

The Importance of Early Identification of Fetal Alcohol Spectrum Disorder (FASD)

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Summary

The court, by requiring that inquiries be made early on regarding alcohol exposure in *utero* and ordering diagnostic evaluations when appropriate, can radically alter the population of juvenile court, the adult criminal justice system and corrections as well as influencing treatment programs for sexual deviancy, mental illness and drug abuse.

A thin, wiry, jittery baby comes into your court in the arms of a foster mother. It is the hearing to determine whether or not the allegations against the parents are true, whether or not the court should take jurisdiction of the minor and if so, what the disposition should be. At the initial hearing, it was reported to the court that the mother and baby had been tested and found to have cocaine in their systems at the time of delivery. The foster mother tells you the baby takes a very long time to finish a bottle, is wakeful, startles easily, does not soothe and will arch away from you as though touch is unpleasant if you try cuddling.

Although you might attribute these behaviors to cocaine exposure in *utero*, it is also possible that the behaviors are the result of the baby's exposure in *utero* to alcohol. It is not, in many jurisdictions, routine for infants to actually appear in court, but there should always be a social worker's report to the court providing information on the health and behavior of the dependent child. The court should request of social workers that they ask mothers specifically about alcohol use during pregnancy; how much, what and when they drank. If these aren't routine questions on the social worker's intake form, consider requesting this question be added to the form and directing social workers to provide you this information in every case. Initially the focus should be on the mother's history, not the physical tests of the baby. Because of the transient nature of alcohol in the body, toxicity tests often do not identify alcohol, as they do other drugs, in either mother or baby. Many mothers who use cocaine, heroin, methamphetamines and other substances also use alcohol. Alcohol is a known teratogen, causing birth defects which last a lifetime, while the effects of the other drugs often lessen over the years.

Fetal Alcohol Spectrum Disorder (FASD) is the recently devised consensus term for what we used to refer to as Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). FASD describes the brain damage (and in 30% of the cases signature physical features such as small head, small eyes, smooth space between the nose and upper lip and thin upper lip) that can occur when a mother drinks alcohol during pregnancy. This damage can take place in the very early stages of the pregnancy, before the mother even knows that she is pregnant, and can result from as little as one evening of 5 or more drinks. It is simply not known how little alcohol exposure can cause this harm since there are many variables, the most significant of which is the mother's metabolism. Every mother has her own rate of metabolizing alcohol; some will pass the alcohol swiftly out of their systems, while in others, the alcohol effects will linger longer. Since the alcohol the mother drinks passes directly to the fetus, via the placenta, within minutes the baby has the same blood alcohol level as the mother. The potential for harm exists every time a pregnant woman drinks. Since 1981, the US Surgeon General has recommended that if a woman is planning a pregnancy or is pregnant she should use no alcohol at all.

Brain damage is the most significant disability that can occur; indeed, alcohol exposure is the major cause of preventable mental retardation. Brain damage from alcohol exposure affects as many as 1 in 100 live births, more than Down's syndrome, Spina Bifida and Childhood Autism. Dr. Ann Streissguth from the University of Washington has been researching this disability since 1973. She has found that appropriate services to address the myriad problems that these babies, children and adults experience can make a very real difference in how effective these individuals are in coping with their environment and its challenges. With diagnosis can come intervention therapies, developmental and parenting classes for caretakers and informational material on effective child-raising. Individuals with this disability can require speech therapy as well as specialized learning techniques and strategies. An understanding of the disability can bring about more realistic expectations from families, adoptive and foster parents, teachers, social workers and others who may deal with these individuals as they grow to adulthood.

With a goal of very early detection of this disability, Dr. Streissguth and her colleagues have, for the past two years, researched the accuracy of ultrasound images obtained through the fontanel to detect this brain damage in newborns resulting from alcohol exposure. The team is very encouraged by their results. Ultrasound is a ubiquitous technology, available in every hospital, non-invasive and inexpensive. Diagnosis in the first three months may well be the future norm, changing radically the prospects for this disability.

If you, as a dependency court judge, ask the relevant questions of the caretakers and follow up where warranted by asking the social worker, CASA volunteer or attorney in the matter to investigate further, you can then order a diagnostic evaluation of the baby or child. The appropriate experts are a dysmorphologist, a specialist in diagnosing birth defects, or a pediatrician with training in identifying FASD (our website has a state-by-state listing of these diagnosticians). You can then put in place interventions while the baby's brain is still growing. A referral can be made to your Regional Child Development Center for services shortly after birth in some locations, somewhat later in infancy in others.

