Fetal alcohol spectrum
disorder (FASD)
and complex trauma
A resource for educators

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Fetal alcohol spectrum disorder (FASD) and complex trauma:
A resource for educators, 2018

This resource is a revised edition of *Understanding and addressing the needs of children and young people living with fetal alcohol spectrum disorders (FASD): A resource for teachers*, 2014.

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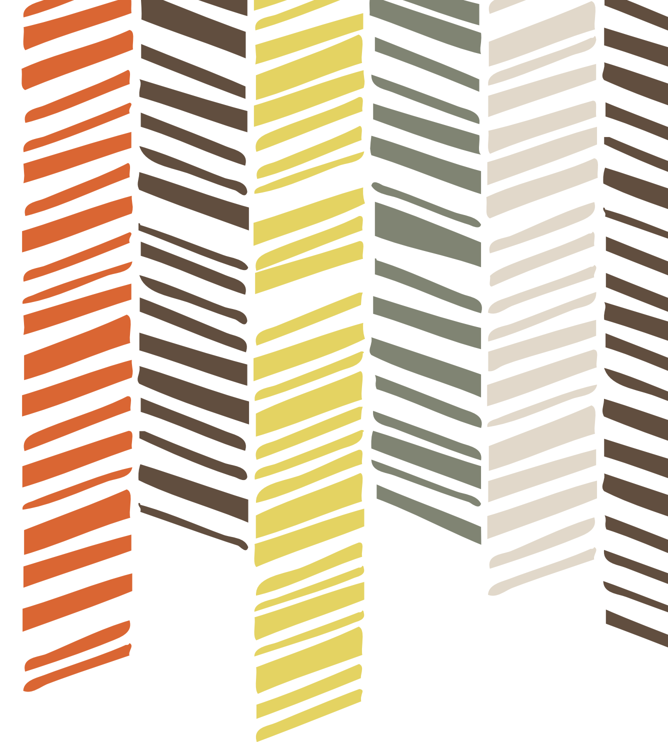

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Foreword

Educators are 'front line' workers meeting the needs of children with fetal alcohol spectrum disorder (FASD) in classrooms, playgrounds and other educational settings. Over the last few decades, FASD has emerged as the most common preventable cause of brain injury, reflected in increasing numbers of children with developmental, learning, behavioural and medical problems. Yet educators have not been provided with the resources to assist them to recognise FASD and address the needs of these children and young people.

Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators is a unique book developed by experienced educators Jane Weston and Sue Thomas. This excellent resource addresses gaps in knowledge and skills faced by educators. It is highly accessible, and provides accurate information about the issues faced by children with FASD. Importantly, and reflecting Sue Thomas' long experience in remote Kimberley schools, FASD is framed in the context of complex trauma and its intergenerational effects. The importance of considering trauma is twofold: prenatal alcohol exposure and trauma act synergistically to impair brain function, and a trauma-informed approach allows tailoring of management plans and maximises the effectiveness of early educational interventions and ongoing educational and social support.

Educators have a crucial role in assisting children with FASD to achieve their academic, social and emotional potential. This must be underpinned by an understanding of the wide-ranging effects of prenatal alcohol exposure on brain function, including impaired cognition, language, attention, motor skills, social and adaptive function, and impulse control. Understanding the capacity of the individual child requires thorough assessment by paediatricians, psychologists and allied health professionals, and observations and documentation from teachers are crucial. In some cases, a child's capacity to learn and their challenging behaviours must be considered and managed in the context of complex trauma. Clinical teams work in partnership with educators and families to develop wrap-around supports.

All children have the right to high-quality education, regardless of their capacity and vulnerabilities. This gem of a book provides educators with the knowledge, skills and strategies to give children with FASD successful educational experiences, thus preparing them for a life well lived.

Professor Elizabeth Elliott, AM, FAHMS
Sydney, June 2018

Background

The Marulu Strategy

The Marulu Strategy is a community-led effort to address FASD prevalence and prevention and provide support for Fitzroy Valley families in response to the known prevalence of FASD in the Kimberley region of Western Australia. The strategy is designed to 'Make FASD History' and strengthen community capacity, resilience and wellbeing.

The Lililwan FASD Prevalence Study was initiated in 2009 after women expressed concern about complex behaviours they were noticing in young children that they had never encountered before. After a long community consultation process, the Lililwan study sought to measure the prevalence of FASD in the Fitzroy Valley. The study was a partnership between Nindilingarri Cultural Health Services and Marninwarntikura Women's Resource Centre (MWRC) in Fitzroy Crossing, and the George Institute for Global Health and Discipline of Paediatrics and Child Health at the University of Sydney.

The study showed that the prevalence rate of FASD in the Fitzroy Valley was among the highest in the world. Children with FASD presented with a range of physical, cognitive, behavioural, emotional and learning difficulties. The results indicated that high numbers of school-age children faced enormous challenges as a result of prenatal exposure to alcohol.

A large proportion of students in classrooms today are significantly affected by FASD and early life trauma. As educators, we need to recognise and respond to these challenges by addressing the diverse changing needs in our classrooms.

The Marulu team at Marninwarntikura Women's Resource Centre, along with our essential partners, is working to create holistic community responses that strengthen the capacity of all those working with families to address new challenges resulting from exposure to alcohol and trauma.

FASD has been identified as an area of growing significance requiring urgent action in the Kimberley, and more widely across Australia. This resource is part of a suite of support materials designed to equip the workforce with current knowledge and understandings about this often 'hidden' diagnosis. It updates the 2014 publication, *Understanding and addressing the needs of children and young people living with fetal alcohol spectrum disorders (FASD): A resource for teachers*.

Marulu is a Bunuba word meaning 'precious', 'worth nurturing'.

The development of this resource has been informed by many committed people who have generously given their time, shared their insights and provided information and perspectives gained from working with children with FASD and their families, both of whom have lived experiences of complex trauma. Finding better ways to understand and address the needs of young people living with multiple vulnerabilities can lead to them having improved learning and life outcomes.

- **Emily Carter**, Chief Executive Officer (CEO) of Marninwarntikura Women's Resource Centre, and **Jadnah Davies**, Manager, Marulu Unit, shared their lived experiences and passion in the development of this resource, and continue working to Make FASD History.
- Special thanks to **June Oscar AO**, Aboriginal and Torres Strait Islander Social Justice Commissioner, for her continuing support, advocacy and inspiration.
- The resource has been strongly informed by **Jane Pedersen** and her 2017 report to the Winston Churchill Memorial Trust, which explores approaches in Canada and the US that empower women, children and communities to overcome intergenerational trauma.
- The **Australian Childhood Foundation** provided valuable support through its School Services Program. We thank **Alexa Duke** and her team for their advice and deep knowledge of addressing complex trauma in school settings. The Nine Principles of Trauma-Informed Care are an important inclusion in this new edition of the book.
- **Professor Elizabeth Elliott, AM, FAHMS**, at the University of Sydney Children's Hospital, Westmead Clinical School Faculty of Medicine and Health, provided valuable advice and support.
- **Royal Far West (RFW)** provided specialist advice and support about complex trauma and the brain science behind it. RFW and MWRC in Fitzroy Crossing have been working together since 2015 under the Marurra-U partnership (a Bunuba word, meaning 'to embrace with love and care') to find innovative ways to increase support and understanding in the Fitzroy Valley community and improve outcomes for children with complex needs and their families. Special thanks go to **Verity Ashover** and **Dagney Hopp** for their insightful review of the trauma materials in the book.

Thanks to all those Kimberley educators, health professionals, school psychologists, specialist support staff, community members and Aboriginal educators who have shared their knowledge and provided information and feedback. We would especially like to thank:

- **Edie Wright**, former Manager of Aboriginal Education, Kimberley Education Regional Office, and **Jo Fox**, Lead School Psychologist, Kimberley Education Region Broome, for their commitment, advocacy and support
- **Jane Salt**, Principal, Bayulu Remote Community School, and **Alex Mountford**, Principal, Yiyili Aboriginal Community School, for their ongoing support and advice
- The **Marulu Strategy Leadership Team** for their commitment and persistence to make a difference over the long term
- **Maureen Carter**, CEO, Nindilingari Cultural Health Services, for ongoing support and commitment to the prevention of FASD
- The Marulu Family Support Workers/Community Navigators, **Edith Cox** and **Sue Cherel**, have provided insights and advice from a community perspective
- **Dr James Fitzpatrick**, Telethon Kids Institute, provided knowledge and expertise for the first edition of this resource
- **Carolyn Hartness**, **Professor Barry Carpenter** and **Dr Carolyn Blackburn**, international experts in the field, for generously sharing their knowledge and expertise.

About the authors

Jane Weston

Jane Weston is an experienced teacher, writer and project manager. She has worked on a range of national and international education initiatives, and has extensive experience in developing resources for teachers and school leaders in areas of considerable educational significance. Jane co-wrote the 2014 publication *Understanding and addressing the needs of children and young people living with fetal alcohol spectrum disorders (FASD): A resource for teachers*, and continues to work with the Marulu team at Marninwarntikura Women's Resource Centre developing a variety of resources, including a toolkit for families dealing with complex trauma and FASD.

Jane is a non-executive director of the Therapeutic Engagement Support Services Association Inc. (TESSA), which develops and implements therapeutic support services for young people.

Sue Thomas

Sue Thomas is an experienced teacher, school principal and researcher. She has extensive experience working in the Kimberley region of Western Australia, and has led numerous projects and education initiatives over the past three decades. After leaving the Kimberley to work on national education projects for Education Services Australia (ESA) and the Stronger Smarter Institute (SSI), Sue returned to the Kimberley as the awareness of FASD and its effects was becoming apparent through the Lililwan Prevalence Study conducted in the Fitzroy Valley. Responding to the need to equip educators working with children with FASD and complex needs, she co-wrote, with Jane Weston, the previous version of this resource. Since 2015, Sue has worked closely with community-led strategies developed by the Marninwarntikura Women's Resource Centre. The Marulu team at the centre are working to strengthen the capacity of all those working with children and families with FASD and complex trauma.

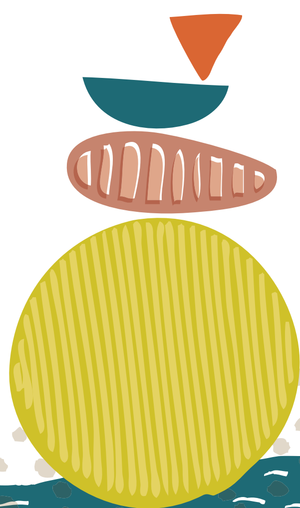
Audience and purpose

This practical education resource is designed to support schools, educators and community members to recognise, understand and work effectively in schools with students with FASD and complex trauma. While the resource has been written for educators and school communities in Western Australia, the materials are also relevant for all school communities across Australia.

Schools in the Kimberley play an important role in developing strong relationships between key health and education professionals, the community, and families, to create successful community engagement frameworks that underpin the comprehensive strategies required to address the needs of these groups.

New research provides a compelling evidence base about how ongoing exposure to trauma can change the brain in ways that impede a person's ability to function. Most Indigenous people experience the many effects of colonisation as ongoing trauma. The incidence of FASD in the Kimberley needs to be seen in the context of this ongoing intergenerational trauma.

Accurate data now available about children and young people with FASD in the context of intergenerational trauma provides us with evidence to inform responses and plan strategies to address the needs of these children.



This resource seeks to provide educators and the communities they serve with an understanding of the needs of students with trauma and FASD by:

- understanding trauma and its effects
- defining FASD
- describing the common learning and behavioural characteristics of children with FASD
- presenting evidence-based strategies that may be helpful in meeting the complex needs of these children and young people
- providing links to further resources that will assist teachers with more comprehensive advice and support.

The material presented has been informed by:

- local, national and international research and evidence
- advice provided by educators with experience in working with students with FASD and trauma
- current effective practices and adjustments designed to meet the needs of this significant group of students.

How to use this book

This is the second edition of a practical 2014 resource, *Understanding and addressing the needs of children and young people living with fetal alcohol spectrum disorders (FASD): A resource for teachers*. That first edition sought to bring together the then current medical knowledge about FASD, identify what it can look like in classrooms and understand how it affects learning. Importantly, it was designed to provide guidance to educators about their role in supporting children and young people with FASD and providing observations to inform multidisciplinary diagnostic teams. A section on 'Taking Action' included a range of promising practices for teachers to support children and young people with FASD.

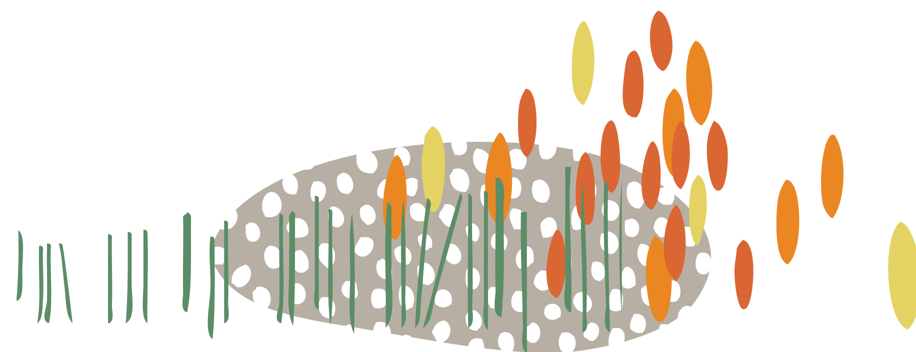
This second edition, *Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators*, updates and refreshes the material within a broader social context that acknowledges the role of complex trauma and its relationship to FASD. The resource draws on new research about the effects of trauma on the developing brain and presents new insights on the interrelatedness of trauma and FASD. As well as a discussion of how trauma affects learning, this resource emphasises that alcohol and drug use are now understood to be a symptom of trauma, and that we need to respond with empathy and understanding rather than judgement and blame. An additional section in the resource explores respectful language when referring to FASD and interacting with families and communities affected by it. The lived experiences of children with FASD and their families inform this second edition.

This resource also draws on the 2016 *Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD)*, which addresses the under-recognition of FASD in Australia and provides health professionals with access to internationally validated diagnostic criteria as well as information about where to refer people for diagnosis or treatment.

The 'Taking Action' section of the resource has been expanded to provide a notes area for each set of strategies for the classroom. This feature encourages educators to make notes relating to their own practice. These pages can be photocopied for a variety of uses.

Due to the sensitive nature of the issues around FASD, and the relative lack of awareness and knowledge of the effects of trauma and FASD in the broader national community, this resource will be of interest beyond education settings.

Much has been learned and achieved in the years since the publication of the first edition of this resource in 2014 and there is still much to learn if we are to Make FASD History.



A strengths-based approach

Deeper knowledge and understanding about what trauma and FASD look like can assist educators and school communities to best make targeted adjustments that meet the complex needs of students with FASD.

The community-driven interventions briefly described in the Lililwan project and subsequent Marulu Strategy demonstrate the power of consultation, collaboration and shared responsibility between communities and a range of allied health, education and other support services.

Latimer et al. commented that the Lililwan project is 'an example of researchers reciprocating both the spirit and intent of the community by working to address the challenges of FASD in genuine partnership – one where research is done with the community and not just about the community'.[1] Mick Gooda, then Australia's Social Justice Commissioner, remarked that 'a process guided by a relationship underpinned by meaningful, respectful engagement and collaboration will always be more effective and successful than one that is not'.[2]

Positive and strengths-based relationships between community and social services, education, parents and all those engaged in understanding and meeting the needs of children and young people affected by trauma and FASD are at the heart of the significant progress made to date under the Marulu Strategy.

Many agencies working to support families in the Fitzroy Valley are becoming more aware of the importance of interrupting the cycle of complex trauma seen in many communities. The good news is that with the right trauma-informed policies and practices, people can recover from the effects of trauma. Healing from trauma is a long and painful process, and educators have a role to play by demonstrating empathy, providing safe and supportive learning environments, and building trusting and caring relationships with students and their families.

The advice in this resource is also predicated on the strong belief that all children and young people with FASD can learn, and lead successful and fulfilled lives. The challenges of achieving and maintaining gains may at times seem overwhelming; however, a growing research base tells us that with early diagnosis, engagement, tailored interventions and personalised learning plans, high expectations can and are being realised. Educators who are knowledgeable and open to making adjustments to curriculum programs and learning spaces while maintaining high expectations can and are producing great gains with children and young people with FASD. Perhaps the greatest gain for children with FASD is a greater sense of self-worth and self-knowledge – the building blocks of a life well lived. Many leadership teams and educators are rising to the challenge and innovating in powerful ways to achieve these aims.

The emphasis in this resource is on how deeper knowledge and understanding about what trauma and FASD look like can assist educators and school communities to best make targeted adjustments to meet the complex needs of students living with trauma and affected by FASD.

This resource does not address specific diagnostic protocols or deal with prevention matters. Other services and professionals are working in those areas, including:

- allied health and other services provide assistance across schools, communities and regions
- leadership teams, school support services and school psychologists are the appropriate people to navigate access to support services
- school principals lead the process to access appropriate services.

Section 1: The effects of historic trauma

The *Uluru statement from the heart*

In May 2017, the First Nations National Constitutional Convention delivered the *Uluru statement from the heart* in Alice Springs, Northern Territory (see page 54 for the complete statement).[3] Over 250 Indigenous delegates had come together after six months of dialogues held around the country to consider the options presented in the Referendum Council's discussion paper regarding constitutional reform to recognise Aboriginal and Torres Strait Islander peoples. When asked what constitutional recognition meant to them, Indigenous peoples told the Council they did not want a simple acknowledgement, but rather reforms that included a voice to the Parliament that would be able to make a real difference in their communities.

