WHEN TRAUMA IS NOT THE WHOLE STORY: THE SYSTEMIC FAILURE TO RECOGNISE AND SUPPORT FASD IN ADOPTION, FOSTER AND KINSHIP CARE

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Conventional therapies and support often fail to address the complexities of FASD, leaving many children at high risk for placement disruption.

FASD in the context of family law

Fetal Alcohol Spectrum Disorder (FASD) is a life-long neurodevelopmental condition which is more common than Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), and yet to date does not benefit from similar levels of social understanding, or clinical and educational provision.

FASD is the most severe of all neurodevelopmental conditions, aside from intellectual disability, in terms of its impact on functioning across the lifespan (Novick Brown & Greenspan, 2021; Novick Brown & Reynolds, 2021).In the UK general population, it is thought that roughly 3.6% of children may be born with FASD, compared with perhaps 2% for children with ASD – albeit that ASD diagnoses are currently increasing for a range of possible reasons – and this may be an underestimate (McCarthy *et al*., 2021). Some screening studies have suggested that the prevalence of FASD may be over 6% (McQuire C. *et al*., 2019), and a 2018 prevalence study by McQuire and Paranjothy at the University of Bristol proposed that up to 17% of children could have symptoms consistent with FASD.

FASD can result from any amount of prenatal alcohol exposure (PAE) at any point during pregnancy; there is no known safe amount or time to consume alcohol, and, consequently, advice from the UK Chief Medical Officers and NHS is to avoid alcohol entirely when planning and throughout pregnancy.

What does this have to do with family law specifically? While FASD affects children and families from all walks of life, some populations are at significantly greater risk of having alcohol-exposed pregnancies. This includes mothers within care proceedings. The percentage of children in care and adopted children who are thought to have, or to be at risk of, FASD, varies depending on the study. Lange *et al*. (2013) suggested a world prevalence of 17% for children in care, while Gregory *et al*. (2015), in a UK-based study in Peterborough, found that 27% of children in care met the diagnostic threshold for FASD. The same study reported a history of PAE in 55 out of 160 health assessments for children in care (34%), and in 34 out of 45 of children put forward for pre-adoption medicals (75% of those children). We can therefore extrapolate from these figures that a significant proportion of children on the case loads of social workers, children's guardians and solicitors may be affected by this condition. Most will be undiagnosed.

Often, it is substance misuse which receives the greatest attention and is most

likely to be documented in social care chronologies, including suspected or confirmed use of substances during pregnancy. There is a common misconception that drugs do the greatest harm to the developing fetus, and yet alcohol, a 'socially acceptable' and readily available commodity, is one of the most teratogenic substances of all. Conversely, with opiates like heroin, following an initial neonatal abstinence syndrome, the long-term neurodevelopmental implications of prenatal exposure are far less severe than those relating to prenatal exposure to alcohol (Behnke *et al*., 2013). Because this is not commonly understood, many babies and children within care proceedings may not have their PAE explicitly documented, which can result in them not receiving appropriate diagnosis post-adoption and later in their childhoods.

The profile of FASD

FASD is best understood as a syndrome: a collection of symptoms and secondary conditions which are caused by prenatal exposure to alcohol. While the most obvious manifestations are brain-based, FASD is a whole-body diagnosis, with multiple physical manifestations, including heart, kidney, eye (vision) and ear (hearing) disorders being linked with prenatal exposure (Popova *et al*., 2016). FASD is also associated with sentinel facial features. The three primary diagnostic facial features associated with PAE (in absence genetic aetiology) are: short palpebral fissures (narrow eyes); a thin upper lip; and a smooth, undefined philtrum (the vertical groove above the upper lip). However, 90% of those with FASD will not have these features. The only context where the presence of sentinel facial features may be clinically significant is when a child with suspected FASD does not have a documented history of PAE. In this circumstance, if the child has all three facial features they can be diagnosed with FASD, despite an undocumented history. This is due to the specificity to PAE of the three features occurring together.

