally diagnosed. In all schools, children who are lagging developmentally in two or more areas are supported with visits to the resource teacher classroom as often as once daily for one - two hour sessions for extra help. Other children who require less intensive supports may have a teacher assistant provide in-class supports as necessary. Extra supports vary according to each student's needs and may include both academic and behavioural interventions as determined by the child's IEP. Each school reported at least 20 special needs students who had been formally diagnosed, however there are many more students who required special support. Additionally, the larger schools had a much higher proportion of special needs students.

Based on participant reports, it appears that most schools have achieved, or are nearing full capacity for their special needs programs. This reality forces schools to prioritize their special needs students from most in need to least, which is the basis to determine who receives extra assistance based on available school resources.

### Current Process of Special Needs Intervention in Public Schools

The guiding principles of the participating school boards, which guide individual school policies, are quite similar. Both school boards emphasize

principles of inclusion as being of utmost importance in shaping the school environment and in addressing the special needs of all their students. In addition, all Toronto schools are reported to approach special needs education utilizing a team-model approach. Addressing special needs in Toronto schools, including FASDs, requires a school environment guided by principles of equality and inclusion of all children.

When a child has a diagnosed special need and/or there is concern as to any child's academic progress, generally the process is as follows:

1) A special needs team is convened, generally comprised of the child's parent(s), teacher, vice principal, and other special needs designated staff as required and/or available (i.e. material and resource teachers, speech/language, occupational therapists and psychologists). While parents are intended to be team-members, it was commonly reported that consistent parental participation is rare.

2) When a student has been diagnosed prior to or during the school year, the child's teacher will develop an IEP with the support of a special needs team. The student's primary teacher is most often responsible for developing and implementing adequate supports.

3) If the student has not been diagnosed but there are concerns, their case will be discussed by a special needs team in the school. If warranted the student will be put on a waiting list for educational assessment. An educational assessment does not always lead to diagnosing a child with a particular learning disorder, but rather it can be used to inform on a child's learning needs by demonstrating their academic strengths and weaknesses.

4) Reports on the educational assessment process varied widely. All participants reported assessments were effective and useful however, the timeframes for assessments to be conducted varied from two weeks in one school to four months in another school. Regardless of the waiting period however, the special needs team in most schools will attempt to support the child's learning needs whether the student has been formally assessed and diagnosed or not.

5) If deemed helpful to the school objective of promoting child learning and facilitating academic success (e.g. by addressing a child's

antisocial/non academic behaviours), the team will recommend the child be seen by their family physician to consider a medical diagnosis and referral to suitable programming.

### **FASDs as a Special Need in Toronto Public Schools**

Perhaps the most significant finding of this study was that only one practitioner interviewed reported having ever worked with a confirmed FASD affected child. Not surprisingly, none of the participants self-reported as confident and knowledgeable in FASD appropriate interventions. As most schools must prioritize the children with highest need to receive limited additional supports, a child with an FASD would not necessarily receive supports if another child was deemed as more critically in need.

With respect to whether or not a formal diagnosis of an FASD in childhood currently results in additional supports, all but one practitioner stated that a medical diagnosis is of no real help in attaining funding and/or additional resources for children in school. All participants indicated that medical conditions rarely, if ever, determine educational practices. Instead, the educators' approach in working with an FASD affected child would be determined by their academic assessment. All practitioners supported that if FASD was classified as a Learning Disorder (LD) it would be most beneficial as school boards do offer additional supports for LDs. Several practitioners stated that if the diagnosis was accompanied with an educational assessment, the child's academic outlook would most likely improve, as the teacher would have a better understanding of his/her needs.

A majority of participants reported feeling unsure about the negative stigma associated with FASD, describing colleagues as judgmental and suggesting that kids with FASDs are possibly better off not being labeled. They suggested that other labels (such as Autism or Attention Deficit Hyperactivity Disorder/ADHD) do not harm the child because they have become so common and part of the school's special needs vocabulary. Whereas information on the nature, implications, possible manifestations, and potentially effective interventions associated with FASDs have not been accessed by educators. It was further

suggested that labels in the school environment were reported to be most useful or helpful for the student in the long term in securing life-long social assistance. There is an apparent need to advocate for further FASD professional development and education opportunities.

### **DISCUSSION**

The interview format yielded some very interesting discussions and afforded opportunities to focus on participant expertise when it was most relevant. As expected, the participants of our exploratory study provided a wealth of knowledge pertaining to the status of FASDs in schools. It would seem that the Toronto education systems' design to address these children's special needs continues to face considerable challenges. Several implications for future research and practice with FASD affected children in schools can and should be acted on immediately.