If an older child comes before you because of an inability to concentrate, focus on learning or attend calmly in the classroom—and he or she has been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD)—ask the social worker, CASA volunteer or attorney what is known of the child's exposure to alcohol in *utero*. It is clearly important to understand the etiology of the child's behaviors since these children learn differently and as a consequence need educational strategies tailored to the disability. Even medication can be problematic since children with FASD often react adversely to commonly prescribed drugs for the treatment of ADD and ADHD. What is effective for the child without brain damage can be wholly ineffective for the child affected by FASD.

And what about the many parents who appear in court and seem to have their own cognitive problems? The court needs to be on the lookout for mothers (and fathers) with suspected FASD, whose lives could be stabilized by a diagnostic evaluation and appropriate services. A foster family, well versed in this disability, could be an appropriate setting for a parent and child or children together, offering much-needed structure for all.

What is the result if these questions remain unasked, the etiology unquestioned, the diagnosis unattained? These individuals experience significant problems which often go unaddressed. Dr. Streissguth's research reveals that 60% of adolescents and adults with FASD have been in trouble with the law. Approximately 50% of those disabled by FASD have been confined in jail, prison, a drug treatment program or a mental hospital. More than 60% have had school disruption. Of this population, around 70% have been sexually or physically abused, approximately 50% have engaged in inappropriate sexual behavior and some 50% or more have had problems with drug and alcohol abuse.

Who with FASD fares better? Those with at least a four-year period in a stable, nurturing home; those who have been diagnosed before the age of 6; and those who have never experienced violence directed against them. But even if the diagnosis is at a later age, it can still be helpful to a person with FASD in understanding their own behavior and to families and professionals who are involved in their lives. Clearly, this is a disability which if not accommodated with interventions, therapies, supports and remediations can lead to escalating problems for the individual, the families and society. Dependency court judges are in essence first responders. Decisions made here can have a lifetime impact on both the child and the family. The pivotal position the court occupies is of huge significance, making possible an entirely different outcome for a large population. The court, by requiring that inquiries be made early on regarding alcohol exposure in *utero* and ordering diagnostic evaluations when appropriate, can radically alter the population of juvenile court, the adult criminal justice system and corrections as well as influencing treatment programs for sexual deviancy, mental illness and drug abuse. Court orders for useful interventions and accommodations for this disability are well justified by the potential for improved outcomes.

The court's charge is to protect these infants and children from the effects of their lifelong disability—particularly because these young ones were not protected by society nor could they protect themselves from the initial harm. As the Florida Supreme Court observed in its 1994 decision in *Dillbeck v. State*, “We can envision few things more certainly beyond one’s control than the drinking habits of a parent prior to one’s birth.”

Central Nervous System Structural and Functional Effects of In *Utero* Alcohol Exposure by Age

Age	Effects
Newborn:	Microencephaly (small head), jitteriness, opisthotonus (hyperextension of body with arched back), seizures, tremors, weak suck, unpredictable and disrupted sleep/wake cycles, hypotonia (low muscle tone), hypertonia (tense muscle tone), decreased vigorous bodily activity, hyperacusis (low hearing threshold), failure to thrive (given adequate opportunity), poor habituation (difficulty tuning out redundant stimuli), EEG abnormalities
Infancy:	Delayed development in one or more area, head banging and/or body rocking, poor fine motor or gross motor control, neurological dysfunction (including cerebral palsy)
Preschool:	Hyperactivity, poor eye-hand coordination, poor balance, central auditory dysfunction, delayed or perseverative (repetitive) language, mental retardation
Early school age:	Attentional impairments, learning disabilities, arithmetic disabilities, specific cognitive disabilities, deficits in higher order receptive and expressive language, poor impulse control
Later school age and adolescence:	Memory impairments, difficulties with judgment, difficulties with abstract reasoning, poor adaptive functioning, inability to read to grade level, playing with much younger children, impulsivity, poor judgment as to friends and activities, repeating the same mistakes over and over, not learning from experience

Adapted from Streissguth, A. *Fetal Alcohol Syndrome: A Guide for Families and Communities*. 1997 Paul H. Brookes, Baltimore, MD.

Please see the “Online Resources” section for additional information on the subject of FASD recommended by Kathryn Kelly.
Editor’s Note: Kathryn Kelly is the project director of the FAS/FAE Legal Issues Resource Center (depts.washington.edu/fadu/legalissues/), a joint project of the University of Washington School of Medicine and School of Law. The Resource Center consults with judges, attorneys, probation officers, corrections and law enforcement as well as maintaining a website which includes summaries of nearly 150 state and federal cases in which FASD was a factor.

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