Cognitive and neurodevelopmental difficulties associated with FASD have a significant impact on an individual's adaptive functioning across the lifespan. While many children and adults with FASD have a near-normal IQ (albeit often having a 'spiky' cognitive profile with significant discrepancies across domains), their broader deficits in executive function (including attention, sequential planning, working memory and emotional regulation), receptive and/or expressive language, auditory processing and social cognition, result in significant functional deficits. That is, their independence and life skills are far lower than their IQ would otherwise predict.

FASD is a disorder of connectivity, which explains the breadth and patterning of impairments, including why there can be islands of relative strength and ability (often in simple, repetitive, uni-hemispherical tasks), while those tasks requiring bi-hemispherical communication (which includes social cognition, auditory processing and executive functioning) are significantly more impaired. The areas of the brain most vulnerable to PAE are central regions, including the frontal and parietal lobes, while lateral areas can be more spared.

Consistent with the impairments described, recent research indicates that 86% of children with FASD will meet diagnostic threshold for (secondary) ADHD, while around 70% of children with FASD will meet diagnostic threshold for (secondary) Autistic Spectrum Disorder (e.g., Mukherjee *et al*., 2011). The ASD phenotype is often markedly different to that of a child with primary/familial ASD, however, with social disinhibition and relatively spared non-verbal communication skills, such as eye contact and facial expression, compared to the classic socially withdrawn profile.

Prenatal alcohol exposure also affects the development of the neuroendocrine system: the hypothalamic-pituitary-adrenal (HPA) axis. The HPA axis is a homeostatic feedback system which mediates the effects of external stressors by regulating various physiological responses. Most notable for those with FASD is the role that the HPA axis plays in emotional and behavioural regulation. For neurotypical individuals, the HPA axis effectively enables us to 'down-regulate', or calm our physiological systems to regain physical and emotional regulation in the context of hyperarousal. While we can feel emotions strongly, we are also able to calm ourselves down without intervention and a well-functioning neuroendocrine system plays a significant role in this process. The HPA feedback system can be disrupted in individuals with FASD, which results in them struggling to regulate their emotional responses to stress. Affected children therefore frequently present with severe externalising behaviour, particularly in overstimulating environments such as school. These behavioural challenges are compounded by impulsivity, poor inhibitory control and poor social understanding resulting from the dysexecutive presentation caused by pre-frontal cortex damage.

Young people (and adults) with undiagnosed FASD can end up with a range of mental health diagnoses in an effort to explain their mood lability and poor emotional regulation, when the aetiology may be organic in origin and relating to brain damage as described. This may also be the case for undiagnosed parents within care proceedings, whose poor adaptive behaviour and regulatory challenges can easily be misunderstood, or at least over-interpreted, as being solely due to childhood trauma and other experiential factors.

Children and adults with FASD are often outwardly very sociable (frequently disinhibited and over-familiar) and engaging individuals, which can mask their underlying deficits. They would pass 'the mingle test'; if you were to have a short conversation with them, you would be unlikely to recognise the severity of their condition. Consequently, in education and other social settings, children and young people with undiagnosed FASD can be misunderstood as simply having a behavioural or attachment problem, rather than the acquired brain injury that FASD represents.

Individuals with FASD are extremely socially vulnerable, which is at its most marked from adolescence and beyond. They are easily exploited due to their poor social cognition and impairments in self-monitoring, and often end up as the 'fall guy' in peer groups. These are young people (and adults) who seem not to learn

from past mistakes and fail to consider the possible consequences of their actions – despite that they so often say all the right things in a one-to-one assessment (including in capacity assessments). There is a strong association with FASD and involvement in the criminal justice system; those with FASD have been found to be 19 times more likely to be sent to prison than those without FASD (Popova *et al*., 2011).