Based on current literature,<sup>12</sup> our sample suggests that between 30 - 40 FASD affected students should have been reported. However, our pilot study demonstrated a clear discrepancy between that literature and our participant reports. As underreporting to this degree was unexpected, determining the reasons for it (underreporting) was beyond the scope of this study. There is no apparent reason to suspect participants did not disclose relevant information given the confidential nature of their participation. Additionally, all participants were very forthcoming and receptive in discussing special needs and their experiences as educators. What can be stated with certainty is that FASD was underreported in all schools. Interestingly, the school in which we knew had several patients attending whom we had diagnosed in the past did not report having worked with any FASD affected children in the past or at present. That particular school also had reportedly have never seen nor read a Motherisk FASD Clinic report, suggesting that the diagnosis was never shared with the school by the child's parent or legal guardian.

With few exceptions, all participants reported that our interview was the first time they had personally engaged in a discussion about the reported prevalence of FASDs in the education system. This includes the training time

participants spent in Teacher's College. Every participant responded positively to the idea of being further educated on FASDs, and pointed out that if it is indeed so common, they must be better prepared to address their students' unique needs. Furthermore, they also expressed frustration in meeting the needs of children with severe behavioural disorders who often cannot be managed in the regular school system. The need for increased access to outside (of school) behaviour intervention programs for students, and for increased professional development opportunities for educators, were common themes.

Overall, the outlook for special needs students in Toronto's public schools seems to be a key area of concern for all involved. A majority of practitioners interviewed expressed a grim outlook for special needs students exacerbated by inadequate resources to address both student & teacher needs. An interesting aspect of this issue is highlighted by how all participant schools had different approaches to account for their number of students with special needs. Some schools include those on waiting lists for assessment, students who are need of support without a specific LD diagnosis, or ones who have a discernible need with no forthcoming assessments. Other schools define special needs students only as those with a diagnosed disorder. With one exception, no participating school reported their program as equipped to address all their current students' special needs. The speculative reason given for this during one interview was that because their school was in an affluent neighbourhood, parents would be more apt to send their child with special needs to a private school. The practitioner expressed that they simply were not facing the need to prioritize their special needs students (as other schools are forced to do), as there were more spaces than special needs students in their school.

While all participants had information to offer on barriers related to special needs education, they also all spoke of their support and commitment in continuing to strive for truly inclusive educational environments. There were several practitioners whom reported high overall satisfaction and few perceived or experienced barriers within their school's approach to special needs education. All of those practitioners also reported working in an

inclusive school environment committed to modifying program plans for any student who had difficulty accessing the curriculum, rather than only formally diagnosed children.

### **Recommendations**

There is little doubt that in order to adequately address the needs of FASD students there has to be a unified team of professionals available to provide care and supports for FASD diagnosed children, from diagnosis to follow-up. While the Motherisk Program is able to contribute to the development of more comprehensive and inclusive supports for children with FASDs in schools, it is also our aim to work within the established framework currently set up in schools and local communities. Key community institutions such as Public School Boards, FASD clinics and Children's Aid Societies around Ontario must consider how to develop effective communication mechanisms to ensure that multi-disciplinary consulting and supports are in place to adequately support FASD diagnosed students.

The remainder of this section will highlight some key areas which, based on study findings, warrant future advocacy and research. It is believed that any number of community agencies may be able to fill such gaps in service.

#### **1) FASD awareness and education in schools**

Promote discussion and knowledge sharing amongst practitioners by expanding education initiatives immediately. To date, there are few (if any) documented school board-wide initiatives for training and support on FASD in Ontario. Although there are several FASD workshops, groups and community initiatives in Ontario offering support services, there has been very little focus on translating the clinical knowledge and FASD research into educational practice. Individual schools should be approached for training by agencies with the budget to provide such services at cost. Community agencies with expertise should provide FASD consultation support to interested schools. Additionally, consideration should be given to training school staff on screening for FASD.

## **2) Advocacy for FASD patients**

Findings support that the comprehensive FASD diagnostic reports provided by Motherisk, which include psychological and academic assessments, are not being shared with schools. FASD Diagnostic Clinics should work closely with, and continue to advocate for effective partnerships and information sharing between referral sources (most often a Children's Aid Society branch, in Ontario), caregivers of diagnosed children, and teachers. Case consultations and support for caregivers, teachers and schools of FASD affected children should be provided.

## **3) Include a full educational assessment as part of FASD assessments**

Without a complete educational assessment, students with special needs are not guaranteed special supports in school. Therefore, in order to render a diagnosis of a Learning Disorder that often co-exists with a diagnosis of an FASD, it is critical to conduct a comprehensive academic assessment to enable schools to understand the unique needs of many FASD students.

