FASD
Friends

‘Ask the Expert’ Event notes: 04 March 2023
Event hosted by Julie Furney Director of FASD & Dr Cassie Jackson Clinical Psychologist & FASD Expert Witness

1. Can we talk a little about the impact of the HPA Axis on the body and how it might impact on children with FASD?

HPA Axis is a complex thing to explain so I will give a bit of an outline without digging too deeply into the neuroscience!

HPA is a set of influences in the endocrine system, **H**ypothalmic, **P**ituitary, **A**drenal glands that work as a feedback loop in reaction to stress.
They work as a regulatory system so when the body sees stress they will rev you up ready to go into the trauma response ‘fight or flight’ and then they downregulate when the stress has reduced.

For children that have been exposed to alcohol or cocaine they are extremely hypersensitive and can be constantly stuck on fight/flight.

HPA will rev you up to be able to ‘battle a tiger’ then bring you down again when the tiger has gone but with FASD they are revved up to face the tiger and then have no way to come back down again……they also may not be facing a tiger but it could be the tiniest thing that revs them up and then the feedback loop doesn't work as it cannot bring them down again so they dysregulate and have toddler like responses.

These changes can lead to lifelong regulatory issues such as anxiety and depression. Without recognising this, what we are historically seeing are adults that haven’t been diagnosed with FASD that are then later diagnosed with ‘personality disorders’ when actually from experience if you dig deeper you will find they have had exposure to alcohol and actually many have FASD.

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Julie asked if this is where it is linked with epigenetics where there is now more research showing the FASD susceptibility can be passed down genetically from parents and grandparents, where put simply if a pregnant woman drinks alcohol in pregnancy and her birth mother also did there is a growing body of evidence that FASD is more likely in that unborn child. So therefore, a no drinking policy should apply for any pregnancies.

Cassie replied that with research it is evolving and we are learning that epigenetics is a factor, but that is more about a change in gene expression which is how it is passed down through generations.
For more reading on FASD epigenetics follow the link here

These adults that have had direct alcohol exposure in utero but it have not been diagnosed will often show itself as a personality disorder.

What we can do about the HPA axis issues are to create as regulating an environment as possible and then they build their own strategies and learn strategies as the endocrine system can't do it for them. They learn to recognise dysregulation in themselves it is not automatic.

For more reading on suggested brainstem soothers free resources please follow the link here

Julie stated that sometimes the fluctuation in hormones are spotted very early in those with FASD so the behaviours are often misdiagnosed or misinterpreted.

Many parents at this point gave direct examples of children in early puberty which is made reference to later in these notes.

Cassie agreed and said it is then labelled as 'bad behaviour'. If children/young people are stuck in fight/flight and HPA can't bring you down it can be described as behaviour issues, ODD (Oppositional Defiance Disorder) etc.

Julie stated this is a very common theme for families where extreme behaviours are seen, where professionals don't consider the damage of alcohol where often it is drugs that have been the focus.

Professionals need to understand the impact of alcohol when supporting children from adverse childhood experience…..support & consider it first….rule it out.
Parents are sent on parenting courses for these 'behaviours' when the focus should be the impact of alcohol. Looking through the lens of FASD should be considered where alternative therapies should be considered.

In Cassie's experience parents are then advised to intensely therapeutic parent which leads to parents feeling like a failure as it can't change organic brain damage, it can help and has a place but expectations must be different.

For more reading on the HPA Axis find this really interesting paper on FASD, Stress & Mental Health

For a short YouTube video on HPA click the link here

For more support on FASD Strategies join us on our FASD strategies workshops or FASD training online, more details from www.fasdinformed.co.uk

OR join us for our April ‘Ask the Expert’, exclusive booking details by following the link here

2. With the hormones in free fall, dysregulation, lack of executive functioning and temptations on all sides how do we let them grow safely when boundaries are blatantly disregarded given any freedom?