There are consequences for capacity in those with FASD, which is rarely straightforward. Often individuals can present as having capacity in structured environments (such as the context of a capacity assessment) and yet continue to engage repeatedly in risky behaviour (to themselves and/or others) in daily life. This is explained by the 'coping collapse in unstructured environments' that Novick Brown & Greenspan (2021) describe, resulting increased levels of criminality and behaviour that places themselves and/or others at risk. Capacity in FASD so often falls apart at the self-monitoring stage in 'real world' environments, particularly in the context of emotional arousal.

The dysregulated and emotionally labile behaviour associated with FASD presents an additional challenge when it comes to children in care and adopted children, because FASD-related behavioural challenges can masquerade as behaviour associated with attachment disruption and trauma. If a child has suffered in this way, it can be tempting to assume that any presenting behavioural and neurodevelopmental difficulties are fully explained by such experiences. This can prevent professionals from remaining curious as to whether something else may be contributing to the child's difficulties.

It has also been found that children with FASD frequently present with what appears to be 'disordered' attachment behaviour, even when they do not have a history of significant trauma. This is because the cortical and neuroendocrine damage caused by FASD results in changes to the way that children understand social relationships and how they behave towards their primary attachment figures (Mukerjee *et al*., 2019). These findings can have catastrophic implications for adoptive families, who are often referred for inappropriate therapeutic intervention because the child's difficulties are assumed to be predominantly attachment-related, whereas if they are instead due to FASD, they require a somewhat different approach to intervention and support.

Sometimes professionals have enquired: 'if a child has trauma and is receiving support for this, what value will an FASD diagnosis add?' The developmental trajectory for a child with 'uncomplicated' trauma, compared with a child who has both FASD and trauma, is very different. The general trend is that a traumatised child will show marked improvements when placed in a stable home and is receiving appropriate therapies. Conversely, the trajectory for a child with FASD is very different; there is an increasing developmental divergence away from neurotypical development throughout childhood and adolescence, regardless of good parenting and therapies.

Furthermore, children with FASD respond differently to traditional approaches to treating trauma and require an adapted approach to managing behaviour and facilitating regulation. Therefore, not acknowledging the possibility of FASD means that a child is unlikely to receive the support and intervention they need throughout their lifetime, which leaves them extremely vulnerable.

We must also consider that the presence of neurodevelopmental conditions like FASD impacts the way that trauma presents itself behaviourally. Without knowing about underlying neurodevelopmental conditions, there is a risk of misinterpreting the reasons for children's behaviour and therefore misattributing aetiology. Psychological assessment of children and young people within care proceedings should therefore always consider the possibility of cognitive and neurodevelopmental impairments, including FASD, and formulate accordingly.

FASD-related difficulties are often not apparent until a child is school-aged, particularly from year one onwards as the curriculum becomes formalised and is less based on free play. As described, a developmental divergence occurs over the course of childhood, such that from the age of around six onwards there is increasing deviation away from the mean; the gap in adaptive functioning between neurotypical children and those with FASD widens over time. This means that the needs and vulnerabilities of affected children also become greater over the years. The onset of adolescence represents a peak period of social vulnerability for children with FASD, with disrupted secondary education, trouble with the law, inappropriate sexual behaviour, dysregulation in the home, and drug and alcohol difficulties being common manifestations of this vulnerability (Streissguth *et al*., 2004). In summary, the needs of a child with FASD not only are very different to those of a child with trauma, but they also become more complex in the course of their lifespan.

The impact of FASD on families

Most of the children seen in FASD assessment clinics are either in care, adopted, or in kinship care. Sadly, many families have reached crisis point by the time they come for assessment, in terms of struggling to manage the significant burden of care associated with the child's complex needs and the lack of services to support them. Well-meaning but inappropriate advice and support from professionals can increase feelings of isolation and despair. Many parents report having to 'fight' for recognition and support across agencies, including schools, social care teams and health services.

While the early years include difficulties with emotional regulation and externalising behaviour, the adolescent period is often when such behaviour reaches a point of crisis. Child-to-parent violence is not uncommon in adolescents with FASD, when poor regulation of normal teenage emotionality, compounded by limited social cognition, impulsivity and poor inhibitory control, too often manifest in severe externalising behaviour.