The statement speaks to a 60,000-year plus spiritual connection to land and sea and asserts that this connection is a vital aspect of identity for Aboriginal and Torres Strait Islander peoples. The statement also refers to the devastating effects of more than 200 years of colonialism and the many destructive elements that have stopped many Indigenous peoples from thriving, and the need 'to empower our people and take *a rightful place* in our own country'. The statement goes to the heart of what justice looks like in the face of overwhelming injustice, and proposes the deep and meaningful processes required to rectify past wrongs with present rights.

The *Uluru statement from the heart* is an eloquent and powerful expression of Aboriginal and Torres Strait Islander peoples' aspirations for formal recognition in the Australian constitution and the culturally appropriate mechanisms to achieve it – a *Makarrata* or the coming together after a struggle. It has inspired Indigenous people and many other Australians to think big about our sense of Australian nationhood and the potential for Indigenous recognition and inclusion in Australian nation building. It proposes that we must urgently address the rebuilding of Indigenous communities whose cultural, social and economic fabric have been shattered by colonisation, and its effects over the generations.

As educators, it is imperative that we understand that when Indigenous people talk about their 'struggles' they are often referring to the effects of complex trauma that have been passed down from generation to generation. The genesis of this trauma has its roots in dispossession, genocide and ongoing social and economic disadvantage.

> There is a truth in this country that we must confront as we move into maturity. Grief, the grief of separation and loss, the shame of pain – deep and unresolved – a woundedness that is much more than the commemoration of the Anzacs, and much more than the celebration, partying and boozing that we have on Australia Day. This country is more than that. It has to be. It holds the trauma of many people across many generations – the Indigenous, the invaders, the immigrants – all seeking refuge from pain and disorder that we humans are so good at creating in this world. It is time we started the work of deep listening – we all together, the 'I's' coming to 'we' – working with each other for transformation.
>
> *Judy Atkinson*[4]

Understanding intergenerational trauma

While the *Uluru Statement* is written from a strengths base, and points to the resilience and good will of Indigenous peoples in the face of the devastating consequences of colonisation, it also speaks of the 'torment of our powerlessness'. This powerlessness has many faces, brought about by historical events, including the decimation of Indigenous populations through massacres and other violence, as well as introduced disease and loss of access to land, resources and cultural practices.

Perhaps the most devastating policy was the forced removal of children from their families. The out-of-home care crisis in Australia today is partly a result of the practice of removing children from their families, and the trauma and suffering it brings.

The 2005 Western Australian Aboriginal Child Health Survey identified family and household factors that can place some children at direct risk of ongoing complex trauma:

- poor physical and mental health of carers, compounded by their substance use (including tobacco and alcohol)
- poor physical and mental health of the child (particularly hearing, speech and vision impairment)
- economic deprivation (such as poverty, overcrowding, or substandard or lack of housing)
- poor family functioning (including money concerns, communication problems or limited support networks)
- poor-quality parenting (which could be negatively affected by past experiences of abuse and neglect)
- exposure to ongoing racism, discrimination and social marginalisation (including living in socially disadvantaged or excluded communities).[5]

The *Bringing them home* report documented the findings from the 1995 National Inquiry Into the Separation of Aboriginal and Torres Strait Islander Children From Their Families.[6] The report described the physical, psychological and sexual abuse, labour exploitation, racism, grief and suffering experienced by Indigenous communities across Australia. Every Indigenous person has been adversely affected by what has become known as the Stolen Generations.

The personal and collective trauma from these events resonates through generations of Indigenous families. Indigenous researchers, such as Professor Judy Atkinson, have demonstrated the connections between the historical experiences of colonisation and the forcible removal of children to vulnerabilities of many Indigenous people and communities. Professor Atkinson has written powerfully about the inter-generational and transgenerational transmission of trauma, arguing that many problems in Indigenous communities – be they alcohol and substance use, mental health problems, family violence or criminal behaviour – are symptomatic of the effects of this unresolved trauma reaching into the present day.[7]

The Aboriginal and Torres Strait Islander Social Justice Commissioner, June Oscar AO, makes a strong connection between trauma and other complex harms and the incidence of FASD in the Fitzroy Valley, Western Australia, and beyond:

> The trauma our communities have sustained has brought into being complex harms, of which FASD is one of the most damaging. With better understanding of trauma, we will overcome its harmful effects, and Make FASD History. We will allow our societal strengths to flourish again as we confront, heal and put an end to all forms of harm caused by intergenerational trauma.[8]

It is important for educators to be aware of the connection between high rates of elevated alcohol and substance use and intergenerational trauma in the communities in which they live and work. Perhaps the most important adjustment needed is an empathic mindset in perceptions about alcohol and drug use.

The trauma our communities have sustained has brought into being complex harms, of which FASD is one of the most damaging. With better understanding of trauma, we will overcome its harmful effects, and Make FASD History. We will allow our societal strengths to flourish again as we confront, heal and put an end to all forms of harm caused by intergenerational trauma.

June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner

> We can't understand anything about FASD without understanding trauma. Many in the Fitzroy Valley drink so they don't have to feel the overwhelming emotions triggered by trauma. Instead of judging people for the outcome of their actions we must start asking what has happened. As soon as we look beyond the judgement, we can start changing the outcome and create better futures.
>
> Emily Carter, CEO, Marninwarntikura Women's Resource Centre, Fitzroy Crossing

This involves seeking to understand and not judge and blame in the first instance.

Emily Carter, CEO of Marninwarntikura Women's Resource Centre in Fitzroy Crossing, makes this powerful point:

> We can't understand anything about FASD without understanding trauma. Many in the Fitzroy Valley drink so they don't have to feel the overwhelming emotions triggered by trauma. Instead of judging people for the outcome of their actions we must start asking what has happened. As soon as we look beyond the judgement, we can start changing the outcome and create better futures.[9]

So, instead of asking 'What have you done?', we should be asking 'What has happened to you?'. This recasting of the questions we ask is vital as we develop and implement education approaches and programs to address the cumulative effects of complex trauma. The first question projects a sense of wrongdoing and blame. The second seeks to understand personal stories and build connection, trust and empathy. Ultimately this aims to produce approaches that change outcomes for individuals and communities. This adjustment also involves changing the mindset we, as educators, bring to the classroom. The simple question 'What has happened to you?' seeks to interrupt the cycle of trauma transmission and to offer hope, healing and empowerment. Most importantly, this question demonstrates empathy, which is the building block for the development of positive and often therapeutic interventions and honest and respectful relationships. When the whole school embraces this trauma-informed approach, a culture of healing emerges.

The Australian Professional Standards for Teachers sets out seven standards for teachers, the first of which is 'Know students and how they learn'.[10] In this context, understanding the effects of trauma and the therapeutic support services available is an integral aspect of an educator's professional responsibility.

> Trauma-informed working practices can help to release a person's brain from toxic stress which can enable the development of resilience through creating positive relationships. Reducing stress releases the brain from focusing on survival and transfers energy to growing other neural connections. The brain begins to expand and the different areas of the brain and the body communicate more effectively, which helps a person to make more meaningful connections with people, community and the world. As these positive connections increase through curiosity, creativity and inquisitiveness the brain transforms. Its cognitive capacity increases and the result: a person whose full potential is endless.
>
> *Bruce Perry and Stuart Ablon*[11]

Essentially, the role of educators and the wider school community is to embrace a collective understanding and a shared language about trauma and its effects on those living with it. Learning cannot happen until trauma is addressed.

Understanding trauma

Trauma is pervasive in society and its short- and long-term effects have been well documented. All of us have at one time or another experienced the effects of trauma to varying degrees. There are many definitions that attempt to capture the essence of what it looks like in different contexts. In the context of remote Indigenous communities in Australia, a useful definition is:

> A trauma is a dangerous and often life-threatening event which happens unexpectedly. It can also be a series of impacting behaviours, feelings and sensations such as

colonisation and ongoing policies of discrimination, living in poverty, or being continuously verbally abused and threatened. In all instances, it triggers a rapid increase in stress, and associated surges in hormones such as cortisol, which are too severe for the body and brain to cope with rationally and functionally.[12]

Many would argue that the effects of complex trauma are often the underlying cause of the most chronic problems in urban, regional and remote communities. Although trauma may be central to many people's challenges, in health care, education and social service settings, their trauma is often not identified or acknowledged. Those affected by trauma therefore often do not receive the appropriate care or understanding they need, and are at risk of being re-traumatised by the very systems from which they are seeking help. All service and support organisations, including schools, play an important role in supporting trauma recovery.

In high doses, complex childhood trauma affects brain development, the immune system, hormonal systems, and even the way our DNA is read and expressed.

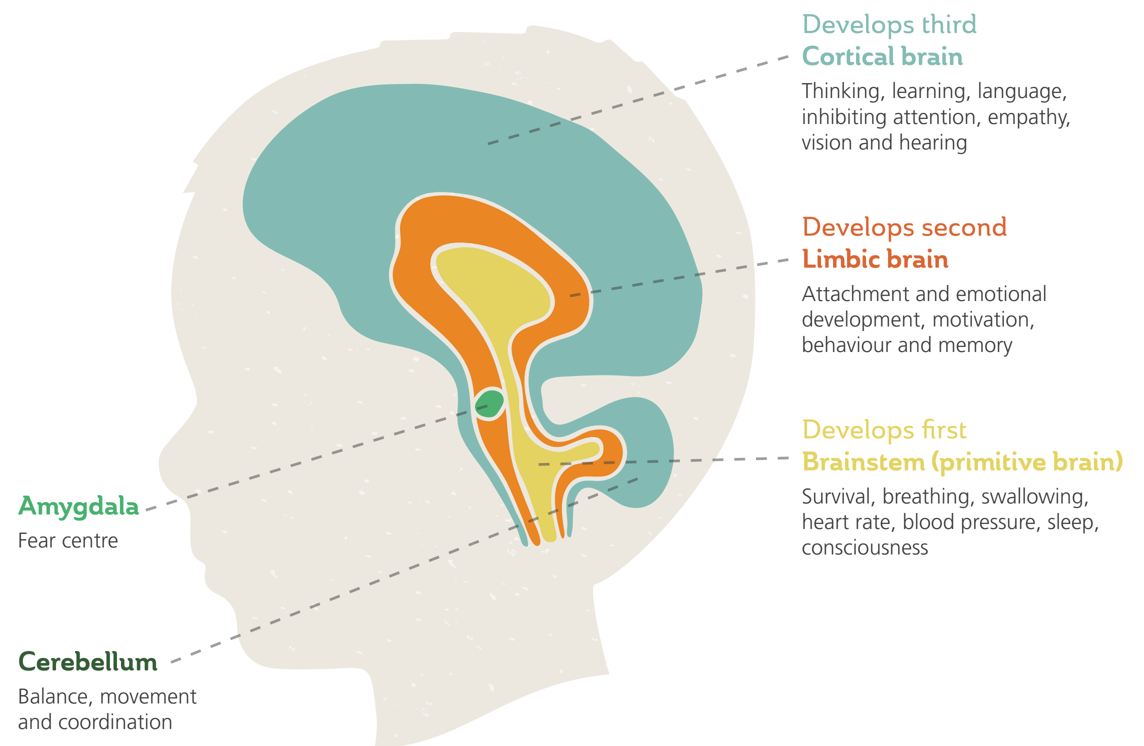
Trauma and the developing brain

New and emerging brain science continues to develop our understanding of trauma and its profound effects on growing children.

Each part of the brain has critical periods of development in utero, infancy and through childhood. If trauma occurs during these crucial periods of development, it will inhibit these connections, and the development and function of that part of the brain will be diminished.

Figure 1 shows the major parts of the brain and their progressive development as a child grows. The **brain stem** is sometimes referred to as the reptilian part of the brain, as it develops first and controls our most basic bodily functions, such as breathing and circulating blood. The **limbic brain** is the next part of the brain to develop. It helps us with processing complex social emotions – such as love, anger and pleasure – in response to social cues and memory. The most evolved part of our brain is the **neocortex or cortical brain**. It is the thinking part of our brain, and it interacts with all the other parts to understand emotions, reason and to plan. The pre-frontal cortex is not fully developed until early adulthood.

Figure 1: Three stages of brain development



Source: Adapted from Beacon House Therapeutic Services and Trauma Team, *Bottom up brain development diagram*, Beacon House, Cuckfield, West Sussex, 2015, beaconhouse.org.uk/wp-content/uploads/3-stages-of-brain-development-2.jpg.

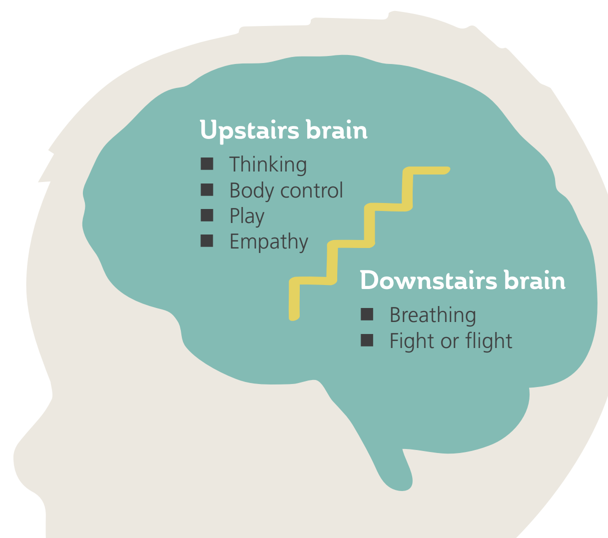
Aboriginal peoples' experiences are rooted in multigenerational, cumulative, and chronic trauma, injustices, and oppression. The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.

National Collaborating Centre for Aboriginal Health

The limbic system houses the **amygdala**, which is the 'smoke detector' of the brain. It determines whether we are safe, or in danger. If the amygdala determines we are safe, we have access to our cortical brain and can function on a high level. If the amygdala identifies a threat, it initiates the 'fear response'. Stress chemicals activate the 'fight or flight' response and disconnect the neocortex. This means that the individual is more likely to run away or fight, and high-level brain functions such as thinking, reasoning and problem solving are inaccessible.

A consequence of repeated trauma is that the amygdala becomes more sensitive and, as a result, registers danger more frequently. Functionally, this means that an affected child is in a state of fight or flight more often. This makes it difficult for them to make non-emotive, rational decisions and respond in a socially acceptable way, with clear judgement, rationality and emotional security. For educators, this may present in the classroom as excessive movement, difficulties paying attention, a major 'meltdown', poor resilience and poor behaviour control. Traditional behaviour management strategies in these cases are ineffective because they require the child to have high-level brain function. Such traditional methods ask 'What did you do?' rather than 'What happened to you?'.

Figure 2: The upstairs and downstairs brain



Source: DJ Siegel & TP Bryson, *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*, Scribe, Brunswick, Vic., 2012

Breaking down the science, Dan Siegel and Tina Bryson introduced the concept of the 'upstairs' and 'downstairs' brain (see Figure 2).[13] The downstairs brain is where the things that keep us alive happen. The upstairs brain takes time to develop and this is where complex thought happens. These two areas of the brain need to learn how to connect. A child dealing with ongoing, complex trauma may respond with their downstairs brain most of the time, as the world for them is a dangerous place where threat is a norm and the fight/flight/freeze/shutdown response is a default position.

The effects of trauma on many Indigenous people as a result of historical and current policies and practices are multiple, cumulative and overwhelming. This intergenerational trauma can begin in utero and extend over a person's entire life span. Many of the Western understandings and definitions of trauma are too narrow to fully embrace the scale of the trauma experienced by Indigenous communities. It is also important that in trying to offer the best approaches in the classroom and beyond, we do not label and pathologise children. When trauma and its effects are medicalised, they can quickly be taken out of context, and the blame or burden of recovery placed on the individual rather than on the wider social-economic context a child lives within and experiences on a daily basis. For many Indigenous people, the notion that most people will eventually overcome trauma responses is not part of their lived experience.

Aboriginal peoples' experiences are rooted in multigenerational, cumulative, and chronic trauma,

injustices, and oppression. The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.

National Collaborating Centre for Aboriginal Health[14]

Trauma can also be a difficult condition to understand and to recognise. It does not conform to clearly definable parameters, as each individual is the sum of their experiences in life, as well as a multitude of necessarily individual influences that make a person who they are. A person can be triggered into a trauma response without obvious warning. Educators working with children who experience trauma or its effects must understand that many children in their classrooms are living in a constant state of hypervigilance due to their overactive amygdalas. At any time, a trauma fight or flight response could be triggered by event or other stimuli that are not related to their specific trauma, but are processed by the individual's amygdala as threatening, causing symptoms such as confusion, frustration or discomfort.

Dr Bessel van der Kolk expresses it well:

> Traumatized people chronically feel unsafe inside their bodies: The past is alive in the form of gnawing interior discomfort. Their bodies are constantly bombarded by visceral warning signs, and, in an attempt to control these processes, they often become expert at ignoring their gut feelings and in numbing awareness of what is played out inside. They learn to hide from their selves.[15]

The diagnosis and subsequent treatment of trauma is the domain of clinical and health professionals. However, there is an increasing awareness that trauma is experienced throughout society, and that with training and awareness raising, mainstream organisations, such as schools, and those who work within them, can make a real difference in understanding and overcoming trauma in individuals. Importantly, we now know that neuroplasticity allows the brain to recover from trauma, given the right trauma-informed practices and care. Schools play an important role in providing a safe, trauma-informed space.

