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Preserving Families of Children in Child Welfare with Fetal Alcohol Spectrum Disorders: Challenges and Opportunities

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Abstract

The mission of child welfare is to ensure children's safety, permanency, and well-being. It is also charged with preserving and strengthening families and with avoiding the removal of children who can be kept at home safely. This paper addresses some of the challenges in meeting these concurrent goals in work with children prenatally exposed to alcohol and their families. Current child welfare practices are unlikely to identify prenatal alcohol exposure or children with fetal alcohol spectrum disorders (FASD). Yet if this exposure is identified when families come into contact with child welfare, a jurisdiction's laws and safety and risk assessment processes may lead to unnecessary removal of children from their homes, particularly for Black and American Indian/Alaska Native families. Drawing from research and discourse in the field, strategies are described that could help the child welfare system care for children who may be impacted by FASD while preserving their families. A crucial strategy is partnering with key child and family service providers to identify and respond to FASD.

The recent emphasis on preserving families is set in the context of a child welfare system that is grappling with the disparate impact it has on families experiencing poverty and children and parents of color (Harp & Bunting, 2021; Milner & Kelly, 2021). Families facing economic hardship, inadequate resources, and unstable housing may be more likely to be involved in child welfare (Conrad-Hiebner, & Byram, 2020; Pelton, 2015). Black

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children are at higher risk than White children for their families being reported for and investigated for child maltreatment, being placed in foster care, and for their families to undergo termination of parental rights (Edwards et al., 2021; Wildeman et al., 2020). Children who are American Indian/Alaska Native also face disproportionate involvement; in one state, children aged seven to 11 in families investigated for child maltreatment were found to be 25 times more likely to be removed from their home than their White counterparts (Edwards et al., 2023). The child welfare system is charged with protecting children from child abuse and neglect and its traumatic effects. Yet there has been a renewed attention to the trauma that the system itself may inflict when children are placed out of home (American Bar Association House of Delegates, 2019; Milner & Kelly, 2021; National Academy of Science, 2018; Sankaran et al., 2018).

Children with fetal alcohol spectrum disorders (FASD) may be at a higher risk of involvement in child welfare, and thus out-of-home placement (Lange et al., 2013; Putnam-Hornstein et al., 2016). FASD is an umbrella term which refers to diagnoses related to alcohol exposure during the prenatal period, including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (PFAS), neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD; Centers for Disease Control and Prevention, n.d.).

While children may not show any indicators of the lifelong neurocognitive impacts associated with FASD at birth (Popova et al., 2020), as they grow, a range of long-term medical, developmental, mental health and social impacts may emerge. Children with FASD may have difficulties in areas such as executive functioning, learning, impulse control, and problems developing daily living skills (Hagan et al., 2016). The communication deficits and challenging behaviors that are more common in children with FASDs may strain relationships with their families. This can lead to significant caregiver stress (Bobbitt et al., 2016; Petrenko, 2019), which may be higher than stress experienced by those caring for children with other types of developmental disabilities (Paley et al., 2006). The difficult behavioral issues that may be present when a child has FASD are similar to those that have been reported to increase a child's risk of maltreatment (Jaudes & Mackey-Bilaver, 2008; Maclean et al., 2017).

The number of children in child welfare who may have FASD is likely high, but a lack of data makes estimating prevalence difficult. Chasnoff and colleagues (2015) reported 28% of 576 children with a history of child welfare involvement were diagnosed with an FASD, which is similar to an estimate of 25% found in an international meta-analysis of children in care (Popova et al., 2019). Current practices and conditions contribute to challenges in understanding how many children in child welfare may have been prenatally exposed to alcohol. As described in articles included in this Special Issue (see Chasnoff et al., 2023; Lloyd-Sieger et al., 2023; Wang et al., 2023), processes used by agencies largely are designed to meet federal requirements that states report the number of infants affected by prenatal substance exposure and develop care plans to address immediate parent, infant, and family needs (Lloyd etal., 2019). These are frequently initiated when medical providers identify exposures to drugs such as methamphetamines or opioids through medical tests of the mother and newborn at birth (Wang et al., 2023). Infants born with other drugs in their systems (e.g., cocaine) may be more easily recognized by both toxicology findings as well as the agitation and other behaviors seen at birth for these infants. However, identifying prenatal alcohol exposure through standard hospital drug testing is ineffective, as evidence of alcohol is typically gone from the body within 12 hours of the last drink (Trius-Soler et al., 2023). Facial features that are associated with FAS are not typically present in other types of FASD diagnoses, such as ARND and ARBD (Centers for Disease Control and Prevention, n.d.). Yet there is little guidance to help child welfare professionals spot children who are older and may have an unrecognized FASD, when their exposure to alcohol was not recognized at birth (Wang et al., 2023).