As the FASD diagnostic process should already include extensive psychological and academic testing, completing a school-board equivalent academic assessment can presumably be done with minimal additional effort on part of FASD clinics around Ontario, in partnership with a child's school, as is necessary. This would help avoid the necessity of placing FASD diagnosed children on waiting lists at school for a new academic assessment. This implies that diagnostic clinics should become familiar with their local school boards assessment requirements.

## **4) Referrals**

Support school capacity to address student needs by ensuring that the mental health issues of FASD children can be treated either in-school or through other community programs, at the time of diagnosis. Whenever possible, agencies diagnosing FASDs should make referrals for behavioural supports at the time of diagnosis. Based on participant reports, it is presumed that schools need support with expedient referrals and access to behavioural support programs for their students.

## **5) FASD as a Co-morbid Disorder**

To recognize FASD as an independent but co-morbid disorder most often associated with a learning and/or attentional disorder. An 'LD' designation seems to be a key to extra support for children in schools, according to current school board policies.

## **6) Stigmatization Study**

Consider further research on stigma associated with FASDs and the possible link to underreporting in schools. Stigmatization associated with FASDs may impact on a child's developmental potential in many ways, stemming from the choice a caregiver makes to not disclose the diagnosis. Parents may fear some kind of bias from their own perspective, or that of the educational practitioner, that might impinge on the welfare of their child. Based on participant reports, how personal disclosures affect the educator's perception and outlook for an FASD diagnosed child warrants further study.

## **CONCLUSION**

The education practitioners working with our target population of FASD children should be the ones on the front lines of intervention services. While they may not have much information on FASD per se, they have a solid understanding and vast experience in addressing the special needs of students with other well defined disabilities. The lack of FASD information available to education experts in Toronto does not accurately reflect the education communities' capabilities, but more likely reflects the shortcomings in dissemination of information from other disciplines. It is apparent that current research and recommended best practices developed by various FASD experts is not reaching educators in Toronto.

As society pays the toll for FASD, in excess of \$5 billion annually in Canada<sup>13,8</sup>, we are all stakeholders in some capacity. As there are no currently existing in-school programs for children with FASDs in Toronto, Canada's largest urban centre, this figure is likely to increase. This will be noted once school boards and governments begin to realize that non-action will be more costly than providing much needed intervention supports during childhood.

While this exploratory pilot study raises some disconcerting and debatable issues, it is intended as a starting point to address the status of FASD in Toronto schools. It is hoped that the reader recognizes themselves as a stakeholder in the discussion on FASD - and has also become aware of some key issues relating to our public schools' capacities to address the needs of FASD affected students. Having provided a starting point for academic research and discussion on FASD in the education system, it is time to begin actively addressing the needs of FASD affected students and teachers!

Effective FASD advocacy must include facilitation of communication mechanisms and information sharing between referral sources, diagnostic clinics, caregivers and teachers. It is hopeful that if we can meet some of these goals, our schools will be in a better position to assist these children and to achieve what our government has aspired to ensure: "the right to childhood experiences which promote the chances of developing into a healthy, well-adjusted and productive adult" (1999, Toronto City Council Resolution).

**Corresponding Author:** [Gal.Koren@sickkids.ca](mailto:Gal.Koren@sickkids.ca)

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## APPENDIX

### **PROTOCOL FOR SCHOOL PRACTITIONERS**

(Including, but not limited to child's primary teacher, special needs workers, school principal, therapist(s) and school psychologist)

\*notes:

- (i) Some questions will only be asked of administrators as their positions may relate to acquiring special needs funding for their respective institutions
- (ii) Questions are to be asked and adapted according to relevance. For example, if not applicable it isn't asked and/or or if the participant has not worked with FASDs, they should instead be asked about 'special needs' (if appropriate).

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#### **FASDs by the Numbers (5-10 minutes)**

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- 1) Have you ever worked with children diagnosed with FASDs before?
- 2) Over the past several years, approximately how many children in your care have been diagnosed with FASDs? How many are presently in your care?
- 3) Do you suspect more cases of FASDs at your school that have not been reported? If so, what makes you suspect more cases?
- 4) How many children in your care would you say have been screened for having special needs but have not yet been formally diagnosed with anything?
- 5) How do special needs funding occur in your agency? How many special needs children are in your care?
- 6) Are you able to access additional support funding if children have not been formally diagnosed with a disorder?
- 7) Do you receive additional funding when a child has been diagnosed with an FASD?
- 8) Is there a shortfall between what is needed and what is funded with respect to special needs students?
- 9) Approximately how much would you estimate FASDs cost in care from within your inclusive framework as compared to other special needs?