Sadly, this is very common especially with teenagers and there is no magic answer as it is a spectrum. The difficulty you have is young people with FASD need more supervision but they lack any insight to their vulnerability so professionals, parents and children can really struggle.

Supervision is really the key and if you can find another safe person to do that supervision so they don't feel suffocated and not as restricted. Also finding a way they can do things in a structured environment so someone is there to monitor.

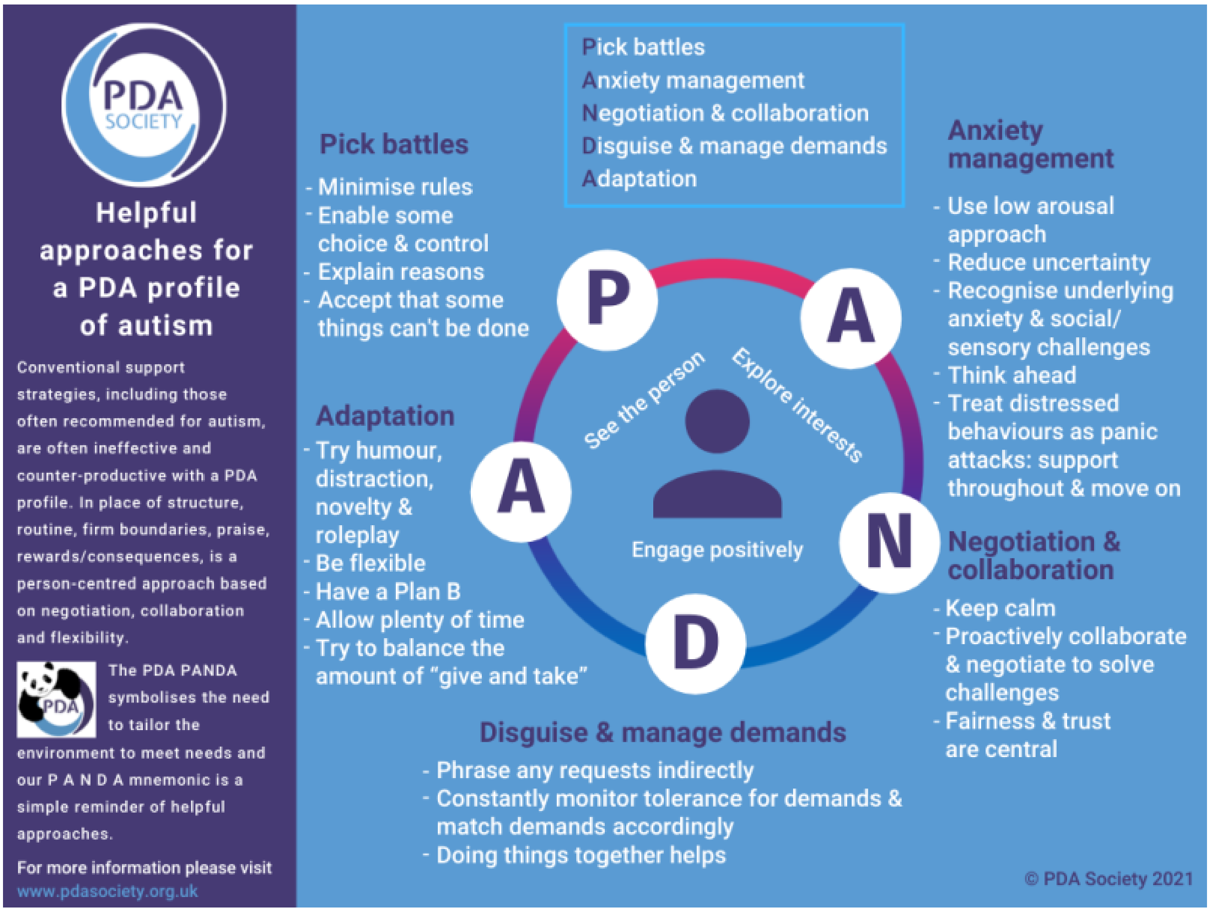
Julie added that finding an alternative safe person is really difficult for families where attachments are tricky and a network around the family has often fallen by the wayside.
We know that therapeutic parenting has its limitations and that any attempt to set boundaries is usually a trigger for dysregulation.