Due to the vulnerability described, other adverse outcomes are also common. There are cases where teenage girls with FASD are suffering sexual exploitation to the point that their parents are no longer able to protect them. There are also cases where the young person has themselves been the instigator of sexual harm, sometimes inadvertently so, due to their poor understanding of social norms and boundaries, and the aforementioned problems with inhibition.

Contact with the criminal justice system is rarely straightforward. Young people with FASD are highly susceptible to leading questions and to providing narratives that are inaccurate and fabricated. They are often poor historians, with the 'blanks' being fleshed out by confabulation due to forgetting, a desire to 'say the right thing', or even to speed up completion of the interview. There have been cases where individuals have provided false confessions for an offence they did not commit. On one such occasion, the individual reported doing so because they believed it would mean they would be released earlier. On another, the adolescent reported that they accepted responsibility because their 'friend' told them to. These incidents highlight the social naivety and vulnerability that characterises FASD. The parents and carers of these young people are those bearing the strain of navigating the risks and filling the gaps in service provision.

There is an increased risk of adoptive placement instability or breakdown in families where children are affected by FASD (Brown & Bednar, 2004), although accurate statistics specific to FASD are hard to find because they are often not measured. Furthermore, the way in which regional adoption agencies capture numbers can differ, and they may not include cases where a section 20 has been signed if a family is seeking joint parental responsibility with the local authority to obtain residential care, or where a section 40 has been instigated for the child to re-enter the care system.

There can be fear and stigma for adoptive families who reach a point of crisis. In November 2025, a six-month BBC investigation reported the results of interviewing 50 families where an adopted child had returned to care. The investigation noted that almost a quarter of those spoken to had been taken into police custody due to allegations of abuse by their adopted children. A pervasive culture of blame was reported in local authorities, whereby adoptive parents are held responsible for their child's behaviour and the placement breakdown. Investigators further highlighted a study from Lancaster University stating that 38% of adoptive parents had considered returning their child to care, indicating that this is not an unusual phenomenon. Almost all parents in the BBC investigation reported receiving insufficient support, respite and understanding as adopters, with many arguing that had they received this, then placement breakdown may have been avoided.

The Adoption Barometer 2025 (Adoption UK) presents a similar picture. Of 3,591 respondents, 42% described their family status as 'facing severe challenges or at crisis point'. The Adoption Barometer 2022 highlighted that 5% of established adoptive families reported a child leaving home prematurely that year. While these

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investigations and reports are not directly related to FASD, given the statistics established with 75% of children undergoing pre-adoption medicals having a history of PAE in one study (Gregory *et al*., 2015), it is inevitable that many of the children involved will be affected by FASD, and that this will inevitably have contributed to the behavioural challenges reported.

Further investigative evidence specific to FASD is required in this regard. Currently, many of the children returning to care will have their behavioural difficulties explained away by early trauma, rather than undiagnosed FASD, even when their histories do not necessarily support this formulation.

While adoption breakdowns ultimately occur due to the untenability of meeting the significant needs of an adopted child, clinical experience of working in this field for almost 20 years has highlighted certain factors that may increase placement instability in the context of FASD.

A key factor is delayed diagnosis due to inadequacy of assessment service provision, misdiagnosis through clinician inexperience, or, in the case of a confirmed diagnosis, the agencies supporting the family failing to understand the impact and trajectory of FASD. In this context, families report feeling isolated and unheard. Intervention is often inappropriate for FASD and weighted towards treating attachment and trauma, including reiterating the importance of therapeutic parenting. The more these strategies fail to elicit the desired improvements, the more hopeless and blamed adoptive families can feel.