It is important that educators understand that student behaviours may often be trauma-triggered behaviours. In all cases, it is important that educators interacting and working with children dealing with the ongoing effects of trauma should not judge students, but rather seek understanding and institute strategies for diffusing traumatic feelings.

Hyperarousal – A heightened state of anxiety or arousal characterised by irritable behaviour, sleep problems, exaggerated startle response and other concentration problems.

Hypervigilance – A heightened state of awareness and expectation that something bad is about to happen. The brain is locked into permanent 'battle stations' or alert, causing inappropriate or even aggressive reactions in everyday situations.

Freeze and dissociation – A state in which a perceived threat is completely overwhelming and too much for the fight or flight system to cope with, such that the brain goes into a 'freeze' state, a collapse response. This type of trauma is experienced as a general shutdown, with emotional separation and detachment.

Vicarious trauma: Coping strategies

Good coping strategies designed to help you take care of yourself and your team are essential in minimising the effects of vicarious trauma.

First, remind yourself of the importance and value of the work you are doing. Stay connected and communicate with family and friends about how you are feeling.

Other important coping strategies might be:

- **Talk it out** – Confide in others. A partner, colleague or therapist can help you process your students' trauma and your own emotions.
- **Find a buddy** – Identify a peer who agrees to support and keep you accountable to your wellness goals.
- **Take brain breaks** – Take brief breaks and walk away when you need to regulate yourself.
- **Self-reflect** – Take part in a structured whole-of-staff reflection process that gives you the opportunity and shared language to reflect and talk about work practices and responses.
- **Self-regulate** – Learn how to calm yourself down when you are upset and cheer yourself up when you are down.
- **Get away from it all** – Ensure there are opportunities for physical and mental escapes. Read books, watch films, take some time off or visit friends.
- **Rest** – Do things you find relaxing, like getting a massage or meditating.
- **Play** – Get involved in activities that make you laugh or lighten your spirits, be physically active or engage in a creative activity.
- **Establish coming-home rituals** – Develop a routine that signifies the end of the working day. It might be turning off your work phone, walking the dog or changing your clothes.

Vicarious trauma: The cost of caring

> When you're learning to be a teacher, you think it's just about lesson plans, curriculum, and seating charts. I was blindsided by the emotional aspect of teaching – I didn't know how to handle it. I was hurt by my students' pain, and it was hard for me to leave that behind when I went home.
>
> *Alysia Ferguson Garcia, educator*[16]

Vicarious trauma is the cumulative effect on professionals from working and empathising with traumatised individuals. Educators may have high daily exposure to the trauma experienced by their students and the communities they come from, resulting in a type of emotional exhaustion or burnout. They will often feel the pain of the ongoing trauma around them as they develop empathic responses and a deeper understanding of the complexities within communities.

The symptoms of vicarious trauma might include anxiety, depression, low self-esteem, having no time for self or others,

and feeling overwhelmed by emotions. Vicarious trauma affects educators' brains in much the same way that it affects their students'. The brain emits a fear response, releasing cortisol and adrenaline that can increase heart rate, blood pressure, and breathing, and release a flood of emotions. We all suffer, often subconsciously, some degree of unresolved trauma from our own life experiences. Educators who have not healed from their own trauma are vulnerable to being triggered by the trauma of those around them; and could then potentially become less effective in their roles.

Developing a trauma-informed workforce that is nurturing and responsive is a powerful way to combat the effects of vicarious trauma on its staff. Trauma-informed care and practice is a strengths-based approach grounded in an understanding of and responsiveness to the effects of trauma. It emphasises physical, psychological and emotional safety for educators, students and their families, with a strong emphasis on self-care. All educators would benefit from developing an in-depth awareness of their own and others' trauma. An understanding of lived experiences and community context will create empathy, compassion and a deeper knowledge of learning contexts.

What puts an educator at risk of vicarious trauma is unique – different people have different risk and protective factors. The things that will address vicarious trauma are personal to the individual and will reflect their own needs, experiences, interests and values. Perhaps the most important aspect of addressing vicarious trauma is to first acknowledge that something is wrong. It is at this point that it is important to prioritise self-care. Self-knowledge is the first step towards self-care, both at the personal and organisational levels. Having a network of caring colleagues and supportive organisational processes will assist in managing this common problem.

We are constantly adjusting our trauma-informed practices as we learn from one another, reflect on successful strategies, and share these experiences with others. It is important for educators to pay attention to their work–life balance, for their own wellbeing and to become more capable of dealing with complexity, being creative problem solvers, and embracing new ideas that challenge them to reshape the way they interact in the world.

A trauma-sensitive school is one that shares awareness about trauma's effects on learning, from the perspective of both the learners and educators. As this awareness grows, the pervasive role that trauma plays in schools develops, as does the need to address it so that students can achieve successful educational outcomes.

How does trauma affect learning?

As discussed earlier in this section, many professionals who support children and young people in remote communities believe that FASD is one of the products of trauma. It can become difficult to disentangle the effects of FASD and trauma. Figure 3 (on page 10) attempts to show some of the key aspects of both trauma and FASD. As each child's experiences are unique, they may demonstrate some or all of the characteristics listed.

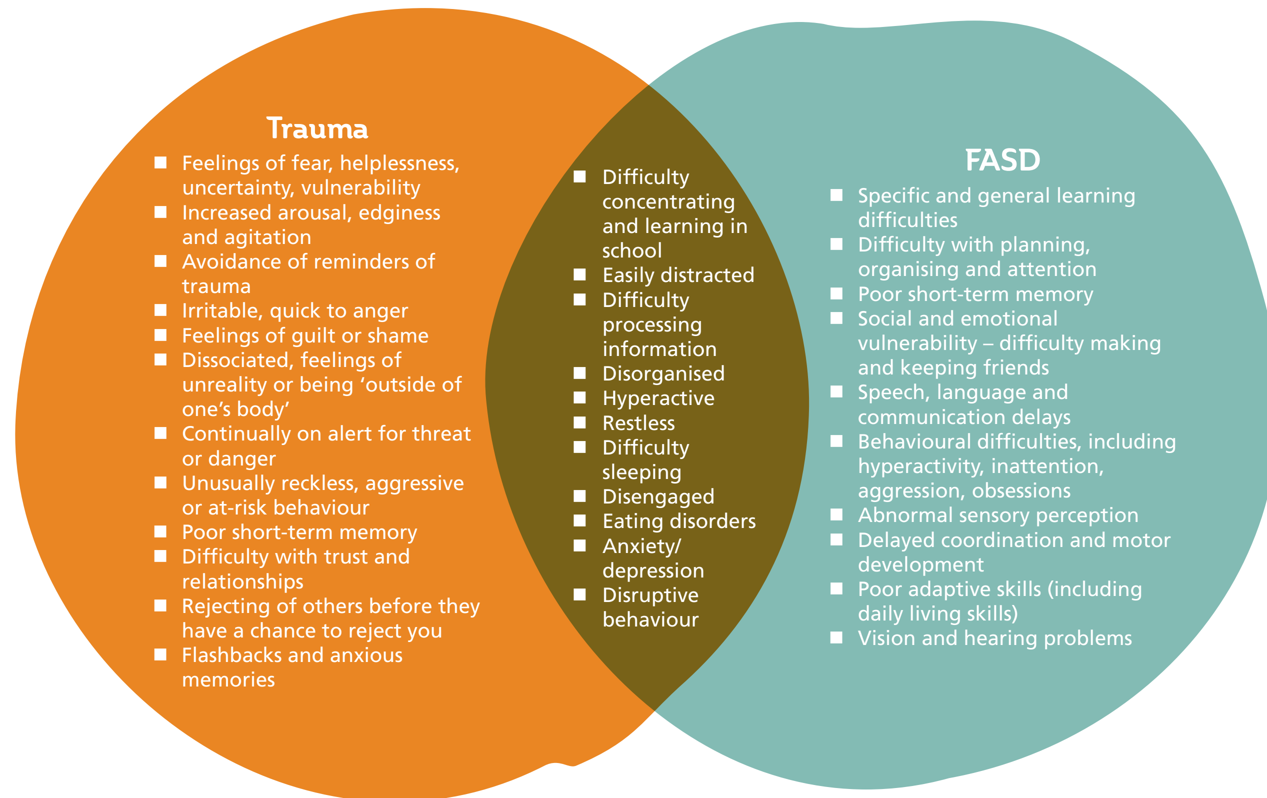
What is important is that FASD is a lifelong condition that structurally alters the brain. It is the result of prenatal damage to the fetus in utero. However, with the right educational and therapeutic interventions, and with coordinated care supports in place, a person with FASD can enjoy a life well lived.

With the right trauma-informed supports in place, those living with multiple traumas can heal from their trauma and fully recover. In education settings, researchers have identified a number of characteristics of targeted educational programs that would facilitate the achievement of academic success among students living with trauma. These characteristics include:

Breathe in to the count of 3, and out to the count of 7 – take note of your physical calming response.

- **Safety** – Creating a safe learning environment, both physically and emotionally. In order to create this environment, educators must know about the lived experiences of their students. The classroom environment needs to include a culture of supportive collaboration, provide a connection with caring individuals, and help students feel they are valued.
- **Knowing your students** – Knowing your students and responding to their needs.
- **Building trust** – Creating classrooms free from physical and relational threats, and fostering warm, trusting environments, which emphasise respect, acceptance and openness.[17]

Figure 3: Symptoms of trauma and FASD and areas of overlap



Source: Adapted from National Child Traumatic Stress Network, *Is it ADHD or child traumatic stress? A guide for clinicians*, NCTSN, Los Angeles, 2016, p. 5, www.nctsn.org/sites/default/files/resources//is_it_adhd_or_child_traumatic_stress.pdf.

Trauma-informed learning and care principles

The Australian Childhood Foundation (ACF) champions the right of all children to have a safe and loving childhood, and seeks to give all children a voice.[18]

Through a range of advocacy, education and direct service delivery programs, the ACF provides families, carers, educators and communities with current evidence-based, trauma-informed support. Table 1 lists nine plain English principles of trauma-informed care that have been adapted for educators from materials provided by the ACF. While the trauma literature can be overwhelming due to its basis in neuroscience, these nine principles will assist educators to support this group of children and young people experiencing vulnerabilities.

Table 1: Nine principles of trauma-informed care

Principle	Implementation
1. Trauma affects physiological arousal levels in children	Children living with trauma need a classroom environment that pays attention to their mood and focuses on adjusting their sensory stimulation to help them stay physically present and feel safe to connect with others. Educators should use predictable strategies that will assist the child to be less reactive, and to minimise volatile or 'meltdown' responses.
2. Trauma reduces a child's capacity to self-regulate	Trauma reduces a child's capacity to self-regulate because of its effect on the brain. Children living with trauma often find it difficult to use reasoning and logic to control their behaviour or reactions. The parts of the brain required for reasoning, thinking, logic, memory and consequences are affected by the experiences of trauma. Feeling calm and secure are essential for children to engage with these skills.
3. Trauma disrupts memory functioning in children	Children living with trauma benefit from strategies that support memory systems under stress. Repetition and consistent routines in the classroom are essential. Educators should use visual cues to prompt short-term memory recall. Children living with trauma may also be unable to generalise their learning from one setting to another due to difficulties with memory. Educators may need to scaffold learning and share strategies with other educators and support staff.
4. Trauma disconnects children from the ability to attach to others in positive and trusting ways	Children living with trauma will benefit from opportunities to experience strong attachment relationships where educators tune in to the needs of the child using infant- and child-led practices. Educators need to be sensitive to the fact that everyday conversations and positive interactions with trauma-affected children help this group to experience the world and relationships in a positive and supported way. Educators may need to explicitly teach and model social skills appropriate for the classroom. This will involve providing consistency, predictability and safety.
5. Trauma restricts the capacity of children to pay attention in the classroom	Children living with trauma benefit from classroom environments that focus on the here and now. Joyful and playful activities redirect their attention away from past trauma and can lead to positive experiences. These types of activities connect educators and children in experiences that promote trust, safety and belonging. Creating positive memories helps to re-wire the brain and provides the basis for healing.
6. Trauma-based behaviour is usually a result of a child's perception that there is a threat present	Educators need to develop an understanding that children living with trauma may have a meltdown in the classroom for no apparent reason. In fact, they have been triggered by any number of possible stimuli that take them to an unsafe place related to the ongoing effects of their trauma. Triggered behaviour is an unconscious attempt to create safety in an environment that feels unsafe. It is important that we, as educators, respond to these instances with empathy and compassion rather than with judgement, blame or an authoritarian approach.

Table 1: Nine principles of trauma-informed care (cont.)

Principle	Implementation
7. Trauma limits children's responses, flexibility and adaptability to change	Children living with trauma may get 'blocked' due to constant trauma triggers. They may enact patterns of defensive behaviour that make sense in the light of their initial trauma(s), but may not seem obvious to those around them. Educators should understand that while in these triggered states, children have little capacity to reshape their responses without the calming help of an empathic adult. In order to avoid these trauma-triggering situations, educators should introduce change in thoughtful, small increments, preparing and supporting children to become accustomed to one change before initiating another.
8. Trauma undermines self-image and identity formation in children	Educators play a key role in supporting children living with trauma to develop a positive sense of self by acknowledging and encouraging them in the classroom. Building a sense of trust and relationship is core. Children living with trauma often lack a sense of being valued, and leading them towards an increased sense of personal agency will assist in the development of a more positive self-image.
9. Trauma diminishes social skills and isolates children from peers	Children living with trauma need support to engage positively with peers in social situations. Educators need to appreciate the importance of their role in modelling social skills and respectful interactions. This will assist the chidlren to build new skills and a network of relationships that promote connection and create further opportunities to reconstruct their relationships.

Source: Adapted from J Tucci & J Mitchell, *9 plain English principles of trauma informed care*, Australian Childhood Foundation, Richmond, Vic., 2015, childhoodtrauma.org.au/2015/april/trauma-informed-care.

Community healing

In Indigenous society, we bring health together with life. Here's a little story to show this.

We had a wonderful wet this year. My sons are hunters and are loving the bounty that a nourishing wet brings.

They've been going for cherabin, our freshwater prawns. Last week they caught the biggest number of cherabin that I've seen for years. Picture it, these aren't city prawns, they are buttery juicy prawns half the size of lobsters. We cooked them on a fire in our garden. For the cost of a fishing net and a little fuel we fed 15 adults and most of my grandchildren and we still had cherabin left! My son played guitar and sung, the children danced and neighbours came over.

We know that this environment offers all the elements needed for a brain to recover from trauma and to form and shape new neural pathways. For brains that have an impairment, such as those with FASD, these elements – familial love, rhythmic music and movement – interacting with the movements of nature and experiencing the freedom of the bush helps our brains to become plastic. Our brains are flexible and when we create safe and trauma-informed environments that believe our brains are changeable, every child, every person can hone their skills and strengths and become the best that they can be.

This is the system that we are building at Marninwarntikura. We counteract trauma by forming the connections needed for a good life well lived.

Emily Carter, CEO, Marninwarntikura Women's Resource Centre

Section 2: About fetal alcohol spectrum disorder

What is fetal alcohol spectrum disorder?

FASD is a person-first disability ... as in, learn about the person first, and then how the disability affects them second. If we don't take time to learn about the individual, we won't come up with the right interventions.

Jeff Noble

Of all the substances of abuse, including cocaine, heroin and marijuana, alcohol produces, by far, the most serious neurobehavioral effects in the fetus.

Stratton, Howe & Battaglia[21]

Alcohol is a **teratogen**, a toxic substance that can potentially cause a baby in the womb to develop abnormally. There is no known safe amount of alcohol or safe time to drink alcohol during pregnancy.

FASD is the result of the harmful effects of prenatal alcohol exposure on the developing fetus. Alcohol is a **teratogen**, a toxic substance that can potentially cause a baby in the womb to develop abnormally. The National Health and Medical Research Council (NHMRC) of Australia advises that the safest option for women who are pregnant or planning a pregnancy is to avoid drinking alcohol. There is no known safe amount of alcohol or safe time to drink alcohol during pregnancy.[19]

The *Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD)* was published in 2016.[20] The guide addresses the under-recognition of FASD in Australia and provides health professionals with access to internationally validated diagnostic criteria as well as information about where to refer for diagnosis or treatment. FASD is an umbrella term for a range of neurodevelopmental and physical abnormalities and may occur with or without facial abnormalities. There are ten domains of neurodevelopment related to different brain functions known to be affected by prenatal alcohol exposure. These domains are:

- brain structure/neurology
- motor skills
- cognition
- language
- academic achievement
- memory
- attention
- executive function, including impulse control and hyperactivity
- affect regulation
- adaptive behaviour, social skills or social communication.

A FASD diagnosis requires objective evidence of severe impairment of brain function in at least three of these ten specified neurodevelopmental domains.

FASD occurs in all parts of Australian society where alcohol is consumed. It has lifelong consequences and is extremely costly to our health, education, disability and justice systems. The personal costs to families living with FASD are enormous. Early recognition and early therapy can minimise the adverse outcomes often seen.