- 10) How does this compare to a 'typical' student versus a non special-needs student?
- 11) Is there an overall model for special needs funding in your agency? (i.e. \$/per child)

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### **FASDs: Knowledge & Training (10 minutes)**

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- 10) Could you describe your thought process when you were told regarding your students/clients diagnosis?
- 11) What do you know about FASDs - and how it might affect children?
- 12) Among special needs students, do you view FASDs needs differently than other special needs? How, if at all, are these needs different than typically developing children's needs?
- 13) Could you give a few examples of the types of modifications you have made in your classroom/school/practice to address your students FASD-related needs?
- 14) Have you ever heard of the Motherisk Program?
- 15) Have you been in contact with any agency or other professional (outside of the school) regarding FASDs education and/or intervention?
- 16) Does this school/agency provide the staff with professional development opportunities focused on working with FASD children? Have you participated in any forums relating to FASDs as part of your professional practice?
- 17) Has this school provided professional development opportunities (i.e. seminars) on working with any other type of special needs? Please specify topic, duration, etc.
- 18) Who specifically, along with their relationship to child/family/agency, is a part of the special needs assessment and intervention team for a child with special needs?
- 19) Does diagnosis of an FASD help you plan for a future student?
- 20) Do you feel that the diagnostic process could be better or more supportive for your practice and/or your students' needs in any way?
- 21) At this point, do you feel knowledgeable about FASDs? Where/when (if at all) have you learned about FASDs?
- 22) In general, what kind of issues/facts do you need to acquire about FASDs that you have not been able to learn about?
- 23) What kind of details, if any, do you feel you need to know about your student in particular in order to better serve them?

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### **FASDs: Perceptions & Attitudes (10 – 15 minutes)**

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- 24) If a child in your class/school were formally diagnosed with an FASD, do you feel their academic outcomes would improve? How? Why, or why not?
- 25) How do you perceive a family's life changes when their child is diagnosed with an FASD?
- 26) Have you recommended any modifications be made at the home of your client/student?
- 27) Do you perceive a negative stigma associated with FASDs? If so, please explain.
- 28) Do you believe that people view children with FASDs negatively, positively, or are generally indifferent and treat them as 'normal' children? Please explain.
- 29) Do you feel that FASDs is an appropriate name/label for this condition? If it were named something else, could a child's developmental outcomes be potentially different?
- 30) Do you think that FASDs should be treated differently than other special needs? If so, how?
- 31) Do you believe a student with FASDs has needs that are different than other special needs children? If so, describe other areas.
- 32) Do you feel the parents share relevant information related to their child's diagnosis or special needs with you and the school?
- 33) Do you feel that in your role of practitioner you have adequate resources to support and promote academic growth for a child with an FASD?

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**Special Needs in School, Individualized Education Plan (IEPs)  
& Special Needs Funding (10 – 15 minutes)**

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- 34) What are the biggest areas of concern that you have for this child?
- 35) What would you say is the biggest areas of concern that this child's parents have about him/her?
- 36) Is this child considered a special needs student?
- 37) What are the criteria for developing an Individualized Education Plan (IEP)?
- 38) Does this child have an IEP?
- 39) Was the child's family a part of developing the plan? If so, could you describe how they contributed?
- 40) Who is involved in implementing the IEP?
- 41) Who or what practitioners are involved in supporting this child's needs at the school?
- 42) What is your role as relating to facilitation of this child's intervention plan?
- 43) In your recollection, were recommendations from the Motherisk's report used when creating the child's IEP?
- 44) Did you find the Motherisk recommendations useful in constructing this child's current IEP? Why or why not?
- 45) Overall, would you say that the FASDs diagnosis has been helpful in planning for and implementing programming for the child? If answer is yes, could you give a few examples? If answer is no, could you give a few examples of how it has been unhelpful or counterproductive?
- 46) How much of the 'special needs student' day is spent alongside 'typical' peers in regular classrooms versus special needs classes or one-on-one work?
- 47) What types of modifications have been made in your class, or school, in order to assist and enhance this child's school experience?
- 48) Do you rely on any other people or services when it comes to providing opportunities for this child?
- 49) On average, how does your school/school board/agency allocate resources specifically for FASD-related services, specialists or supports (if any at all)?
- 50) In your opinion, do you feel this is adequate, more than is necessary, or too little?
- 51) Overall, what types of supports and specific techniques have you found to be most effective when working with this child/FASD children?
- 52) What resources or agencies in the community do you know of that are supportive to FASD-affected children?
- 53) What programs, agencies or government initiatives have you accessed with respect to FASD-related intervention at your site?

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**'The System' (10 – 15 minutes)**

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- 54) What would you suggest are some key barriers of our systems to achieve the above?
- 55) Overall, what kinds of changes in our systems (if any) do you feel still need to be made in order to optimize our intervention initiative with FASD or special needs in general?
- 56) What are the issues you feel are most urgently needed in order to help you carry out your professional role in working with this child, the family and/or intervention team? (i.e., information/education, more programs, funding, etc.)

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