A child's history of prenatal alcohol exposure is important in recognizing children who may be impacted, given the limitations of medical tests. Routinely obtaining and documenting information on a mother's use of alcohol during pregnancy could help identify children who could be at risk of developing FASD (Burd et al., 2011; Waite, 2023). It could facilitate early referrals to providers qualified to diagnose a child, such as developmental pediatricians and child mental health specialists. When a child receives a diagnosis, it can lead to services that can mitigate the negative effects of FASD (Chasnoff et al., 2015; Petrenko, 2015). Diagnosis can also help families understand their child's behaviors, give them information about effective strategies to care for their children, and offer opportunities to obtain peer support, all of which may reduce family conflict and risk of child maltreatment. This may reduce safety concerns and avoid the need to place a child out of the home.

Yet conversely, obtaining and documenting information on prenatal alcohol exposure in individual child welfare cases may lead to consequences that can heighten the risk that a child will be separated from their family. The use of information about prenatal substance exposure is driven by state laws, child welfare agency and hospital processes, and medical provider and child welfare professionals' practices (Atkins & Durrance, 2020; Lloyd et al., 2019; Rebbe et al., 2019; Wang et al., 2023). These may lead to unnecessary family involvement with child protection, services that do not match family needs, and out of home placement (Lloyd et al., 2019). It may also contribute to over-representation of Black and American Indian/Alaska Native families (Karvonen et al., 2023; Schoneich et al., 2023).

The decisions that are made when a child's prenatal exposure to substances is recognized have significant and long-lasting impacts on the child and their family. Currently these decisions are made in an environment that creates conflict between meeting a child's need for services while working toward preserving their families. Drawing from research literature and discourse in the field, as well as from articles featured in this two-part *Child Welfare* special issue, this article describes current challenges for child welfare professionals in meeting these concurrent goals, as well as ways to address those challenges.

The Use—and Misuse—of Information on Children's Prenatal Exposure to Alcohol

Information on a Child's Prenatal Exposure to Alcohol can Cause Unnecessary Involvement of Families in Child Protection

The structural factors that bring families into contact with child protection unnecessarily lead to further disproportionate representation and inequitable outcomes for families of color (Sanmartin et al., 2020). These factors include state laws related to prenatal substance exposures, and processes which guide how information on the use of alcohol during pregnancy is applied.

First, efforts to preserve families are obstructed by state laws that criminalize or define prenatal substance exposure as child maltreatment. According to Guttmacher Institute (2022), 24 states define prenatal substance use as child maltreatment. In response to these laws, pregnant individuals may not disclose drug and alcohol use, and avoid prenatal and substance use treatment services due to fear of losing their children (Stone, 2015). This may explain study findings of states enacting punitive prenatal substance exposure laws, which have reported reduced use of substance use disorder treatment services overall (Atkins & Durrance, 2020), and by pregnant individuals specifically (Kozhimannil et al., 2019) as well as lower rates of prenatal care (Kozhimannil et al., 2019; Meinhofer et al., 2022). The lower rates of substance use treatment and prenatal care in turn may explain research that suggests that when states enact these laws, rates of newborns with neonatal withdrawal syndrome increase (Faherty et al., 2019; Meinhofer et al., 2022). The negative health outcomes associated with these policies have financial implications as well. In states that define prenatal alcohol exposure as a type of child maltreatment, babies are more likely to be born prematurely (Subbaraman et al., 2018). In the year 2015 this was estimated to result in 12,372 additional preterm births at a cost of over $58 million (Subbaraman et al., 2019).

Vandervort (2019) argues that state laws should define prenatal substance exposure as a type of maltreatment, and that it be considered an "aggravating circumstance" which absolves the state from making efforts to reunify the child with their family and allows for faster legal processes to terminate parental rights. However, appeals of court decisions justify concerns raised by Seay and McRell (2023) about the potentially harmful consequences to bringing families into the child welfare system when there is little evidence of imminent child danger or future risk of maltreatment. Appealed findings of child abuse and neglect cases have involved mothers who stopped using illegal drugs after they realized they were pregnant, and individuals who participated in medication assisted treatment during pregnancy; an appeal of a termination of parental rights involved a mother receiving physiciansupervised medical marijuana treatment for seizure disorders (American Bar Association & Quality Improvement Center, 2021).