Many of the common physical characteristics associated with FASD occur during the six-week period in early pregnancy when a woman may not yet know she is pregnant. However, a spectrum of disorders can occur depending on the frequency, quantity and timing of alcohol exposure, genetic influences, maternal age and health and the use of other teratogens during the pregnancy. FASD is thought to be the most common cause of intellectual disability and birth defects in the Western world, and it results in lifelong challenges for children and young people with FASD and their families.

How does fetal alcohol spectrum disorder affect learning?

There is an established research and knowledge base about the effects of prenatal alcohol exposure on brain structure and function, including memory, cognition, executive functioning (forming, planning and carrying out complex or goal-directed activities), gross and fine motor control, sensory processing, language, and behaviour.

While there are many barriers and challenges to learning for children and young people with FASD, it is important to frame these challenges in a strengths-based educational context. Many children with FASD have learning strengths around literacy and practical subjects, such as visual arts, performing arts, sport and technologies.[22]

It is important that educators cater to the specific needs of each individual child and build personalised learning plans for this diverse group of students. Children and young people with FASD, who may or may not have a diagnosis, require supportive practices, such as personalised learning and care plans and close monitoring and evaluation of behaviours. The best starting point is to ascertain their individual strengths and build from there.

Best practice teaching for children and young people with FASD focuses on engagement and social and emotional learning. It is important to provide learning opportunities that allow students to experience success. It has been shown that success and strengths-based approaches build emotional resilience, which is especially vital to enable children and young people with FASD to grow and better understand the boundaries of their abilities and disabilities.

Some of the challenges children and young people with FASD experience are listed in Table 2 (on page 16).

> We need to acknowledge that there are people in our community living with unique and complex needs, and that it is upon us to become informed and educated about the appropriate and respectful responses we can provide to those children.
>
> *June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner*

Children and young people with FASD experience a range of developmental, learning, behavioural, social, emotional and sensory difficulties, which create barriers to learning. These have effects not only within the educational context, but also on the acquisition of crucial social and other life skills. Although they may have working/short-term memory difficulties, rote learning and long-term memory can be strengths. It is thus important to identify personal strengths, as these will become the foundations on which to develop personalised curricula, to encourage and develop further strengths, and to build emotional resilience.

> In Australia, FASD is under-recognised and often goes undiagnosed. It is often referred to as a 'hidden harm'.
>
> Professor Elizabeth Elliott

Table 2: Challenges experienced by children and young people with FASD

Challenge	Effects
Developmental challenges	FASD can cause significant delays in achieving developmental milestones such as toileting and hygiene skills, in some cases beyond the primary years.
Medical challenges	Medical and health-related challenges include organ damage, sleep problems, eating and dietary difficulties, small stature, and vision and hearing impairments.
Learning challenges	It may be difficult to understand cause and effect, which affects social interactions and the ability to build strong social relationships, and increases the incidence of risk-taking behaviours. There may be speech, language and communication delays or disorders, including verbosity, difficulty comprehending or expressing information, poor social cognition and communication skills, and difficulty using sophisticated language in social contexts. Cognitive difficulties may arise, including poor short-term memory. Poor concentration and inattention may interfere with learning. Understanding abstract mathematical concepts, such as time and money, may be difficult. Frontal lobe damage to the brain, associated with FASD, results in impaired executive functioning, including issues with the ability to organise, plan, understand consequences, maintain and shift attention, and process and memorise data. Executive functioning affects all aspects of daily life (see below).
Behavioural challenges	Hyperactivity, inattention, aggression, obsessions with people and objects, and agitation can cause anxiety and frustration for children and young people as well as parents and educators. These difficulties, although often seen as behavioural issues, can also be related to sensory processing disorders (SPDs, see below), requiring occupational therapy input.
Social challenges	Difficulties acquiring appropriate social and emotional skills affect the development of friendships, and any activity that requires an understanding of the state of mind of others, and the ability to predict how this might affect their actions and responses. Reading emotions and other non-verbal cues can also be difficult. Children and young people may not understand boundaries and can be frustrated by their own behaviour, seemingly unable to control it, leading to poor self-esteem.
Emotional challenges	FASD may cause mood swings, which are common and difficult to control. The need to rely on external prompts from adults can result in ongoing frustration. Children and young people begin to identify the differences between themselves and peers (and vice versa), resulting in low self-esteem. They are often bullied. Secondary challenges, such as mental health problems, disrupted school experience, trouble with the law, inappropriate sexual behaviours, and problems with independent living can result from lack of an early identification of needs, and lack of support and intervention when children are in primary school.

Table 2: Challenges experienced by children and young people with FASD (cont.)

Challenge	Effects
Vulnerability at times of transition	Children and young people with FASD may be socially and emotionally vulnerable as they move through the education system and into adult life. There is a need for extrinsic motivation to learn new skills or complete tasks such as life skills, hygiene routines, and school-based tasks, particularly in secondary-school-aged children with FASD, who can spend as little as 40% of their time engaged in learning tasks. They require reminders and refocusing from supportive peers and adults. As they transition through the school years, children and young people with FASD are vulnerable to bullying and other difficulties associated with making and keeping friends due to their poor social and communication skills and the compounding nature of their disability. These challenges can also be affected by co-existing disorders, such as autistic spectrum disorders (ASDs) and/or ADHD.
Sensory processing disorders	SPDs is an umbrella term covering a variety of neurological disabilities, and relate to the inability to process and use information received through the senses. These include: · Sensory moderation problems that pertain to how a child regulates his/her responses to sensations. This may result in a child being over-responsive (hypersensitive), under-responsive (hyposensitive), or sensory seeking, and some children may present all of these characteristics at different times. · Sensory discrimination difficulties include children experiencing difficulty in distinguishing one sensation from another. The eight senses involved are visual, auditory, olfactory (smell), tactile (touch), and gustatory (taste) as well as the three internal senses – proprioceptive (internal sense of body movement), vestibular (sense of balance), and organic (organ awareness). Each of these senses influences the way we perceive and respond to our environment and perceive sensations such as pain, smell, taste, balance and sound.
Attachment challenges	Children with FASD may have experienced less than secure attachments to a primary carer in the first years of life. A solid attachment with a primary carer is associated with a having secure, healthy relationships. Poor attachment with a primary carer is associated with having emotional and behavioural challenges later in life.
Executive functioning challenges	Executive functioning refers to a set of cognitive processes that helps connect past experience with present action. People use it to perform activities such as planning, organising, strategising, paying attention to and remembering details, and managing time and space. Some children with FASD may have well developed executive ability in one or more of these processes and others may demonstrate difficulties with some or most of these processes.

Source: Adapted from C Blackburn, B Carpenter & J Egerton, *Educating children and young people with fetal alcohol spectrum disorders: Constructing personalised pathways to learning*, Routledge, London, 2012, pp. 29–38.

What might FASD look like in classrooms?

Perhaps the most important tool in an educator's skill set is an open mind and an empathic approach to every student.

Educators and school communities may have limited knowledge and understanding of FASD and the adaptations required to meet the needs of this cohort of children. Recognising certain behaviours as markers of a medical condition rather than as evidence of wilful negative behaviour is important for all educators.

When educators are able to read behaviours as indicators of the need for a referral to specialist support services, a range of positive interventions can be arranged. These may include:

- adaptations to the classroom environment
- tailored teaching processes and personalised learning plans
- building capacity across the school to support learning and address the needs of children with FASD
- maintaining a culture of commitment to professional learning.

Perhaps the most important tool in an educator's skill set is an open mind and an empathic approach to every student.

In conversation with educators and school leaders, it is evident that understanding FASD has a dramatic effect on the way we work with and respond to children with FASD. By addressing the specific needs of children and young people with FASD in ways that promote understanding and compassion, rather than judgement and frustration, we are all better equipped to succeed in our various support roles.

It is therefore important, that educators are able to recognise and identify the behaviour characteristics of children and young people with FASD.

The scenario described in Case Study 1 (on page 19) underscores how important the diagnosis of FASD can be in informing teaching practice. Educating and caring for children and young people with FASD and its associated neurodevelopmental impairment needs a unique approach that relies on reflective practice and adaptive teaching techniques.

Primary behaviour characteristics are those believed to most clearly reflect underlying brain injury.

Secondary challenges are defensive behaviours that develop over time due to repeated failure and low self-esteem.

Behaviour characteristics of children with FASD

Primary behaviour characteristics are those believed to most clearly reflect underlying brain injury. These include:

- inattention
- impulsivity
- memory problems
- slower processing speed
- difficulty with skills such as abstracting and predicting.

Secondary challenges are defensive behaviours that develop over time due to constant failure and poor self-esteem and include:

- anxiety
- frustration
- depression
- isolation
- aggression and other expressions of a lack of self-esteem or confidence.

These behaviours may contribute to students disengaging from education.

Source: D Malbin, *Trying differently rather than harder: Fetal alcohol spectrum disorders*, 2nd edn, D Malbin, Portland, OR, 2002.

The earlier primary behaviours can be identified and a diagnosis made, the more preventable are many of the secondary behaviours.

Case study 1

An early childhood teacher expressed her frustration at a pattern of behaviour in a pre-primary student who refused to respond to directions when an activity commenced and continuously swept objects off the table in frustration.

The teacher repeated her directions, often raising her voice with each attempt. This seemed to exacerbate the situation, resulting in the child totally shutting down and the teacher feeling lost and frustrated.

She was unaware that the child had an auditory processing disorder on a background of hyperactivity and that the repeated directions heightened the frustration and made the situation worse for both of them. Once the child was known to have an auditory processing delay, the teacher responded by giving her time to process directions, using fewer words along with hand gestures to communicate the instruction.

She also began to implement consistent routines with visual cues so that the child could predict classroom processes. Once the child understood the activity she could respond appropriately and participate fully.

The increased empathy and understanding from the teacher improved communication and made it much easier to build a positive relationship.

Table 3 (on page 20) lists common behaviours, misinterpretations and characteristics of children with FASD, which might be useful for teachers to use as a reflection tool when planning for students in their classrooms.

When teachers better understand the behavioural implications of the range of medical conditions that comprise FASD and complex trauma, these understandings lead to a paradigm shift in both teacher expectations and teaching and learning strategies and environments. Teachers have a responsibility to adapt and change what they do in order to respond to and meet the needs of these children and young people with FASD and complex trauma.

Learning cannot occur if we do not accommodate these needs.

When teachers better understand the behavioural implications of the range of medical conditions that comprise FASD and complex trauma, these understandings lead to a paradigm shift in both teacher expectations and teaching and learning strategies and environments.

Table 3: Common behaviours, misinterpretations and characteristics of children and young people with FASD

Behaviour observed	Could be misinterpreted as:	Should be interpreted as possibly:
Being non-compliant	Wilful misconduct Attention seeking Stubbornness	Having difficulty translating verbal directions into action Not understanding Having had limited exposure to Standard Australian English (SAE) Needing to have words/processes explicitly taught more than once Needing to become familiar with ways of operating within the school environment to understand expectations
Repeatedly making the same mistakes	Wilful misconduct Being manipulative	Being unable to link cause to effect Being unable to see similarities Having difficulty generalising Requiring medical screening for conditions such as fluctuating hearing loss (otitis media) Being multilingual (Kriol and other Indigenous languages) and requiring additional support with SAE
Not sitting still Fidgeting Being restless	Attention seeking Bothering others Wilful misconduct	Having neurologically based need to move while learning Experiencing sensory overload Not understanding personal space, and needing barriers and visual cues to define appropriate distance Needing explicit teaching of expected behaviours Needing alternative strategies that help to calm them while they are concentrating Being hyperactive
Not working independently Not completing required tasks	Wilful misconduct Having poor parenting	Having chronic memory problems Being unable to translate multiple verbal directions into action Not fully understanding what is expected Needing additional scaffolding of instructions

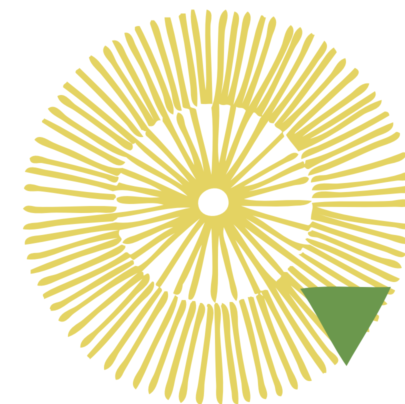


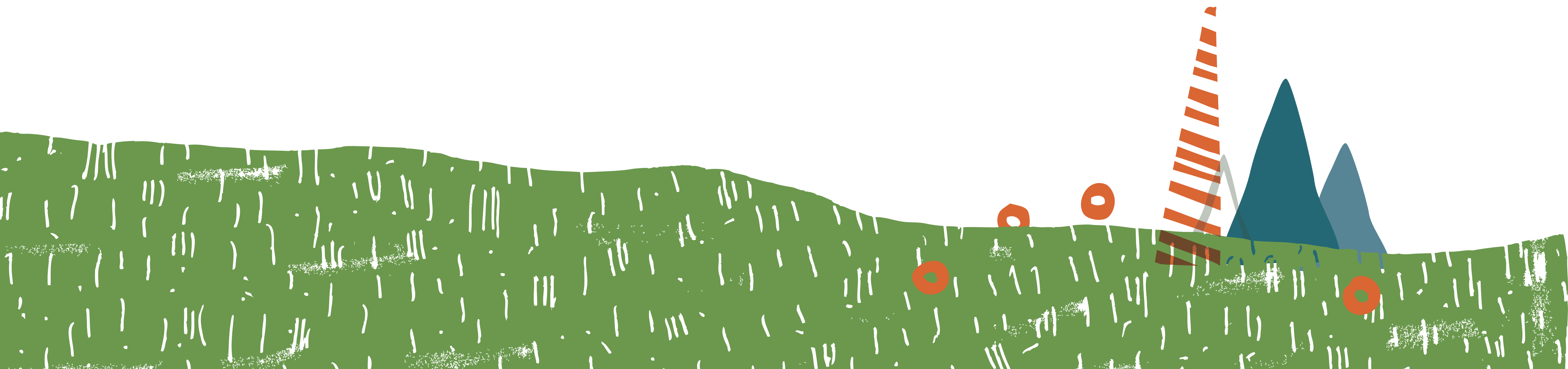
Table 3: Common behaviours, misinterpretations and characteristics of children and young people with FASD (cont.)

Behaviour observed	Could be misinterpreted as:	Should be interpreted as possibly:
Not completing homework Not participating in class activities	Being irresponsible, lazy Having unsupportive parents/carers Having an unsuitable home environment	Having memory deficits Being unable to transfer what is learned in class to a homework assignment or a different context Being unable to link today's decisions with future opportunities Fearing failure, being unsure what is required, being unable to understand expectations Requiring a supportive environment that can accommodate requirements and/or coaching Having cognitive difficulties
Often being late	Being lazy, slow Having poor parenting Wilful misconduct	Not understanding the abstract concept of time Needing assistance to organise Having limited resources, such as clocks, phones and other time-keeping devices
Displaying poor social judgement	Having poor role models Wilful misconduct Being an abused child Being unable to feel or show empathy	Being unable to interpret social cues from peers Being unsure what social conventions are appropriate in different contexts Not understanding the implications of actions Not being able to read social cues
Being overly physical	Wilful misconduct Deviancy	Being hyper- or hypo-sensitive to touch Not understanding social cues regarding boundaries Mimicking violent behaviours seen on television or home environment Demonstrating immature egocentric thinking
Stealing	Deliberate dishonesty Lacking a conscience Lacking respect Selfishness	Not understanding the concept of ownership over time and space Being unable to generalise what's wrong from one setting to another setting

Table 3: Common behaviours, misinterpretations and characteristics of children and young people with FASD (cont.)

Behaviour observed	Could be misinterpreted as:	Should be interpreted as possibly:
Lying	Deliberate dishonesty Displaying sociopathic behaviour Lacking a conscience	Having problems with memory/sequencing Being unable to accurately recall events Trying to please by telling you what they think you want to hear Experiencing confabulation or disturbance of memory without the intention to deceive
Being egocentric	Selfishness Only caring about self	Only seeing the superficial or concrete level of social behaviour Not linking cause and effect Being unable to read social cues
Being volatile Being easily triggered	Having poor parenting Having an aggressive nature Being short-tempered	Being exhausted from the stress of trying to keep up Responding to trauma Feeling overwhelmed Being extremely over-stimulated
Performing inconsistently	Not trying hard enough	Having chronic short-term memory problems Being unable to generalise learning from one situation to another Feeling overloaded Experiencing sensory processing issues

Source: Adapted from C Blackburn, *Foetal alcohol spectrum disorders: Focus on strategies. Building Bridges With Understanding Project*, Sunfield Research Institute/Worcestershire County Council, Worcester, 2009, p. 22; and Yukon Department of Education, Canada, *Making a difference: Working with students who have fetal alcohol spectrum disorders*, Government of Yukon, 2006.



The importance of respectful language

It is important that educators frame their understanding about FASD in a 'no blame and no shame' context. We now know that complex trauma is a powerful determinant of alcohol use in many communities. In this sense, alcohol is a form of self-medication, and women should not be judged, shamed or stigmatised about alcohol use during pregnancy. Alcohol causes the harm, not mothers. That said, FASD is a neurodevelopmental and physical disability, as alcohol causes structural, developmental and even cellular damage to the brain in utero. Typically, the most common symptoms of this brain damage seen by educators are behavioural challenges and learning difficulties. Only 10% of children – those exposed in the first trimester of pregnancy – will have identifiable facial feature changes or birth defects associated with FASD. Children with FASD may be slow to respond to stimuli, have difficulty making decisions and have trouble doing tasks independently.

