

Appendix A9: Referral and screening guidelines for FASD

A. Referral guidelines

The following are principles for referral for FASD diagnostic assessment in Australia:

- Consideration of prenatal alcohol exposure should be part of ‘mainstream’ clinical practice for all health professionals taking a pregnancy history.
- FASD should be considered as a possible diagnosis in any individual with unexplained neurodevelopmental problems.
- If there are concerns about prenatal alcohol exposure (PAE) and/or possible FASD, referral to appropriate services for formal assessment is recommended.

It is recommended that:

- Discussion of maternal drinking and associated risks should be integral to *all* prenatal and postnatal care of women and children by *all* health care professionals. This should be conducted in a *sensitive and respectful manner*.
- Obstetric history taking should *always* include discussion of alcohol use in pregnancy and assessment of the risk of prenatal alcohol exposure – *as standard practice* – as for any other significant prenatal exposure e.g. medications, illicit drugs and infection. Standardised validated screening tools such as the AUDIT-C should be used to assess alcohol intake.*
- FASD should be part of the differential diagnosis for any individual presenting with significant developmental or behavioural problems, until prenatal alcohol exposure is excluded.
- Supports should be provided for individuals, caregivers and families as part of the referral process, including appropriate intervention if alcohol misuse is ongoing.

Referral for a FASD diagnostic assessment should occur when the following are identified:

- Prenatal alcohol exposure is at high risk levels*.
- Neurodevelopmental impairment and/or distinctive facial features and confirmed or suspected prenatal alcohol exposure.
- The individual, their parent or caregiver is concerned that there was PAE and/or may be a FASD diagnosis (regardless of the above).

** Please refer to the Australian Guide to the diagnosis of FASD - Section A: Assessing maternal alcohol use*

Referral threshold for individuals at increased risk of FASD

The threshold for referring for a FASD diagnostic assessment should be lower for individuals in the following high-risk groups and/or settings.

Children, adolescents or adults:

- Who are living in out-of-home care (adoption/foster/extended family). (1,2)
- Who are in contact with the justice system. (3)
- Who have a family member with Fetal Alcohol Spectrum Disorder.

- Who have a birth mother with a known alcohol-related illness or dependency.
- Who live in a community where there are high rates of alcohol consumption.(4)

Depending on age, location and available services, individuals could be referred to:

Assessment teams:

- Specialist FASD assessment clinic
- Child development assessment service (with multidisciplinary team)

Specialists:

- General or developmental paediatrician – public or private
- Adolescent physician
- Child and adolescent psychiatrist
- Adult psychiatrist
- Clinical geneticist

These specialists can work with local mental and allied health clinicians to complete a multidisciplinary assessment.

Specialist FASD diagnostic clinics in Australia currently include:

Please refer to the FASD Hub for information on clinics and services across Australia:

<https://www.fasdhub.org.au/services/>

Screening tools for FASD

- There are *no validated* standardised screening tools for FASD (e.g. equivalent to the M-CHAT for Autism Spectrum Disorder).
- This is partly related to the wide spectrum of possible neurodevelopmental impairments in FASD and hence the variation in presenting symptoms.
- Further research is required to develop reliable validated screening tools.
- Some non-validated tools are available:
 - National Screening Tool Kit for Children and Youth Identified and Potentially Affected by FASD (5)
 - Youth Probation Officers' guide to FASD screening and referral (6)

B. Primary developmental surveillance

Canadian and US data indicate that FASD is a common and preventable developmental disability, with similar prevalence rates to Autism Spectrum Disorder (7).

Primary care developmental surveillance, such as that done by Child Health and School Nurse programs, should identify children with or at risk of developmental and behavioural problems. Some of these children may have FASD (with or without other conditions).

Infants and children from high risk groups or settings for FASD warrant close developmental surveillance. They are at higher risk of neurodevelopmental problems as they are more likely to have been exposed to alcohol in utero as well as other adverse pre and postnatal factors.

References:

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3. Canadian Department of Justice (DOJ), FASD prevalence in the justice population. 2016. Online report. <http://www.fasdjustice.ca/fasd-basics/prevalence-justice-population.html>
4. Fitzpatrick J, Latimer, J, Carter M, Oscar J, Ferreira M, Carmichael Olson H, Lucas B, Doney R, Salter C, Try J, Hawkes G, Fitzpatrick E, Hand M, Watkins R, Martiniuk A, Bower C, Boulton J, Elliott E. Prevalence of fetal alcohol syndrome in a population-based sample of children living in remote Australia: The Lililwan Project. *Journal of Paediatrics and Child Health* 2015; 51: 450–457.
5. Canadian Northwest FASD Research Network. National screening tool kit for children and youth identified and potentially affected by Fetal Alcohol Spectrum Disorder. 2010. Canada: Canadian Association of Paediatric Health Centres.
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7. May P, Baete A, Russo J, Elliott A, Blankenship J, Kalberg W, Buckley D, Brooks M, Hasken J, Abdul-Rahman O, Adam M, Robinson L, Manning M, Hoyme H. Prevalance and Characteristics of Fetal Alcohol Spectrum Disorder. *Pediatrics* 2014; 134 (5): 855 – 866.