Some states have revised their laws in ways that may drive families needlessly into contact with child welfare in response to the Child Abuse Prevention and Treatment Act/ Comprehensive Addiction Recovery Act of 2016 (CAPTA/CARA).[1] This federal legislation directs states to require health care providers to notify child welfare of newborns affected by prenatal exposures to legal and illegal substances, including alcohol, in order to initiate a process to ensure infants and their families are offered services. As Lloyd and colleagues (2019) note, this legislation does not suggest notifications are equivalent to a report of child maltreatment, yet some states have implemented CAPTA/CARA by revising laws mandating medical providers report all newborns prenatally exposed to substances to child protection—even when there are no additional abuse or neglect concerns. These types of laws require medical providers to report child maltreatment when pregnant people disclose that they used alcohol before they knew they were pregnant— which is particularly troubling, as studies have reported 20 to 50 percent of pregnant individuals may drink alcohol early during pregnancy (England et al., 2020; Sundermann et al., 2021).

Laws and processes that drive families into the child welfare system also further disproportionate involvement of families of color. Pregnant individuals and their infants who are Black and American Indian/Alaskan Native are more likely to be tested in hospitals for prenatal substance exposure (Jarlenski et al., 2023; Karvonen et al., 2022; Schoneich et al., 2023), and subsequently reported to child protection when tests are positive, than their White counterparts (Karvonen et al., 2022; Rebbe et al., 2019). Once they enter the child welfare system, inequitable outcomes continue to accumulate. Black and American Indian/Alaska Native children are more likely to experience foster care (Wildeman & Emanual, 2014; Yi et al., 2020) and their parents are more likely to have their parental rights terminated (Putnam-Hornstein et al., 2021; Wildeman et al., 2020).

Information on a Child's Prenatal Exposure to Alcohol May be Used to Label Children as at High Risk for Future Maltreatment

A child's known prenatal exposure to alcohol and diagnosis of FASD may be inaccurately used in assessments of a child's current safety, and future risk of maltreatment. In 2018, Structured decision making (SDM) instruments were used by child welfare agencies in 33 states to standardize safety and risk decisions (Bosk, 2018). Manuals guiding use of the SDM instrument direct workers to interpret a child's diagnosis of an FASD as evidence of a mother's severe alcohol use disorder, which in turn is used as an indicator that a child is at higher risk of future child abuse and neglect (Evident Change, 2009; Evident Change, 2021; Evident Change, 2022).

Yet this interpretation of FASD as proof of a mother's severe alcohol use disorder is not based on evidence. Most women who use alcohol during pregnancy—including those engaging in binge drinking episodes—do not meet the criteria for alcohol use disorder (Esser et al., 2014), and most stop drinking once they realize they are pregnant (McCormack et al., 2017). Yet even low amounts of alcohol during pregnancy, or alcohol use before a

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[1] The Comprehensive Addiction and Recovery Act (CARA) of 2016 amended CAPTA in sections 106(b)(2)(B)(ii) and (iii)Subsections (b)(2)(B)(ii), requiring states to have "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants…. such notification shall not be construed to I.-establish a definition under Federal law of what constitutes child abuse or neglect; or II. - require prosecution for any illegal action."

woman realizes she is pregnant, may impact the child (Chambers et al., 2019; Easey et al., 2019).

An instrument that directs caseworkers to interpret a child’s FASD diagnosis as evidence of severe alcohol use disorder is guiding decisions —such as whether a child will be removed from their home, and what type of services parents must complete to have their children returned to them—based on false assumptions. Mothers of children with an FASD could be compelled to complete alcohol disorder treatment services unnecessarily, in line with research suggesting substance use treatment is a required component of service plans in cases where there is no evidence of parental substance use disorder (D’Andrade & Chambers, 2012). When services are not aligned with actual needs, families must complete multiple requirements that are burdensome and unrealistic and engage in services that are unnecessary, ineffective, and stigmatizing (Wolfson et al., 2021).