The language we use when talking about those affected by FASD should be respectful, and promote dignity and understanding of those with FASD and their families.

The Manitoba FASD Coalition comprises a group of Canadians concerned about the relationship between stigma and FASD. They have developed a guide to respectful language to provide alternative words or phrases for those commonly used in society, and this has been adapted in Table 4 for the Australian context.

Table 4: Respectful language when talking about FASD

People with FASD

Please use:	Instead of:	Why?
Person/ individual with FASD	Suffering with FASD Damaged by FASD	Many people who have FASD find these words offensive because they imply that they are not living happy, productive lives. People with disabilities prefer others to focus on their strengths and positive attributes. People with FASD don't perceive themselves in negative ways and aren't looking for people to feel sorry for them.
	Living with FASD	The FASD community has removed 'living with' to reflect the language used to describe other disabilities/conditions.
	FASD kids	FASD is not limited to children, and is not necessarily a lifelong problem. The FASD community prefers to use 'person-first' language. This means that you talk about a person who has a disability (as well as many other traits) rather than presenting the disability as the whole of who they are. Another example would be 'a person with an addiction' rather than an 'addict'.
	(Innocent) victims or injured	These words imply that there has been a perpetrator and are very negative towards mothers. Many people with FASD do not blame their mothers, and they don't want others to. Birth mothers do not seek to harm their children. This language may jeopardise both a woman's willingness to seek help and a child's future relationships with their mother.

Table 4: Respectful language when talking about FASD (cont.)

People with FASD (cont.)

Please use:	Instead of:	Why?
Affected/impacted by	Afflicted by	The term 'afflicted' presumes that the person does not lead a happy, productive life. 'Affected by' presents a more neutral tone to this disability.
Support person/circle/ network/coach	External brain	The term 'external brain' was created many years ago to give people an understanding that someone with FASD may require coaching from others at times to help with certain brain functions, like memory, problem solving, managing money or everyday living. However, it has since been rejected by some as being offensive because it implies that they need a whole new brain to be 'normal'. A 'support person' is a more accurate and neutral term.
Cognitive or neurodevelopmental disability	Mentally disabled	'Cognitive disability' is a more respectful terminology to describe people who may have cognitive challenges or a low IQ.

Women who use alcohol during pregnancy

<table>
<tr><th>Please use:</th><th>Instead of:</th><th>Why?</th></tr>
<tr><td>Confirmed alcohol use</td><td>Admitted to alcohol use</td><td>The term 'admitted' implies that this is a confession of wrongdoing, and has a moral judgement overtone. The term 'confirmed' is neutral.</td></tr>
<tr><td>Women who use alcohol or drugs</td><td>Alcoholics/addicts
Women who choose to drink</td><td rowspan="3">Research tells us that women do not intentionally seek to drink to harm their unborn children. Some women may be unaware of their pregnancy when drinking heavily. Some women have addictions and mental health challenges and find quitting extremely difficult, despite pregnancy. Some women have abusive partners who pressure them to drink while pregnant.
Shaming women with these words does not promote prevention efforts, but rather makes women afraid to seek services that may help them.</td></tr>
<tr><td>Parents/caregivers</td><td>Don't care about their children
Bad parents</td></tr>
<tr><td>Do not use these terms. There are no replacements.</td><td>Poor choices
Irresponsible
Child abuser</td></tr>
</table>

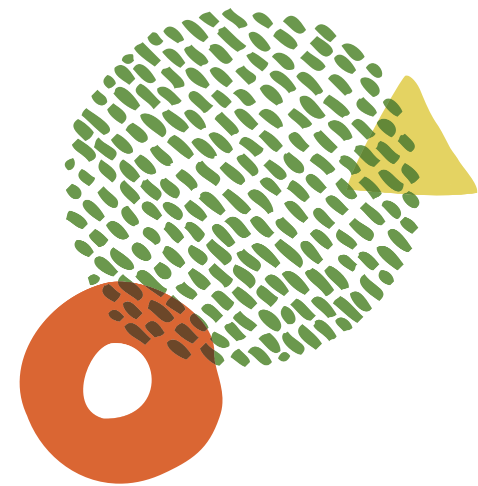


Table 4: Respectful language when talking about FASD (cont.)

FASD in general

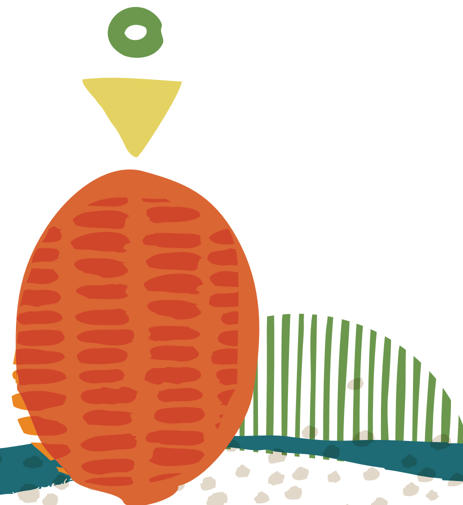
Please use:	Instead of:	Why?
Preventable *Use with caution:* Think carefully about the context and audience in which the term 'preventable' is being used as it can have negative effects	100% preventable	Saying '100% preventable' oversimplifies a complex issue. While theoretically possible, totally eradicating alcohol use during pregnancy, like all other alcohol-related harms, such as addiction, is not a likely reality. This oversimplification removes all context in a woman's life and defines the issue as a single, easy choice. In turn, this erodes society's understanding and compassion for an issue with multiple causal factors for many women.
It is safest not to drink during pregnancy	Just one drink can cause FASD	There is no clinical evidence that having one drink during an entire pregnancy causes significant harm. Conversely, there is also no clinical evidence proving lower levels of alcohol use during pregnancy to be safe. This is why Australia supports the message that 'it is safest not to drink during pregnancy'.
A balanced approach/ focus on how supports/ adaptations have made good things possible	Focusing mostly on challenges	The public understands that people with FASD have challenges. A continual focus on this creates a belief that these challenges are the main attributes of people with FASD. It is optimal to take a strengths-based approach, focusing on positive attributes.
Focus on neurodevelopmental disability	Focus on facial differences	Everyone diagnosed with FASD has a neurodevelopmental disability, the effects of which can vary from person to person. Only 10% of individuals with FASD have any physical signs, such as facial differences. Focusing on those with physical differences implies that they have a more severe form of FASD, which is not true.
FASD with three sentinel facial features **FASD with fewer than three sentinel facial features**	Fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related neurodelopmental disorder (ARND), alcohol-related birth defect (ARBD), fetal alcohol effects (FAE), neurodevelopmental disorder-alcohol exposed (ND-AE)	As of 2016, only two diagnostic categories are recognised in Australia: FASD with three sentinel facial features, and FASD with fewer than three sentinel facial features. The diagnosis of FASD is understood to encompass any term used to describe alcohol-related diagnoses in the past. The other acronyms are no longer used for diagnostic purposes.

Table 4: Respectful language when talking about FASD (cont.)

FASD in general (cont.)

Please use:	Instead of:	Why?
Secondary challenges/ effects/risks	Secondary disabilities	'Secondary disabilities' was created in the US several decades ago to describe the adverse life experiences that were documented to occur in individuals with FASD at a disproportionate rate (mental health issues, addictions, criminality, unemployment, poor school engagement etc.). New science suggests that mental health concerns and addictions may be a primary part of FASD, but challenges that are not biologically driven (e.g. homelessness) should not be termed a disability, nor are they specific to FASD. Concerns like dropping out of school and criminality are more likely to occur in any individual who has not been provided with adequate supports and understanding or has not been diagnosed and provided with help early in life.
FASD is caused by prenatal alcohol exposure/when an embryo or fetus is exposed to alcohol in utero/before birth	FASD is caused by maternal alcohol use/maternal alcohol exposure	When describing or defining FASD, the least stigmatising approach is to move the emphasis away from the behaviour of the birth mother and shift the emphasis towards the substance of alcohol.

Adapted from Manitoba FASD Coalition, *Language guide: Promoting dignity for those impacted by FASD*, Manitoba FASD Coalition, Manitoba, 2017, www.fasdcoalition.ca/looking-after-each-other-project/fasd-language-guide.



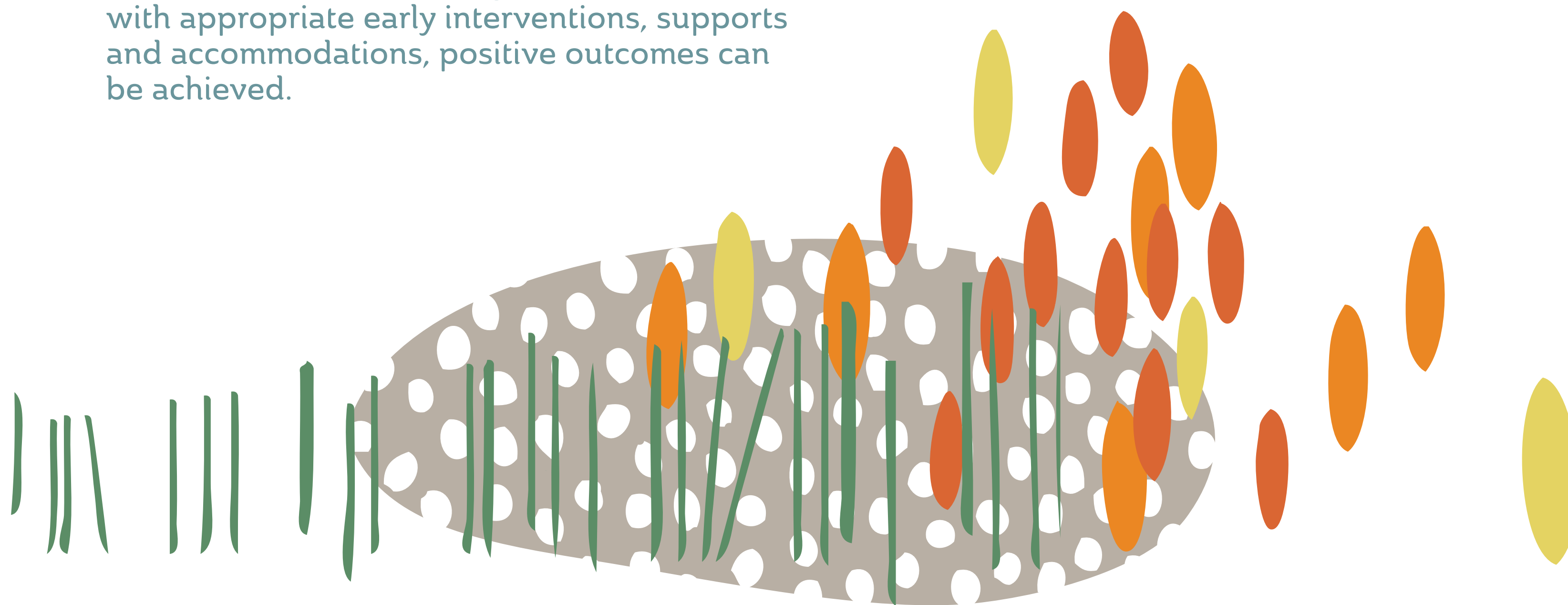
Section 3: Taking action

Taking action

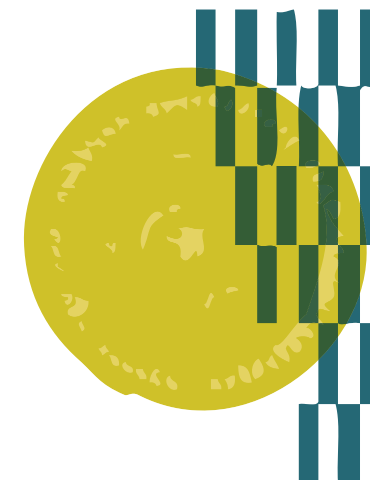
It is important to realise that educators are not alone in dealing with students with FASD. To take action, seek the assistance of school support and psychology services in the first instance, and involve other educators and school leaders in finding out more about the information and services available. These key supports can also provide ongoing advice and input to meet the needs of individual students and ensure quality teaching and integrated care.

Children and young people with FASD can learn, and teachers must be very careful to use the knowledge and increased understanding around FASD and complex trauma to inform their practice and ensure they are delivering quality education that meets the diverse needs of all students. Great gains can be achieved when educators learn about FASD and complex trauma, network effectively with the available range of support services and adjust both the learning environment and their teaching practice to meet the needs of this cohort of students.

The brain injuries caused by alcohol are incurable and have lifelong effects. However, with appropriate early interventions, supports and accommodations, positive outcomes can be achieved.



The importance of early diagnosis



> I just learned that I'm not the problem. I have a problem. I can deal with that.
>
> *15-year-old with FASD[23]*

This heartfelt statement of self-understanding about his condition is from a 15-year-old boy with FASD. It reveals a lot about the effect that increased understandings can have and also signals one important aspect of early diagnosis. Instead of seeing himself as 'the problem', this boy has come to understand he has a medical condition, which explains why he is not like others his own age. Importantly, his self-understanding brought him some relief from the constant frustration of not being able to keep up with his peers. His observation that 'I can deal with that' is the bridge upon which more self-aware and purposeful steps into his future can be planned. Without early referral, assessment and diagnosis, a lack of awareness by education professionals and families of a child's difficulties can lead to consistently unrealistic expectations, and the child can become frustrated. The lack of a diagnosis can significantly affect a child's self-esteem. Inappropriate interventions can also add to feelings of despair for the children and young people, and their parents/carers and teachers.

The brain injuries caused by alcohol are incurable and have lifelong effects. However, with appropriate early interventions, supports and accommodations, positive outcomes can be achieved. The diagnosis of FASD is complex, and ideally requires a multidisciplinary team of clinicians to evaluate individuals for prenatal alcohol exposure, neurodevelopmental problems, and facial and other physical abnormalities, in the context of a general physical and developmental assessment. Alternative diagnoses must be considered, including genetic diagnoses and exposure to other teratogens, such as lead or anticonvulsants, which can also adversely affect the developing fetus. FASD may co-exist with these and other conditions. The effects on neurodevelopment of both physical and psychosocial postnatal exposures, such as early life trauma, must also be considered.

A diagnosis of FASD requires evidence of prenatal alcohol exposure and severe impairment in three or more of the ten domains of central nervous system structure or function. A diagnosis of FASD can be made in one of two sub-categories:

- FASD with three sentinel facial features, namely a thin upper lip, smooth philtrum (the vertical grooves in the area between the nose and upper lip) and decreased width of the eye opening
- FASD with fewer than three sentinel facial features

FASD with three sentinel features replaces the previous diagnostic term of fetal alcohol syndrome, but without a requirement for growth impairment. FASD with fewer than three sentinel facial features encompasses the previous diagnostic categories of partial fetal alcohol syndrome (pFAS) and neurodevelopmental disorder-alcohol exposed (ND-AE).[24]

Early diagnosis of children and young people with FASD is vital to their development, education and long-term life chances. Thorough assessment enables identification of a child's strengths and needs.

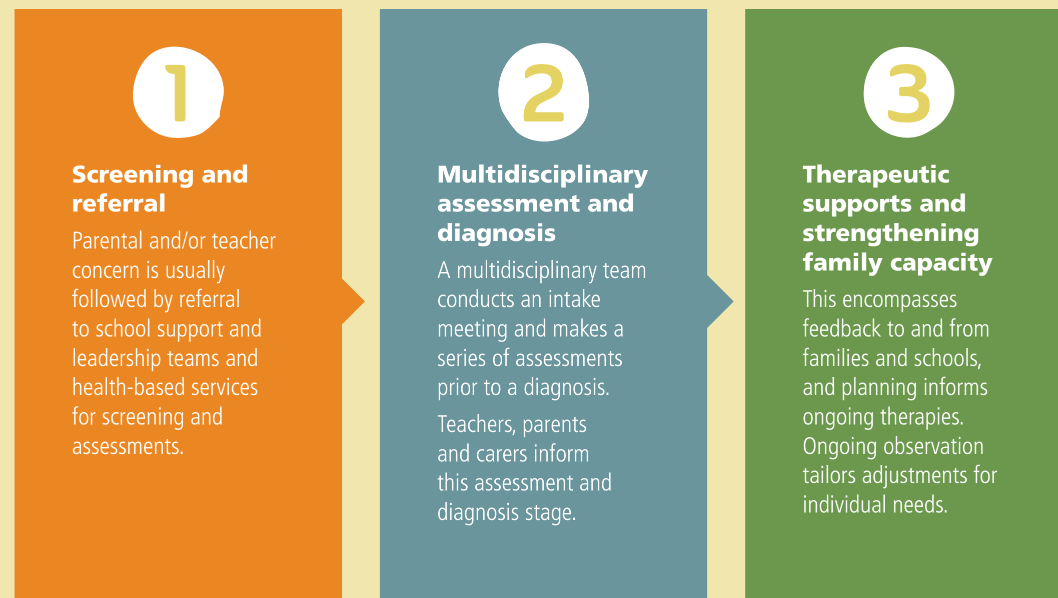
Research shows that with early diagnosis, preferably before the age of six, the required network of professional and social supports can be put in place, and can produce significant improvements to the quality of life of a child or young person with FASD. Schools play a vital role in connecting families and health services in ways that enable families to navigate the referral and diagnosis processes. When working effectively with families, educators can draw on knowledge of a child and focus on accessing a range of therapeutic services.