Even when a child receives an FASD diagnosis, there is rarely a clear pathway to support. Families often find themselves locked out of local services due to arbitrary referral criteria. For example, many children's learning disability teams continue to use IQ as a proxy for functioning. As most children with FASD will have near-normal IQs (and yet be functioning in the intellectual disability range), families are then prevented from accessing a service where support, enablers and much-needed respite might otherwise have been offered. The provision of respite and an attuned Team Around the Family model has the capacity to pull families back from being on the edge of care.

The limited availability of specialist educational placements is a further problem that can contribute to placement instability. Because mainstream schools are often unable to meet such complex needs, children with FASD can find themselves on reduced timetables, or entirely out of education, while specialist placements or Education Otherwise Than At School (EOTAS) packages are being finalised. Again, this leaves parents with little respite from challenging behaviour and the impact on family finances of one parent having to leave the workplace adds further financial strain. Some families are only able to function if a child is offered a residential educational placement to share the responsibility of care and supervision across the week. If this placement breaks down or is unavailable, the adoptive home can quickly escalate into crisis.

Avoiding placement breakdown

Having introduced some of the primary risk factors for placement breakdown in families affected by FASD, we can also consider some of the factors that can prevent families from reaching edge of care status. This may include input from agencies and professionals, such as pre- and post-adoption/SGO social workers, children's guardians, medical professionals and CAMHS teams.

Preventative work begins at the pre-adoption stage. Anecdotally, many adoptive parents report that PAE and risk for FASD were not clearly documented in pre-adoption assessments and paperwork. Others report that when risk was recorded, they were still inadequately prepared for what raising a child with FASD might entail. The training received either 'glossed over' FASD, or the overriding message was that the of mending attachments ultimately cured all.

The Adoption Barometer 2025 references a tendency towards 'excessive optimism' within the system, which may contribute to prospective adopters being matched with a child prior to receiving the full picture required to make informed decisions. One could argue about the moral dilemma of potentially deterring families from adopting PAE-affected children, who might then find it increasingly difficult to be placed. However, adoptive processes that do not highlight the significant future needs associated with PAE are not preparing adoptive families for what may lay ahead, which increases the risk of future placement breakdown.

The reported 'excessive optimism' within adoption teams is no doubt well-intended. It may also highlight gaps in training and knowledge about FASD and its impact across the lifespan. There is a significant need for adoption teams to acquire such training in order that adequate information is cascaded to prospective adopters and appropriate recommendations can be made during the matching process.

As has been explored in other sections, it is also imperative that suspected or known PAE is well documented in social care chronologies so as to enable adopters to seek appropriate assessment and diagnosis. Many families find themselves spending extended periods of time waiting for social care teams to review historical records, sometimes across several local authorities. This again prevents timely assessment and diagnosis.

When adoptive families find themselves struggling to meet the needs of their child, the response they receive from agencies can strongly determine outcomes. Reiterating trauma-informed interventions can alienate parents, who have often already engaged in numerous therapeutic parenting courses and attachment therapies. A Team Around the Family approach is often necessary to ensure that support is coordinated. Therapies and interventions must be FASD-specific and include the entire family system, rather than simply the child. Support may include a combination of respite and practitioners providing direct family support, in addition to therapies being commissioned through a child's Education, Health and Care Plan (EHCP), such as speech and language or occupational therapy.

Members of the Team Around the Family must be upskilled regarding the nature of FASD-related challenges and their pervasive impact on the family system. This will help to mitigate the perceived culture of blame that families report.

FASD causes arrested development (Novick Brown & Greenspan, 2021) and adaptive functioning impairments across the lifespan. Consequently, support cannot simply cease at the point of adulthood. There should be planning for transition to adulthood in good time to avoid the frequently reported 'services falling off a cliff' (direct quote) phenomenon at the age of 18. For some individuals with FASD, this may include supported living arrangements should their families be unable to continue caring for them. The intellectual disability equivalence phenomenon will be relevant when seeking support from adult services.

The support and scaffolding that an individual with FASD – and by extension, their family – receives at times of need can be the making or breaking of them, and the implications for failure are not just at a family level, but also at the societal level and beyond.

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