When a child’s FASD is used to label a parent as severely addicted, it increases the likelihood of a family’s court involvement and mandated services. Caseworkers are less likely to offer alternative response or voluntary services when parents are identified as having substance use issues (Radel et al., 2019). This is compounded for Black families, who are less likely to be offered alternative response services than White families (Connell, 2020). When families of children with an FASD enter a dependency court process, they can find themselves in front of a judge and district attorney who view substance use as an intractable, unsolvable family problem requiring the child’s removal (Radel et al., 2019). Parents can be without adequate legal representation that could help mitigate their family’s involvement with the child welfare system, as not all states provide parents with attorneys in child protection cases, or they may be appointed later in the case process (Wood & Russell, 2011). Yet parents in states defining prenatal exposure as maltreatment are in particular need of legal support, as children are more likely to be removed, and less likely to be reunified with their families in cases involving parental substance use (Sanmartin et al., 2019; Sanmartin etal., 2020).

The Child Welfare System and its Partners can Use Information on a Child’s Prenatal Exposure in Caring for the Child and Promoting the Well-being of the Family

There are alternatives to viewing a child’s prenatal alcohol exposure as evidence that parents are unable to safely care for their children. To do so, it is important to consider it in the context of assessments of a child and family’s needs.

Partnering with other service providers to obtain critical services for children who may be impacted by FASD could be an important strategy to reduce the risk of unnecessary separation of a child from their family. Children who show indicators that they might be affected by an FASD necessitate referrals to a professional trained to conduct an initial screening to determine if a further assessment by a provider who is qualified to make a formal diagnosis is warranted (Mattson et al., 2023). Initial screenings can be conducted by professionals with whom the agency frequently interacts, who are experienced in using validated tools to screen children. They include child developmental specialists (including developmental assessors, early intervention, infant/child mental health specialists, child psychologists, etc.), pediatricians and other health care providers including public health, mental health and family therapists, and educational special needs assessors (Benson et al., 2020; Berkman et al., 2015; Weitzman et al., 2015). Professionals who screen children can ensure informed consent procedures and use confidential processes to communicate with the mother about her use of alcohol during pregnancy (McLachlan et al., 2022). This helps to house information on prenatal alcohol exposure in the domain of the child's service needs, separating it from processes used to judge parental fitness.

If a child's initial screening suggests further neurocognitive assessment is needed to determine whether a child has an FASD, professionals typically involved in formal diagnosis (often in multi-disciplinary teams) are pediatricians, psychologists, neurologists or related experts with special training in FASD diagnoses, occupational and/or speech-language pathologists (Chasnoff et al., 2015). These teams often operate in specialized FASD clinics and university hospitals, which are not universally accessible. However, Carmichael-Olson and colleagues (2023) present a clinic and consultation model that is staffed by psychologists trained to diagnose conditions under the FASD umbrella which is a feasible option for communities to consider implementing. This brief consultative model provides information and support to parents, and guides child referrals to services such as special education and developmental services.

Child welfare agencies can create pathways in their community for assessment and referral processes that aid in the establishment of a child's diagnosis. Partnering with professionals that the agency routinely interacts with, such as those in medical and behavioral health services, is a useful starting point to consider how cross-system work can improve care. Similar efforts to meet the mental health needs of children in the care of child welfare have successfully improved assessment and referral coordination with mental health providers, increasing access to services and improving children's behavioral health outcomes (Bunger et al., 2022).

Delivering Services and Addressing Bias

Opportunities to Identify and Develop a Service Array to Meet the Needs of Children with FASD and their Families

Services that build on the community's strengths and traditions can reinforce a family's cultural connections, reducing isolation and offering ongoing support. The article by Geary and colleagues (2023) provides a description of partnering with a Tribal community to understand and further articulate culturally restorative practices to support children prenatally exposed to substances and their families. This article on the Red Lake Nation's approach to mapping and managing these issues while retaining the cultural identity of children and their communities is an important contribution to the knowledge in the field.

Studies have found that a child's challenging behaviors, such as hyperactivity, difficulty with transitions, and disobedience are associated with foster parent stress and placement instability (Konijin et al., 2019; Leathers et al., 2019). These stressors are ones that parents of children with FASD are likely to face. For those families who have substance use issues, the combined impact of use and the effects of exposure on the child, may require specific support to build attachment, and support positive relationship development between parents and their children (Mirick & Steenrod, 2016). Intensive in-home services, delivered to families while children remain in their parents' home, could reduce the likelihood that children enter care, though variation in their effectiveness suggests that the quality of implementation of these programs is important (Bezeczky et al., 2020). It is also critical that these services are designed, or adapted to children who may have differences in learning, communication, and memory, as parents may need to learn specific strategies to effectively interact with and care for their children (Chasnoff et al., 2023).