The stigma associated with a label of FASD may be seen by some as negative. However, without a diagnosis, children and young people with FASD might be judged as being noncompliant, uncooperative or unmotivated, when those behaviours are in fact symptoms of a serious underlying medical condition. An inaccurate diagnosis may also be harmful. For example, stimulant medications for attention deficit hyperactivity disorder (ADHD) may not help a person whose attention deficits stem from prenatal alcohol exposure and subsequent brain injury.

Diagnosis and referral

The particular steps and processes required to diagnose children and young people with FASD will vary from school to school, depending on the resources available and local arrangements. Typically, paediatric and allied health services work together in multidisciplinary teams to establish or refute the diagnosis and to develop ongoing care plans (see Figure 4). This team will usually assess children and include a paediatrician, occupational therapist, speech pathologist and psychologist trained to work with children. A range of other health professionals could be consulted for their expertise; for example a geneticist, radiologist or psychiatrist.

Figure 4: Three-step approach to diagnosis



It is vital to obtain a careful and comprehensive medical assessment and definitive diagnosis to ensure that educators can make appropriate adjustments based on accurate information.

As we have seen, diagnosis can also help the child understand their own strengths and challenges, give parents/carers and educators insights into why a child responds in certain ways, and provide an evidence base from which to plan interventions.

1. Screening and referral

Concerns raised by parents and/or educators usually lead to a referral to school and health services for screening and assessment about neurodevelopmental problems.

An educator's role is not to make the diagnosis, but rather to raise concerns and work with the family, school psychologists and other health professionals to inform a diagnosis. Teachers describe behaviours rather than interpret why these behaviours occur.

Educators play an important role in identifying behaviours that may indicate triggered responses and other challenging behaviours, and provide important information to increase understandings of children's behavioural and learning difficulties. Allied health professionals and support services can be informed by the student's profile, documented evidence and observations that educators provide. This important process leads to co-designed learning and care plans.

2. Multidisciplinary assessment and diagnosis

Once a referral is made, a multidisciplinary team conducts an intake meeting and makes a series of assessments prior to diagnosis.

This assessment and diagnosis stage is informed by educators, parents and carers, and the quality of the evidence can greatly assist the assessment process. Information from these meetings is shared with the school when the parents and carers give consent. It is vital to build relationships with families to ensure there is no shame or judgement, but rather a shared willingness to work together to find the best early interventions possible.

An Aboriginal educator and grandmother cautioned educators to get to know the parents/carers before coming to them with concerns or recommending referral. Her advice was that they see their children as normal and accept them without judgement. Educators need to build relationships and trust with parents and carers and ensure we are understood to be seeking solutions and being supportive rather than judgemental. We should take the time to make sure parents and carers understand the assessment process and are fully informed. A diagnosis emerges from the combined knowledge and understandings of parents/carers and teachers, along with the professional knowledge of the multidisciplinary team.

3. Therapeutic supports and strengthening family capacity

Once a diagnosis is made, individualised learning and care plans are developed. Based on these plans, educators make adjustments to their programs in ways that are appropriate for individual student's needs.

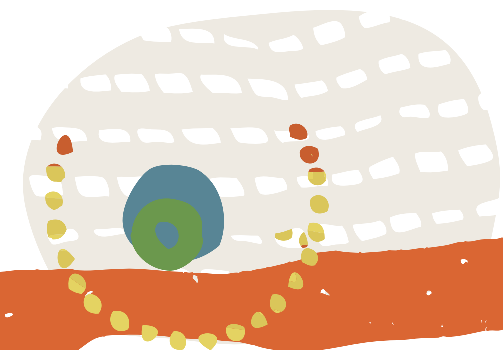
Many of these strategies are described in the folloiwng pages.

Educators play an important role in building on the knowledge of what works with individual students and making sure these understandings inform parents, and other health and education professionals. This information is especially important as children transition from pre-primary to primary to secondary school settings.

The importance of an early diagnosis for a child with FASD cannot be overstated. Parents and carers speak of the relief when a diagnosis is achieved, as it provides an explanation for a range of behaviours and learning challenges. It is the starting point for a plan to meet the child's needs in a coordinated, compassionate and understanding manner.

> Studies have shown that early detection and early intervention … can reduce the consequences of FASD two to fourfold.
>
> *Dr James Fitzpatrick, Telethon Kids Institute*

Teachers describe behaviours rather than interpret why these behaviours occur.



Classroom strategies for educators

The most important element of this shared meta-language is that it allows teachers to discuss individualised learning programs from the strengths-based perspective of what children and young people with FASD can achieve, rather than a deficit model of what they cannot achieve.

The last 15 years have seen an explosion in the international research and literature around how educators can adjust both the physical environment/classrooms and their teaching programs and strategies to best meet the needs of children and young people with FASD. Australian educators can now draw on the lessons learned from colleagues in other parts of the world. The United Kingdom, Canada and the United States have all produced extensive support materials that draw on recent FASD research and effective teaching and learning practices. Links to a selection of these resources appears in Section 4.

Best practice in supporting children and young people identified as having FASD is based on principles of:

- consistency
- simplicity
- structure
- repetition
- routine
- constant supervision
- valuing a child's strengths.[25]

In the following pages, some of the practical core elements of successful school and educator practice have been drawn together to assist educators with a significant cohort of children and young people with FASD in their classrooms.

A range of teaching and learning strategies can assist teachers meet the needs of this student cohort. Many of the successful strategies addressing the needs of children with FASD and trauma draw on the seven principles outlined above. The strategies are grouped in terms of useful skills and development domains, rather than learning areas. It is important that educators use a shared professional meta-language when describing both the symptoms of the condition and the teaching adjustments required. By using this shared language, educators share common understandings and become part of a professional learning community focused on continuous improvement and learning.

The most important element of this shared meta-language is that it allows teachers to discuss individualised learning plans from the strengths-based perspective of what children and young people with FASD can achieve, rather than a deficit model of what they cannot achieve.

The strategies are *not* arranged according to age or the Australian Curriculum in order to ensure flexibility and appropriateness. There is a wide variation of developmental age and ability among children and young people with FASD (see Figure 5 on page 33). Personalising learning approaches to individual needs is the best way to meet the needs of this group. When some strategies are put in place to support individual children and young people with FASD, often all students benefit from the adjustments.

> I find that all students benefit from a classroom environment that caters to individual student needs.
>
> *Educator*

The advice that follows is relevant for:

- early childhood educators
- Aboriginal educators
- trainee teachers
- newly qualified teachers
- special education teachers

- curriculum and leadership teams
- professionals responsible for supporting educators or students.

The strategies should be seen as being interrelated and holistic. They address cognitive, communication and emotional development domains, as children and young people with FASD need ongoing support in one or more of these domains throughout their learning journeys.

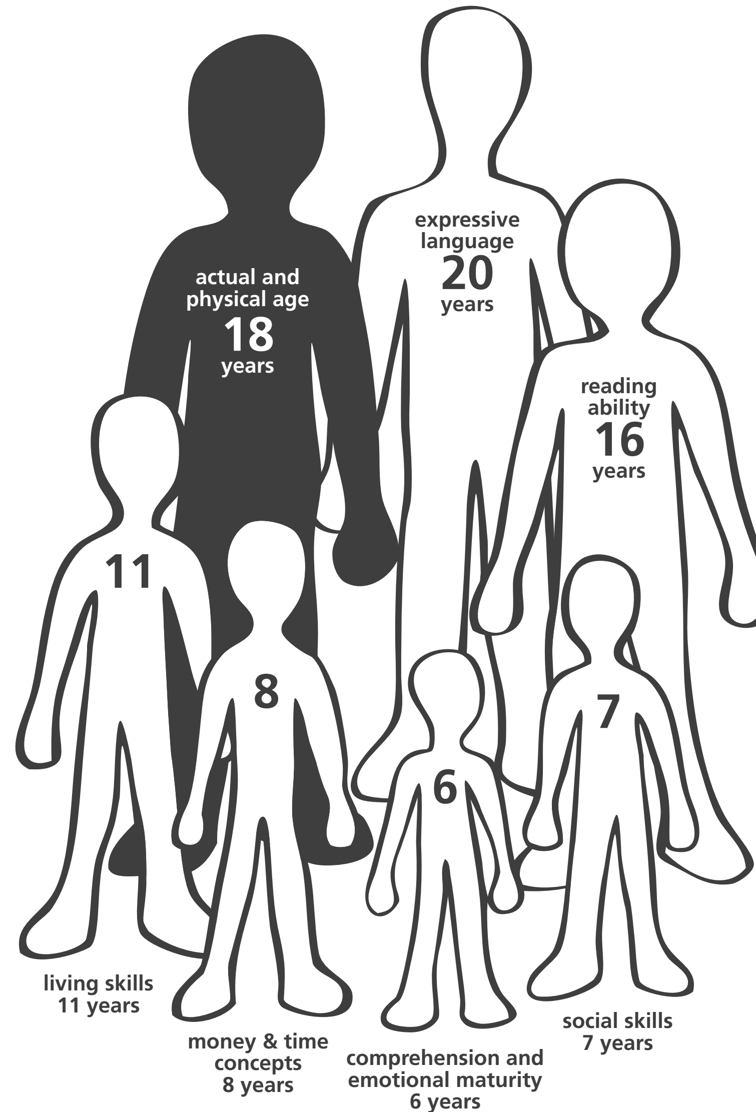
A school needs to commit to collectively building capacity and strengthening knowledge and understanding among its staff. With such a whole-school approach, all are then better equipped to respond.

Table 5 (on page 34) provides an overview of the range of teaching and learning strategies that can assist teachers to meet the needs of students with FASD. A more comprehensive list of strategies can be found on pages 37 to 48.

Case study 2

An educator placed exercise bikes at the back of the classroom. Children were taught that the bikes were for their use when they felt anxious or needed to self-regulate. At any time during the class, a child could go to the back of the room, ride an exercise bike and return to the class when they felt ready to learn again. Some educators also spoke about using a punching bag between classes to allow students to decompress before moving into a new learning environment or class.

Figure 5: The developmental age and ability of an 18-year-old with FASD



Source: Adapted from Jodee Kulp, www.betterendings.org.

Table 5: Eight keys to working effectively with children and young people living with FASD

Principle	Teaching and learning strategies
Concrete terms	Children with FASD do well when parents/carers and educators talk in concrete terms, especially to children and young people learning SAE as an additional language or dialect. Refrain from using words with double meanings or idioms, e.g. 'Jump on the computer'. The social-emotional understanding of children with FASD is often below their chronological age; therefore it helps to 'think younger' when providing assistance, giving instructions, etc. It is also important not to make deficit judgements.
Consistency	Due to the difficulty that children with FASD experience in generalising learning from one situation to another, it is best to create an environment with few changes. This includes consistency of language and routines. Educators and parents/carers should coordinate with each other to use consistent language. Using communication books is an effective way of sharing what's happening and advising on language use and behaviours in classrooms and homes, and to guide everyone to focus on strengths rather than deficits.
Repetition	Children with FASD have chronic, short-term memory problems. They forget things they want to remember, as well as information that has been learned and retained for a period of time. In order for them to commit something to long-term memory, it often needs to be repetitively re-taught. This can be frustrating for all involved, but sensitivity and positive reinforcement will create the best learning environment.
Routine	Stable routines and consistent visual cues that do not change from day to day make it easier for children with FASD to know what to expect next, and decrease their anxiety, enabling them to learn.
Simplicity	Remember to keep input short and sweet. Children with FASD are easily over-stimulated, leading to 'shutdown', at which point they can take in no more information. When children are living with trauma, this tendency towards 'shutdown' is exacerbated. Break down tasks, and always communicate the task in the positive: e.g. 'We walk inside' instead of 'Don't run!'.
Specific language	Say exactly what you mean. Remember that children with FASD have difficulty with abstractions, generalisations and 'filling in the blanks' when given an instruction. Tell them step-by-step what to do. This will help them develop appropriate habit-forming patterns. Keep instructions concise and broken into achievable chunks.
Structure	Structure is the 'glue' that enables a child with FASD to make sense of the world. If this glue is taken away, things fall apart. A child with FASD achieves and is successful because his or her world provides appropriate structure as a permanent foundation for learning. With these supports in place, a child with FASD can experience success, a vital element in developing self-worth and self-confidence.
Supervision	Due to their cognitive challenges, children with FASD bring a naivety to daily life situations. They need constant supervision, as with much younger children, to help them develop habitual patterns of appropriate behaviours, and ensure their safety and wellbeing at all times.

Source: Adapted from C Blackburn, *Foetal alcohol spectrum disorders: Focus on strategies. Building Bridges With Understanding Project*, Sunfield Research Institute/Worcestershire County Council, Worcester, 2009, p. 3; and Yukon Department of Education, Canada, *Making a difference: Working with students who have fetal alcohol spectrum disorders*, Government of Yukon, 2006.

Case study 3

An experienced educator shared her strategies for dealing with students who showed signs of distress and frustration and who were often finding themselves vulnerable in situations that escalated into serious conflict or confusion.

In the first instance she used a thumb sign (thumbs up for 'yes', thumbs down for 'no') to communicate with the child around whether they were safe or hungry. Her observation was that often children confused feelings of anxiety as hunger. So they would go to her office and she would put a timer on and give them something to eat and a drink of water, and provide a safe quiet space where the child could calm down. This familiar routine defused the situation and provided an opportunity to learn more from the child about what triggered certain reactions or responses.

Once the timer went off she would ask again whether the child felt safe or hungry, using the thumbs up or down gesture, which gave them a language that allowed them to express what was happening for them.

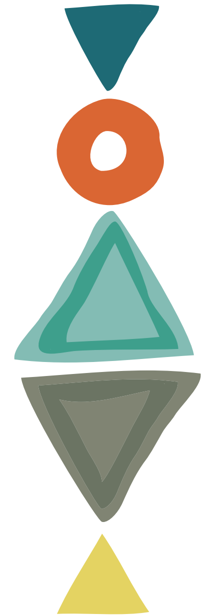
Once the child had calmed down, they were ready for learning and to return to the classroom. Together with the classroom teacher, they reflected on what happened with a new, calm mindset and new understanding and trust between child and educator.

Having explicit behaviour management frameworks, such as the WA Positive Behaviour Support program, with consistent language across the school enabled everyone engaging with the child to reinforce the same messages.

Whole-school approaches

Successful 21st-century schools build their professional learning and development around a functioning community of practice, where teachers are constantly planning together, sharing strategies and successes, reflecting on their practice through planned interactions with other teachers and support staff, and constantly innovating around the results of these activities.

In the context of addressing the needs of children and young people with FASD, a vital component in a whole-school approach is a successful team approach involving representatives from all of the main agencies working with the children and their families.



Case study 4

Fitzroy Valley District High School have implemented inquiry-based learning (IBL) across the primary classrooms (K–6). The leadership team, along with key IBL experts, developed a two-year curriculum map or learning framework that is drawn from the Australian Curriculum. This incorporates the general capabilities and cross-curriculum priorities, and guides teachers to implement the inquiry methodology in a sustainable way.

All staff have undergone extensive training and are working together to implement the Australian Curriculum through IBL. One teacher talked about how, once her students were a part of such learning, they became more engaged and made connections from one learning cycle to the next. She has also observed a reduction of FASD behaviours in her classroom.

The dynamic learning communities being created and the reflective practice taking place is very impressive. See the YouTube video by upper primary school teacher Lauren Grinter: www.youtube.com/watch?v=yASuATAgOOY.

Personalised learning

Education research supports the need for increased personalised learning. This paradigm shift has been unfolding for some years, and is becoming embedded in mainstream teacher training. Personalising learning for children and young people with FASD and complex trauma is at the core of improving the life chances of this group of students with vulnerabilities. David Hargreaves pointed to the vital role that educators play: 'Personalised learning requires teachers and schools to respond to the needs of individual students in a very targeted manner'.[26]

Children and young people with FASD need specialised support to personalise their learning. Two resources can assist with this:

- The Australian Curriculum, Assessment and Reporting Authority (ACARA) national curriculum documentation includes advice about meeting the needs of students with disabilities. This advice includes the requirement that all students with a disability are able to participate in the Australian Curriculum on the same basis as their peers through rigorous, meaningful and dignified learning programs. Principals and schools should give consideration to reasonable adjustments to ensure that students with disability are provided with opportunities to participate in education and training on the same basis as students without disability. Before any adjustments are made consultation takes place between the school, student and parents or carers.[27]
- The Early Years Learning Framework describes the principles, practices and outcomes that support and enhance young children's learning from birth to five years of age, as well as their transition to school.[28]

The advice in both these documents is built around the notion of adjustment within a differentiated curriculum. Many educators have been adjusting their teaching and learning approaches to meet the cultural and linguistic needs of a diverse cohort of students for many years. The advice also echoes the literature about how to best address the needs of children and young people with FASD and complex trauma, with its focus on engagement within a strengths-based pedagogy.

The key elements of personalised learning in the context of children and young people with FASD are:

- identifying strengths and building from them
- setting realistic, ambitious and achievable objectives
- challenging personal targets
- using rapid intervention to keep students on track
- ensuring constant and responsive assessment to monitor and maintain progress.

Many schools across Australia are building school cultures and creating learning environments with high expectations to best meet their school and community needs. This means having high expectations of all staff and supporting them to deliver quality teaching and learning to all students. It means building on a strengths base and striving for quality outcomes for all children. It means working with community, including families, and other support and health services to achieve the best possible outcomes.

With significant numbers of students with FASD and complex trauma in many classrooms, it is vital to ensure that inclusive approaches are instituted for this cohort of students. Deficit thinking models automatically result in lowered expectations, often unconsciously. It is important for educators to maintain high expectations and ensure they deliver high-quality education that meets the diverse needs of the students they teach.

The Stronger Smarter philosophy is highly recommended for all schools considering whole-school change. This approach focuses on four key elements: taking responsibility for change, using a strengths-based approach, embracing a positive Indigenous student identity, and building high-expectations relationships.[29]

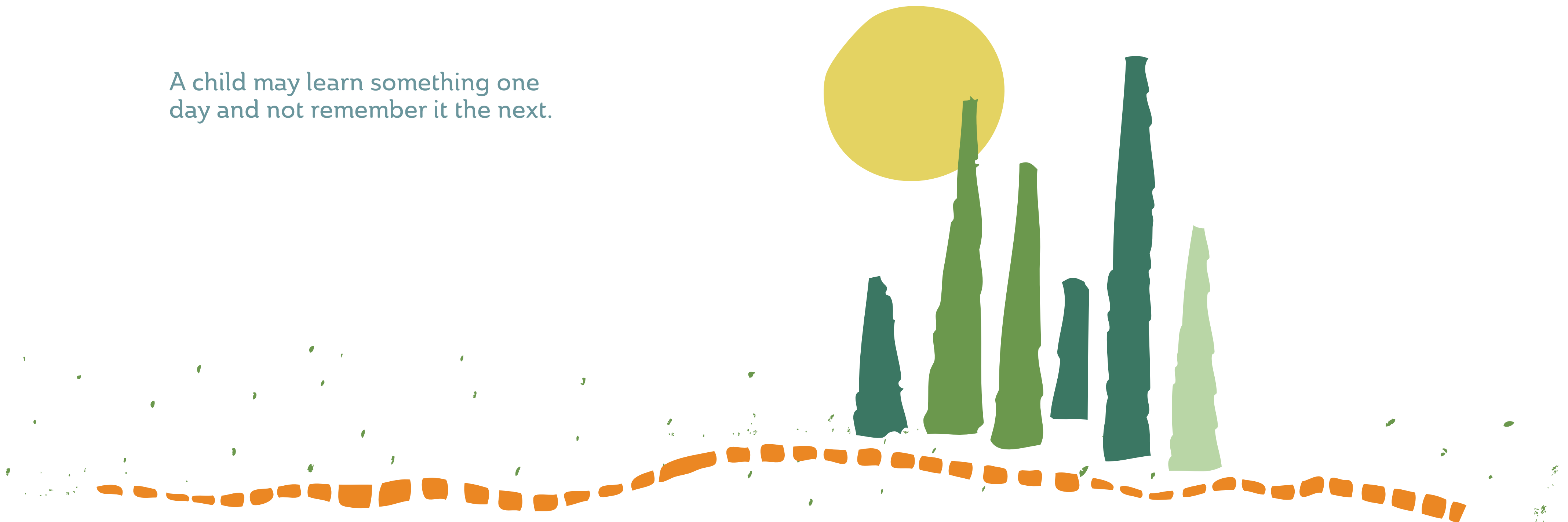
Strategies to support cognitive and communication development

Children and young people with FASD and early life trauma often experience developmental delays that affect the way they are able to function in the classroom. Often, underlying medical issues affect their ability to engage with mainstream curriculum. Sensory processing disorders can lead to inattention, hyperactivity and distractibility. Often these issues accelerate in the secondary school setting as the delays become more apparent. Students with FASD often prefer the company of younger students due to these developmental delays. Again, it is important that teachers are able to recognise and identify the behaviours that point to SPDs, and provide appropriate support to help children and young people with FASD progress through the curriculum – addressing their needs while maintaining high expectations.

The following teaching strategies support cognitive and communication development, and are based around:

- communication
- literacy skills
- abstract concepts
- money and time
- number sense
- executive functioning
- sensory processing challenges.

A child may learn something one day and not remember it the next.

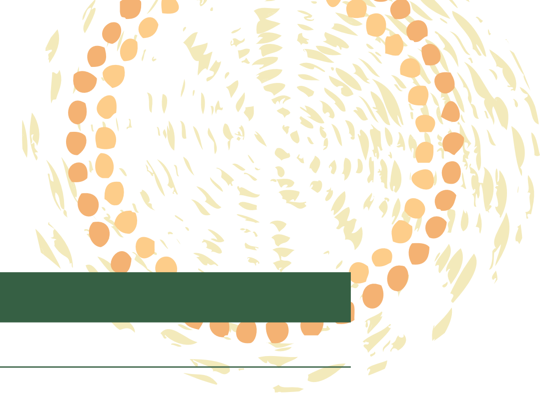


Communication: Break it down

Strategy	Notes
Provide opportunities for small group work. This will provide a secure environment in which children and young people may feel more confident to ask and respond to questions than they would in large-group situations.	
Provide a space for children to work alone without distractions.	
Enlist the support of Aboriginal educators in the classroom to interpret and reinterpret Standard Australian English instructions into the students' first language, such as Kriol or Aboriginal English.	
Break down instructions into chunks. Keep instructions as short as possible, provide them one at a time, and reinforce with visual cues.	
Break down tasks into small achievable steps, starting with what the student can already do.	
Provide concrete examples of what you are teaching. Allowing the student with FASD to touch, see and/or feel something will help him/her to succeed in learning what you are teaching. However, appropriate safety precautions must be taken. This is particularly so for practical subjects such as science, where the need to touch and feel objects can lead to dangerous situations. Provide individualised instruction with the student before the class to ensure that safety messages are understood, which can reduce impulsivity and reduce risks.	
Use the student's own life experiences and knowledge when teaching new ideas. This will give them a reference point to support their learning and make connections with their prior learning.	
Provide visual aids (such as pictures, symbols and timetables) to reinforce instructions and tasks (for both primary and secondary students).	
Make visual timetables concrete by including photographs of the children doing activities rather than symbols or drawings (for both primary and secondary students). As a child's proficiency with reading progresses, you can rely more on the written word.	
Use consistent language throughout the school. For children with more complex communication needs, use hand gestures or other communication supports.	
Use positive language. Tell children what you would like them to do rather than what you would not like them to do. For example, say 'We walk inside' rather than 'Don't run'.	
Avoid confusion by being direct. Instead of saying 'Do you know where your pencil is?', say 'Where is your pencil?'. Give one instruction at a time. Check for understanding.	
Scaffold key words/concepts for a topic and discuss separately before the topic is introduced to the whole class.	
Ensure that language used in the classroom reflects the language used in tests and exams, to avoid confusion.	

Literacy skills: Target teaching and be explicit

Strategy	Notes
Literacy blocks with consistent routines are effective ways to embed targeted teaching in everyday classrooms. Build a repertoire of techniques that are predictable in order to provide scaffolding to all children, especially children and young people with FASD and complex trauma.	
If children have difficulty learning to read, encourage them to build up a sight vocabulary by using a multi-sensory approach such as 'Look, Cover, Write, Check'. Expect to repeat words frequently.	
The ability to build a story by sequencing symbols and pictures is a simple way to build confidence. Use a range of techniques to build social stories.	
Encourage the enjoyment of books at a level that is developmentally appropriate to the child. Picture books and graphic novels without too much text may be more appealing regardless of age.	
Provide children with a journal where they can record their reading at school and home. Ensure that reading targets are broken down into achievable steps (perhaps two to three pages at one sitting). Provide two or three comprehension questions for them to answer about the text. Segment the testing – one item at a time.	
If children have difficulty with the direction of the text, use coloured stickers to indicate the correct direction. Explain that we start at 'green' and stop at 'red'.	
Allow opportunities to tell or record stories pictorially as the children may not be ready for lengthy writing. Story boards are also a helpful tool.	
Consider colour-coding words for sentence construction. For example, nouns could be red, verbs yellow and adjectives green (taking into account the children's own colour preferences and ensuring they are not colour-blind). This works well when used with writing frames (a guided response template). Portable tablets such as iPads offer a useful platform for this type of work.	
Use pictorial dictionaries where possible to aid vocabulary development.	
Provide audio recordings of a variety of texts, such as literature and social stories.	
Provide a laptop or mobile device and/or scribe if necessary for written work. This can help to improve enjoyment of a task and improve concentration and engagement. Headphones can be useful to assist with minimising distraction.	
Consider using mind maps to help children to organise thoughts and tasks and help embed understanding of subjects and tasks.	
Use writing frames or scaffolds for written homework to provide a clear structure and concise organisation showing what to put on the page and where. This makes tasks more manageable.	
Consider other methods of recording progress, such as drawings, photos, graphs and video for children who find lengthy writing tasks difficult.	



Abstract concepts: Make it concrete

Strategy	Notes
Demonstrate a concept (show rather than tell), and be prepared to repeat the demonstration/instruction constantly.	
Provide concrete examples of abstract concepts, such as number lines, an abacus for understanding place value, and real objects for counting in sequence.	
Create a visual journal that documents learning.	
Use art projects to make abstract concepts more concrete. Use coloured sand to teach students about volume.	
Use ICT as a visual representation of number rules and mathematical concepts. Computer-based learning programs may work well because they are repetitive and visual and provide immediate feedback, coupled with a hands-on learning experience.	
Teach cause and effect with the use of three-dimensional tactile resources, such as pop-up toys, scented bubbles, jigsaws, and books with sound effects.	
Use vertical number lines instead of horizontal number lines so children can visually identify that adding results in numbers going up and subtracting results in numbers going down.	
Plan games and activities involving right and left instructions.	
Plan physical activities involving mathematical concepts such as number, positional language, colour and shape, as movement can aid memory retention.	
Use consistent language for all concepts and in all classrooms/lessons. For example, do not say 'nought' one day and 'zero' the next.	
Use one or two maths problems or questions on a page, with plenty of white space between. Too many problems/questions on one page might look overwhelming.	
Include children's names in word problems.	
Make mathematical process cards by highlighting examples of mathematical processes (e.g. multiplication, division and subtraction) broken down in a step-by-step process for the child to refer to as a reminder.	
Avoid mixing addition and subtraction, multiplication and division problems on the same page. Ensure that the operation symbol is in large and bold type so that it is clear what the child is expected to do.	
Questions and problems involving a story that needs decoding is an extra task that may be overwhelming. Allow extra time and provide additional scaffolding and guidance.	
Provide graph or lined paper to help children to line up mathematical problems more easily.	
Expect learning to take place at a slower pace, make teaching interactive, and allow children to talk through mathematical processes and problems, as this may help with memory.	

Money and time: Make it real

Strategy	Notes
Use real money and analogue clock faces as they are more concrete and this will allow children to move the hands on the clock. Sensory input assists learning.	
Consider the use of a digital clock if children find conventional clock faces difficult.	
Use objects in the classroom and around the school, such as calendars, clocks and watches, to highlight numbers and number patterns, to encourage the ability to generalise.	
Use reminders on a tablet such as the iPad to assist with task monitoring and memory.	
Plan role-play sessions involving time and money with shopping scenarios. Use real objects so children build a stronger association with real-life scenarios.	
Use sand timers, egg timers and daily calendars to help children visualise the passing of time.	
Use timers to help children recognise how long they have to complete a task. For example, instead of a school bell, play familiar songs to children. When the song ends, everyone knows they need to be in class.	

Number sense: Make it visual

Strategy	Notes
Relate numbers to meaningful concrete objects to enable children to view numbers as values rather than labels. For example, there are two wheels on a bicycle, three wheels on a tricycle, and four wheels on a car.	
Create a large number line across the classroom or outside space that children can physically move along.	
Help children recognise that many things cannot be measured precisely, by providing practice with estimation in a range of situations.	
Provide a range of materials that involve number and number representations, such as dice, dominos, playing cards, coins, clocks and rulers.	
Look for ways to incorporate children's own interests and strengths into number work in order to personalise their learning. For example, football teams provide countless opportunities for number work.	

Executive functioning: Reinforce and repeat

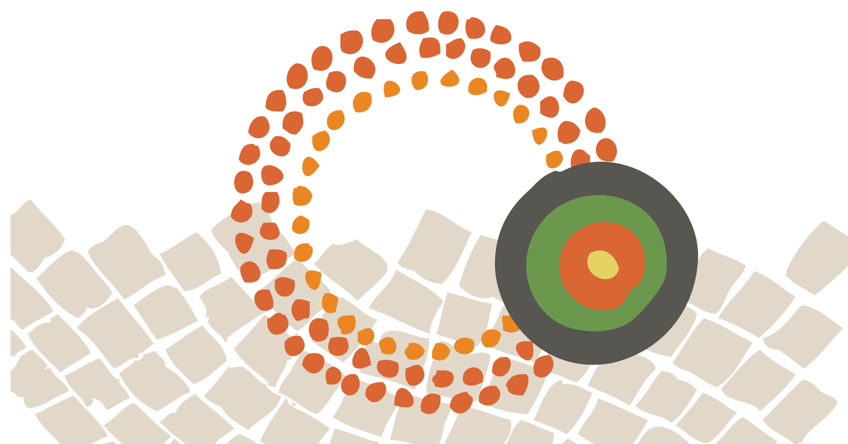
Strategy	Notes
Consider whether non-compliance with rules is due to difficulty with understanding or because the children have been distracted.	
Provide clear, consistently applied rules across the school to reduce the number of things that need to be remembered.	
Expect to repeat instructions frequently.	
Ensure that the consequences of not following rules are consistently applied. This will ensure children are more aware of their own actions and help them make better decisions.	
Use short sentences in instructions and lesson delivery to reduce complexity.	
Allow extra time for children to process information. This will help to reduce anxiety, which is known to cause more problems for children and young people with FASD and can result in outbursts, lack of engagement with a task/subject and poor self-esteem.	
Using an animated face, facial expressions and exaggerated gestures will engage the children who are developmentally younger, and aid their memory retention.	
Provide visual timetables in classrooms as a memory aid and to enable children to see what is happening now and next.	
Remember that it might be frustrating for you, but it is also very frustrating for the children. Navigating the world with a cognitive disability is confusing and frustrating.	
Unpack emotions by using an animated face with questioning techniques and then talk about feelings.	
Use visual timetables with photographs of the children as a concrete representation of what is required and what is happening next. When children can read, words can replace images.	
Check the student's understanding of instructions and tasks frequently, particularly in relation to homework.	
When asking children to repeat an instruction you have given, ask them to repeat it in their own words to ensure that they have processed and understood the information.	
Build relationships with parents/carers to communicate progress and share and build on successes.	
Use appropriate incentives that reward children for their individual achievements and motivate them personally.	

Sensory processing challenges: Be calm and moderate

Strategy	Notes
Handle challenging behaviours triggered by sensory processing disorders in a calm and non-judgemental manner. Children and young people with these particular disorders experience high levels of frustration and confusion, and it is important that they do not feel judged or punished.	
Ask an occupational therapist to conduct a sensory profile/assessment if children seem frequently switched off or easily overwhelmed by texture, noise, light, smell, movement, sound, temperature, crowded places or too much dialogue, as they may be hyposensitive or hypersensitive, or both, at different times.	
Consider turning off fans and intense fluorescent lighting as some teachers report that this reduces agitation in some students.	
Consider whether diet or hunger are contributing factors or if there are any underlying/undetected health issues.	
Provide apples for chewing, stress balls, fidget toys, exercise bikes and brain breaks to encourage focus and calm children.	
Closely observe a child to assist in identifying what triggers them.	
Remove as many distractions from the learning environment as possible.	
When making changes to wall displays in the classroom, make the changes one at a time, so as not to make the familiar become unfamiliar too quickly.	
In some instances, it may be useful to use curtains to block out sections of a room in order to reduce distractions and interference.	
Seat children consistently in the same place, ideally where the teacher can easily see them (and vice versa). Maintain eye contact. Some children will be better placed near the front and others may need to be at the back where they can see everyone and leave the room if necessary. Ensure that all staff are aware of the issues relating to sensory processing disorders and their effect on learning. Some children may seek out an adult such as an Aboriginal educator to provide support, such as interpreting, reinterpreting and repeating instructions.	
Audit the classroom and school environment in terms of noise, light, sound and ease of access. Particular problems include fluorescent lights, scraping chairs, air conditioning units, school bells, ticking clocks, echoes in changing rooms and toilets, chemicals and Bunsen burners in practical lessons, textiles in technology lessons, some food items and perfume aromas.	
Provide an alternative space offering a calmer environment than a classroom that children can visit when they become overwhelmed. Provide earphones, calming music, masks and lavender. Lavender is used as a remedy for a range of ailments from insomnia and anxiety to depression and fatigue. Research has shown that lavender can produce calming, soothing and sedative effects when its scent is inhaled.	
Place carpet or tennis balls on the legs of tables and chairs to eliminate noise when other children move furniture.	

Sensory processing challenges: Be calm and moderate (cont.)