Research suggests that parents respond more positively and may be more likely to participate in these family-focused services (Maltais et al., 2019). Studies have found an integrative approach, such as substance use interventions emphasizing the child-parent bond rather than individualized, parent-oriented treatment, can be more effective in reducing parental alcohol and drug use (McGovern et al., 2022). Bondi and colleagues (2023) offer an example of this type of family-focused treatment, which addresses both the needs of the parent and the needs of the child, and actively supports the relationship between them.

Federal legislation offers opportunities to develop a service array for children with an FASD and their families. The Family First Prevention Services Act (FFPSA) of 2018 enables state child welfare agencies to use funding for programs listed in the Title IV-E Prevention Services Clearinghouse, which have been reviewed for evidence of effectiveness (Wilson et al. 2019). There are evidence based FASD interventions that address family functioning, behavioral management, and learning. Examples include Parents and Children Together (PACT), which improves the executive functioning and emotional regulation of children and helps parents to prevent and address their child's behavioral difficulties; Families Moving Forward (FMF) which is a manualized, customizable family intervention tailored to families raising children with FASD (California Evidence-Based Clearinghouse for Child Welfare, 2023). These programs have not yet been reviewed but could be put forward for consideration for eligibility for FPPSA funding.

Case managers have a critical role in improving care for children with an FASD, as they act as important service referral brokers in the system (Bunger et al., 2012). They can promote timely referrals to providers that conduct initial assessments, connect assessment results to referrals to diagnostic services, and follow-up to ensure recommended interventions are incorporated into the child's service plan. Clear referral and documentation processes, and staff training, can enhance these efforts by helping case managers understand when children should be referred, whom they are referred to, and why it is important (Kerns et al., 2014). Families whose primary language is English, as well as families speaking diverse languages may find it difficult to understand medical recommendations; staff can help parents follow-through with treatment by confirming they understand next steps (Schneiderman et al., 2010). Providing families involved in child welfare with concrete assistance—such as help in filling out applications and scheduling—makes it more likely that they access and engage in services (Bunger et al., 2012). Connecting families to peers, including FASD family advocacy organizations, may be critical. Linking families to support groups where they can share their experience, and hear from others who have similar experiences, can be a valuable source of information and encouragement (Sparks, 2023).

Given the overall prevalence of people with FASD, staff may work with parents who themselves are affected by their prenatal alcohol exposure. Like children, adults with FASD present with varied range of abilities and challenges. Staff can work more effectively with parents with impaired memory and executive functioning by making explanations and goals concrete, repeating information, and providing help with coordinating services (Brown & Harr, 2019).

Training is Needed to Inform Service Delivery and Reduce Bias

To know which children can benefit from a referral for initial screening and/or further assessment, child welfare staff will need training to understand the indicators and impacts of FASD. Multiple articles in this special issue note the gaps in knowledge regarding prenatal alcohol exposures and FASD identified by child welfare professionals themselves (see Loch et al., 2023; Morehouse et al., 2023; Seay & McRell, 2023). Understanding the long-term impact of prenatal exposure to alcohol can help child welfare professionals understand the importance of considering when children may be showing indicators of an undiagnosed FASD. While each child presents differently, staff should understand common neurocognitive effects, and how these may be observed in children at different stages of their development (Hagan et al., 2016). Children may display symptoms that lead to incorrect diagnoses, as the impacts of FASD resemble other conditions such as ADHD (Chasnoff et al., 2015) and can present alongside emotional and behavioral symptoms of trauma (see Kable et al., 2023). If staff understand this, it will help them consider whether a child whose treatment for ADHD is ineffective, or who are not responding as expected after referrals to mental health services, may be impacted by prenatal alcohol exposure. This can then lead to referrals to providers for further screening and evaluation.