Strategy	Notes
Seat children as far as possible from distractions such as windows, doors and the movement of other students.	
Frame children's working areas (including seat and desk) with masking tape to keep their attention focused on their work space and enable them to remember their personal space and boundaries.	
Consider using colour and shape to code items that children need to access frequently, e.g., red triangles for maths books, or yellow circles for literacy books.	
For carpet work, provide individual cushions for children to remind them of their personal space.	
When children become agitated, ask them to carry an object to another person in a different room, as a special helping task. This can be calming and grounding and also builds responsibility while de-escalating situations.	
Keep tasks short and achievable and break them up with physical activity to expend energy and refocus attention.	
Gradually build up the time that children are expected to sustain attention. Make a visual chart showing progress with tasks and share it with them so that they can see their own achievement in terms of sustained attention.	
Allow children to enter and leave the lunchtime facilities before or after peers in order to avoid noisy/busy corridors when moving from one classroom to another.	
Use percussion instruments for children to create rhythms and practise following instructions to play and copy patterns. They will need to listen and sustain attention to hear the patterns.	
Music therapy sessions can provide a safe space for children to explore and express emotions and feelings, reducing anxiety and hyperactivity. This can also improve listening and attention skills. Give children time to explore instruments and provide a piece of fabric for them to cover themselves, as this can make them less inhibited when singing.	
Provide opportunities for movement, such as climbing frames and swings. This can help with self-regulation and grounding.	



Strategies to support behaviour development

Behaviour management frameworks, such as Positive Behaviour Support (PBS) or Promoting Alternative Thinking Strategies (PATHS), teach all children explicitly and enable consistent language and understandings to be reinforced clearly across the whole school.

Children and young people with FASD and complex trauma may lack inhibition and often do not understand cause and effect and the consequences of actions. These characteristics can place them at significant risk of disengaging with education and increase the likelihood of their coming into contact with the criminal justice system. Teachers can assist children and young people to learn about boundaries and appropriate behaviours by providing specific and reinforced support in forming appropriate relationships and developing empathy. Children and young people with FASD may need close adult supervision throughout the day to ensure their and others' safety.

Impulsivity/lack of inhibition: Be flexible and responsive

Strategy	Notes
Provide specific teaching about routines and safety rules.	
Provide constant supervision and appropriate adult–student ratios in practical lessons and laboratory situations.	
Be prepared to repeat instructions/routines/rules as often as necessary to ensure understanding. This helps increase confidence and motivation.	
Provide a quiet space to discuss sensitive issues with the student.	
When changes to timetables and schedules are necessary, ensure that the student is informed as soon as possible and given an appropriate explanation. This will help reduce anxiety and disruptive behaviour.	
Provide adult support to prepare the student and guide them through changes to timetables and arrangements.	
Provide a quiet area where the student can go to self-regulate and calm down.	
Provide weighted blankets, fabrics, headphones, eye masks, dark sunglasses, lavender and calming music. Provide individual prompts for individual students, as different children have different preferences. Ensure that this is viewed by the student as a positive aid for them to regulate their own emotions in order to build confidence and self-esteem.	
Provide visual prompts showing required behaviour, preferably using photographs of the student rather than pictures or symbols.	
Record the occurrence of incidents in order to identify possible triggers that may be causing distress. Monitor to see if incidents occur at particular times, with particular peers or members of staff, and make adaptations in order to reduce occurrences.	
Whole-school approaches to providing appropriate spaces and visual supports can assist all students. Best practice schools consistently share what works and undertake frequent review cycles to ensure that teachers benefit from one another's knowledge. This builds strong collective understandings and a supportive environment in which to provide professional and personal supports to teachers, students and families.	

Strategies to support social and emotional development

For children and young people with FASD and complex trauma, establishing, maintaining and understanding age-appropriate relationships is a challenge because of their lack of understanding of social cues, and difficulties with memory and understanding cause and effect and the consequences of their actions. Adolescents with FASD often suffer social isolation as a result of these challenges. Teachers and school support staff can assist with these issues by mentoring or playing a life coach role in the lives of these vulnerable students.

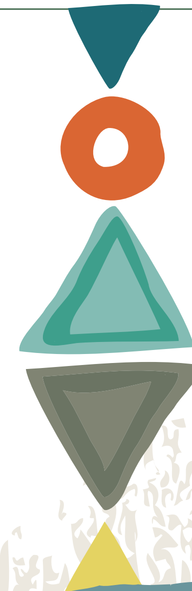
The single biggest factor that influences whether students try or give up, leave or stay, is their sense that somebody in school knows who they are and cares about what happens to them.

Supporting relationships: Engage and enable

Strategy	Notes
Use social stories and scripts to explain to students how to behave in different social situations. Provide a script for each situation, as children may not be able to generalise from one situation to another. Repetition of stories and scripts can help improve memory, engagement, confidence and understanding.	
Use puppets, role play and drama to explore feelings and attitudes. This can help improve peer relationships through language development and conversation.	
For paired activities, pair the child with FASD with another child who is a good role model, and plan groups carefully to ensure the child with FASD has good role models to observe at all times.	
Plan for turn-taking games and circle games to encourage appropriate social interaction.	
For students who interrupt or find it hard to know when it is their turn, provide a concrete object such as a small ball as a holding item to indicate when it is appropriate to talk or take a turn – when the ball is in the child's hand it is their turn.	
Provide the opportunity for supervised social situations with good role models in unstructured free time, including peer–buddy groups for break times and lunch times, to facilitate friendships.	
Provide a key worker with whom a child with FASD can discuss social and emotional difficulties related to home or school life (this could be an Aboriginal educator, teaching assistant, learning mentor or teacher) and who is well known to the child and with whom the child is able to bond.	
Discuss with the child their general state of emotional wellbeing at the beginning of each day, using a scale from one to five, and record this in their planner. This can be used as a communication aid among support staff about the child's mood and ability to cope with the coming day. This may help reduce anxiety throughout the day.	

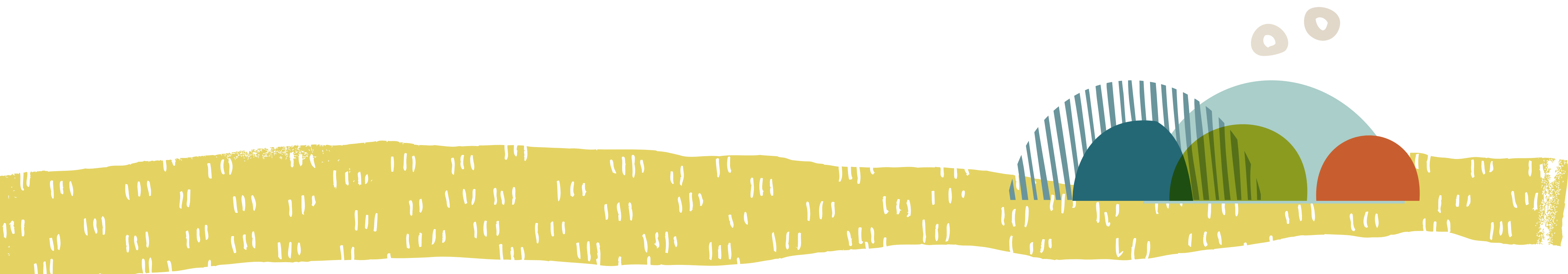
Supporting relationships: Engage and enable (cont.)

Strategy	Notes
Ask students how they feel as this often elicits a positive response – showing a sense of being acknowledged and that they are cared for – and helps build positive relationships.	
Balance opportunities for children to contribute and share ideas for group work and participate in group performances, then provide sufficient praise and encouragement to support them in these situations in order to build confidence.	
Use role play, social stories and scripts, and photographs to prepare children for special events, including trips.	
Ensure parents/carers have advance notice of social events and trips so that they can prepare children adequately.	
Provide the child with a photographic record of their new school – with members of staff, learning environments, new uniform, journey details and other important information – so that they can familiarise themselves with the new setting well before they arrive.	
Discuss with the child, individually and in small groups, the many reasons why people bully others, including feelings of unhappiness, loneliness and frustration, and attempts to make themselves feel bigger and stronger. Use concrete examples and simple language.	
Encourage a restorative justice approach across the whole school as this provides opportunities to hear how people feel, share feelings and build empathy.	



Inappropriate interactions: Understand consequences

Strategy	Notes
Use role play and social stories to talk through social scenarios and demonstrate appropriate and inappropriate interactions with others. Encourage appropriate understanding of 'self' through discussion time activities.	
Provide low-impact one-to-one supervision where necessary and, if possible, a separate changing room for the student. This will reduce the risk of inappropriate interactions and/or the child acting on impulse.	
Use protective behaviour programs to explicitly teach all children about appropriate interactions. These sessions enable children and young people to visually represent boundaries and link different interactions with different relationships.	
Allow extra time for discussions and other planned activities to ensure understanding of basic information about personal and/or private space.	
Ensure that sex education highlights concrete rules that are easily understood. For example, unprotected sex is always unsafe sex, and masturbation must always take place in private (ensuring an understanding of what 'private' means). Clearly and simply explain consequences, using role play, social stories and repetition, and apply them consistently.	
It may not be realistic to expect a child with FASD to understand that unprotected sex may or may not end in pregnancy or disease, or that there is a time delay between intercourse, pregnancy and the arrival of a baby. The delivery of these concepts may require careful planning, liaison with parents and carers, repetition and extra time for discussion and explanation.	
Engage external services to look for a community peer to support the child through social scenarios and provide positive role models.	
Invite parents/carers to sex education lessons so that discussions in the classroom can be extended at home using the same concepts and language, and in order to reduce any concerns parents may have about sex education. Invite health services in regularly to reinforce safe sex messages.	
Monitor and record the incidence (including time of day, type of environment, particular room, other children involved, preceding incidents) of inappropriate interactions to determine any patterns and possible reasons.	



Section 4: Further resources

Powerful pedagogies and effective approaches

In developing this resource we have visited schools, talked with teachers and seen some powerful teaching and learning occurring across a range of schools and communities.

This section links to some pedagogies and effective approaches that Kimberley educators are currently using to provide for the diversity of needs and complex challenges many of their students face. They reinforce the benefits of preparing students for learning, and provide meaningful teaching and learning programs that create genuine engagement and build positive respectful relationships.

The Alert Program

This program is being used to assist children to regulate their bodies in readiness for learning. Children are given the language and strategies to determine whether their 'engine' is running low or high, and provided with clear strategies to adjust. The self-monitoring process is explicitly teaching life skills and benefits all children, but particularly children with FASD.

alcoholpregnancy.telethonkids.org.au/our-research/research-projects/alert-program

Primary Movement

A combination of primary movement and yoga is used to prepare students as they transition from outside activities to structured learning activities.

www.primarymovement.org/about

Kath Murdoch Model of Inquiry-Based Learning (IBL)

An inquiry-based teaching, learning and assessment model takes students through a learning cycle that fosters inquiry, exploration of ideas and develops deep thinking, research and understandings. This model is being implemented across K–6 at Fitzroy Valley District High School.

www.kathmurdoch.com.au

TEACCH

Strategies from TEACCH Autism Program are being used in a range of settings to cater to students with diverse needs.

teacch.com/about-us/mission-st

Kimberley School Psychology Service

Leadership and student support teams in schools engage school psychologists to work with individual teachers and whole-school staff to implement effective behaviour management programs.

Some schools are implementing a combination of the following:

Positive Behaviour Support
det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/positive-classrooms/positive-behaviour-support/

Promoting Alternative Thinking Strategies (PATHS) curriculum
www.kidsmatter.edu.au/primary/programs/paths-curriculum

You Can Do It! Education
www.youcandoiteducation.com.au

Restorative processes such as No Blame Bullying Prevention
www.kidsmatter.edu.au/primary/programs/no-blame-bullying-prevention

Protective behaviours

Holly Ann Martin from Safe4Kids has been working in many Kimberley schools to run protective behaviours workshops with students, teachers, school leaders and community. She explicitly teaches children about appropriate and inappropriate interactions and gives children clear boundaries, strategies and language to keep safe. The importance of such programs in our schools is highlighted by the evidence showing how vulnerable students with complex needs can be.

www.safe4kids.com.au

Useful resources

The following resources have been useful for our research and will provide practical information and strategies to inform teachers to understand and address the complex needs of their students with FASD.

FASD: Focus on strategies. Building Bridges With Understanding Project

A framework and practical ideas for working with primary and secondary students. Available online at:
barrycarpentereducation.files.wordpress.com/2013/06/fasd-strategies-for-practitioners.pdf

Fetal alcohol spectrum disorders: Education strategies. Working with students with a fetal alcohol spectrum disorder in the education system

Prepared by the National Organization on Fetal Alcohol Syndrome – South Dakota. This handbook presents educational strategies for teachers working with children and young people living with FASD. Available online at:
www.usd.edu/-/media/files/medicine/center-for-disabilities/handbooks/fasd-educational-strategies-handbook.ashx?la=en

Making a difference: Working with students who have fetal alcohol spectrum disorders

Published by the Yukon Department of Education, Yukon, Canada. Available online at:
www.fasd.ie/documents/fasd_manual_2007.pdf

Secondary framework: Teaching and learning strategies to support secondary aged students with foetal alcohol spectrum disorders (FASD)

Published by the National Organisation on Fetal Alcohol Syndrome, UK, as part of the Facing the Challenge and Shaping the Future for Primary and Secondary Aged Students with Foetal Alcohol Spectrum Disorders (FAS-eD) Project. Available online at:
www.nofas-uk.org/documents/FAS-eD%20SECONDARY%20FRAMEWORK.pdf

What educators need to know about FASD: Working together to educate children in Manitoba with fetal alcohol spectrum disorder

Published by Healthy Child Manitoba and Manitoba Education, Citizenship and Youth, Manitoba, Canada. Available online at:
www.gov.mb.ca/healthychild/fasd/fasdeducators_en.pdf

Australian FASD organisations

Marninwarntikura Women's Resource Centre
www.mwrc.com.au

Marulu Strategy
www.marulustrategy.com.au

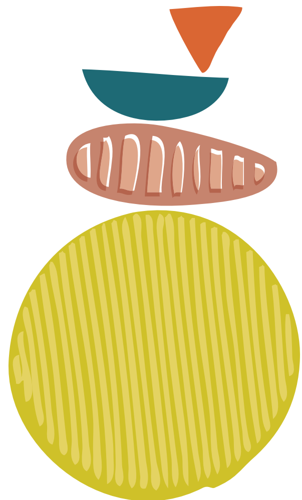
Russell Family Fetal Alcohol Disorders Association (rffada)
rffada.org/2-uncategorised/54–0russell-family-fetal-alcohol-disorders-association

National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD)
The Loop e-newsletter: www.nofasd.org.au/community/the-loop-e-newsletters/
Fact sheets: www.nofasd.org.au/resources/fact-sheets

Telethon Kids Institute
What is FASD?: alcoholpregnancy.telethonkids.org.au/alcohol-pregnancy-and-breastfeeding/about-fasd/

FASD Hub Australia

Rich web-based information on FASD for Australian health professionals, teachers, justice professionals, service providers, researchers or parents and carers.
www.fasdhub.org.au



Endnotes

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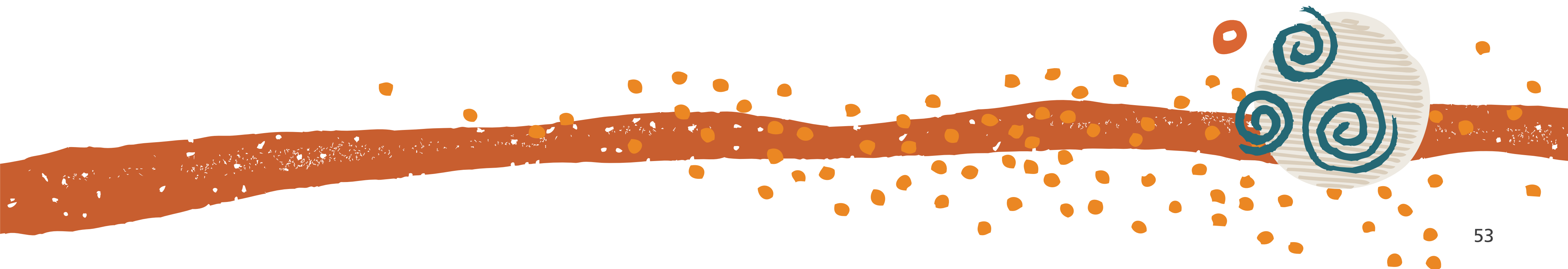

Uluru statement from the heart

We, gathered at the 2017 National Constitutional Convention, coming from all points of the southern sky, make this statement from the heart:

Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands, and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from 'time immemorial', and according to science more than 60,000 years ago.

This sovereignty is *a spiritual notion: the ancestral tie between the land, or 'mother nature', and the Aboriginal and Torres Strait Islander peoples who were born therefrom, remain attached thereto, and must one day return thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty.* It has never been ceded or extinguished, and co-exists with the sovereignty of the Crown.

How could it be otherwise? That peoples possessed a land for sixty millennia and this sacred link disappears from world history in merely the last two hundred years?

With substantive constitutional change and structural reform, we believe this ancient sovereignty can shine through as a fuller expression of Australia's nationhood.

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is *the torment of our powerlessness*.

We seek constitutional reforms to empower our people and take a *rightful place* in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

We call for the establishment of a First Nations Voice enshrined in the Constitution.

Makarrata is the culmination of our agenda: *the coming together after a struggle*. It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination.

We seek a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history.

In 1967 we were counted, in 2017 we seek to be heard. We leave base camp and start our trek across this vast country. We invite you to walk with us in a movement of the Australian people for a better future.

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