When staff understand the implications of a child's FASD they are in a better position to identify services that will effectively support children and their parents (Brown & Harr, 2019). Studies have found that well-matched services are more likely to prevent maltreatment than those which do not align with family needs (Fuller & Zhang, 2017; Lin et al., 2020). Children and their families may not receive appropriate services if agency staff are not aware of the potential implications of a child's exposure to alcohol and unique needs. For children with an FASD and their families, it can be particularly important to avoid parent training programs/services focused on "cause and consequence," which tend to be ineffective (Chasnoff, Wells et al., 2023). An example of this is parenting classes that teach techniques which assume children can learn from their own experiences, which are unlikely to be unsuccessful for children with an FASD, as they frequently have cognitive disabilities and struggles with memory and attention (Streissguth et al., 2007).

Training must also address staff bias, which may influence how they assess the harmful effects of drug and alcohol exposures, their attitudes toward people who drink during pregnancy, and their judgement of parenting skills of families affected by an FASD. Studies suggest that professionals' responses differ depending on the types of substances to which children are exposed (see Seay & McRell, 2023; Wang et al., 2023). Harsher responses of medical providers and child protection professionals to drugs associated with communities of color, such as cocaine, can drive inequitable decisions (Harp & Bunting, 2020). Alcohol exposure may be overlooked, as it is unlikely to be identified at birth, and is less likely to be reported to child protection than illegal drug exposures, such as amphetamines (Putnam-Hornstein et al., 2016). Because it is a legal substance, the effect of alcohol exposure on children may be taken less seriously despite it having the most serious long-term neurodevelopmental consequences (Wang et al., 2023). Reflecting on their own bias and how it can influence their judgement, could help staffto make equitable decisions (Russell & Summers,2013).

While staff may believe prenatal exposure to other substances are more harmful, and underestimate the effects of prenatal alcohol exposure, they can also be biased toward women who drink alcohol during pregnancy (Roozen et al., 2022). Training could challenge staff assumptions by presenting information on the high prevalence of drinking alcohol during pregnancy, and that it occurs more frequently in mothers of higher income and education (England et al., 2022). Staff should also understand that alcohol used early in pregnancy can cause FASD, and that a study of mothers of children with FASDs found less than 11% continued drinking after they discovered they were pregnant (Popova et al., 2020). This information can counter the narrative of women knowingly harming their children, which may drive bias toward mothers of children with an FASD (Corrigan et al., 2017).

Studies of families who have adopted children and provided foster care—who are deemed as parents who are safe by the child welfare system—report that the behaviors of their children with an FASD led to unfair criticism of their parenting skills, which increases the family’s isolation (Balcaen et al., 2021; Sanders & Buck, 2010). Families of children can be admonished for failing to control the behavior of a child with an FASD (Breen & Burns, 2012). Yet if they are taught and apply traditional parenting techniques, which are ineffective for children with learning and memory issues, they may be unfairly blamed when these techniques don’t work. Understanding how the learning, communication, and behavioral effects of an FASD leads to difficult parent-child interactions can help staff respond to parents with empathy and support, rather than harsh judgments.

Conclusion

Children with FASD and their families are at risk of experiencing a punitive response from the child welfare system. In a state with laws defining a child’s prenatal alcohol exposure as a form of maltreatment, a mother who discloses her use of alcohol during pregnancy is giving evidence that can be used against her in court. This evidence may be used to substantiate allegations of maltreatment, to separate her child from her care, and to legally terminate her parental rights. Even in states without these laws, decisions leading to these outcomes may be made using processes that promulgate false information and may be made by staff who lack knowledge of FASD, and whose views of prenatal exposures may be biased. If a mother is Black or American Indian/Alaska Native, the likelihood of inequitable decision-making increases the risk that the family will experience severe consequences.

Partnerships between child welfare and other community providers can focus on information on prenatal alcohol exposure as an indicator of a child’s needs and use it to facilitate assessment and diagnosis of children. To improve services for children with FASD and their families, interventions that address FASD specifically can be implemented, and existing services can be adapted to account for the neurocognitive impacts of prenatal alcohol exposure. Ongoing review of data focused on racial and ethnic disparities will help maintain attention to equitable access to voluntary vs. mandated services, the types of referrals children and families receive, and child and family outcomes.

Developing services that build on the community's cultural strengths could improve access to effective services. Improving knowledge of the impact of prenatal alcohol exposure and addressing staff bias is critical to recognize children who may be showing indicators of an FASD, and to promote engagement of and support for families. Th is type of response to prenatal alcohol exposure could emulate Red Lake Nation's focus on a healing and wellness approach that believes in the resiliency of parents.

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