Cassie agreed it was realistically about juggling. She also added that PDA (Pathological Demand Avoidance) is not a standalone diagnosis within FASD but the strategies for PDA are really useful for children with FASD.

They avoid using direct confrontation which ups the anti in dysregulation, it can give the child a perceived choice and perceived element of control.

We will be running a session in our May ‘Ask the Expert’ looking at this out of the box PDA approach with Clinical Psychologist Dr Naomi Fisher where you can secure your ticket now by booking HERE for ‘Tuning into FASD Superpowers’ 21st May 1pm- 2pm

Strategies such as the 'closed choice', very simple language. When they hit teenager chronological years they are locked into a battle for control over their own lives when they are extremely vulnerable and have no insight.



PDA SOCIETY

Helpful approaches for a PDA profile of autism

Conventional support strategies, including those often recommended for autism, are often ineffective and counter-productive with a PDA profile. In place of structure, routine, firm boundaries, praise, rewards/consequences, is a person-centred approach based on negotiation, collaboration and flexibility.

The PDA PANDA symbolises the need to tailor the environment to meet needs and our P A N D A mnemonic is a simple reminder of helpful approaches.

For more information please visit www.pdasociety.org.uk

Pick battles
Anxiety management
Negotiation & collaboration
Disguise & manage demands
Adaptation

Pick battles

- Minimise rules
- Enable some choice & control
- Explain reasons
- Accept that some things can't be done

Anxiety management

- Use low arousal approach
- Reduce uncertainty
- Recognise underlying anxiety & social/ sensory challenges
- Think ahead
- Treat distressed behaviours as panic attacks: support throughout & move on

Adaptation

- Try humour, distraction, novelty & roleplay
- Be flexible
- Have a Plan B
- Allow plenty of time
- Try to balance the amount of "give and take"

Negotiation & collaboration

- Keep calm
- Proactively collaborate & negotiate to solve challenges
- Fairness & trust are central

Disguise & manage demands

- Phrase any requests indirectly
- Constantly monitor tolerance for demands & match demands accordingly
- Doing things together helps

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Infograph by kind permission of the PDA Society

Remember children, young people and adults are developmentally trapped in a chronically older body so tricky for people who are not trained to tune into these needs.

Cassie is not saying that all children with FASD are also PDA but the strategies for PDA can be useful for our children.

She also agreed that finding the right person is incredibly difficult and what is available is different in each area, in an ideal world you would use a 'youth mentor'.

Julie added that finding the right person could be a friend or a neighbour, someone to bounce off of and to develop your own in-house strategies for example they use a code word they text when things are tricky. It is a real balance between boundary setting and triggering.

Cassie reminded us that parenting a child with FASD there is no 1 strategy that will always work forever, as the child will evolve and change, the key thing is to remember to alter your expectations.

Remember to think ‘why is the behaviour like this’ and think on a brain level, remember it is not personal…… it’s the HPA, pre frontal cortex stuff mentioned previously.

It is about accepting that this is the way it is and that is why these parent groups are so valuable and vital to talk it all through with each other. Helping each other is the best way forwards because you get each others worst day without prejudice & without any judgement.

3. Our son has extensively researched and trialled cannabinoids as his drug of choice for his anxiety and concentration and is adamant, having prolonged discussion with his psychiatrist, that in small doses it helps better than his prescribed meds. Has this been reported by other teenagers?

This is something I have worked with a lot and it is something that I hear about people essentially self-medicating, usually when they aren't taking their ADHD meds.

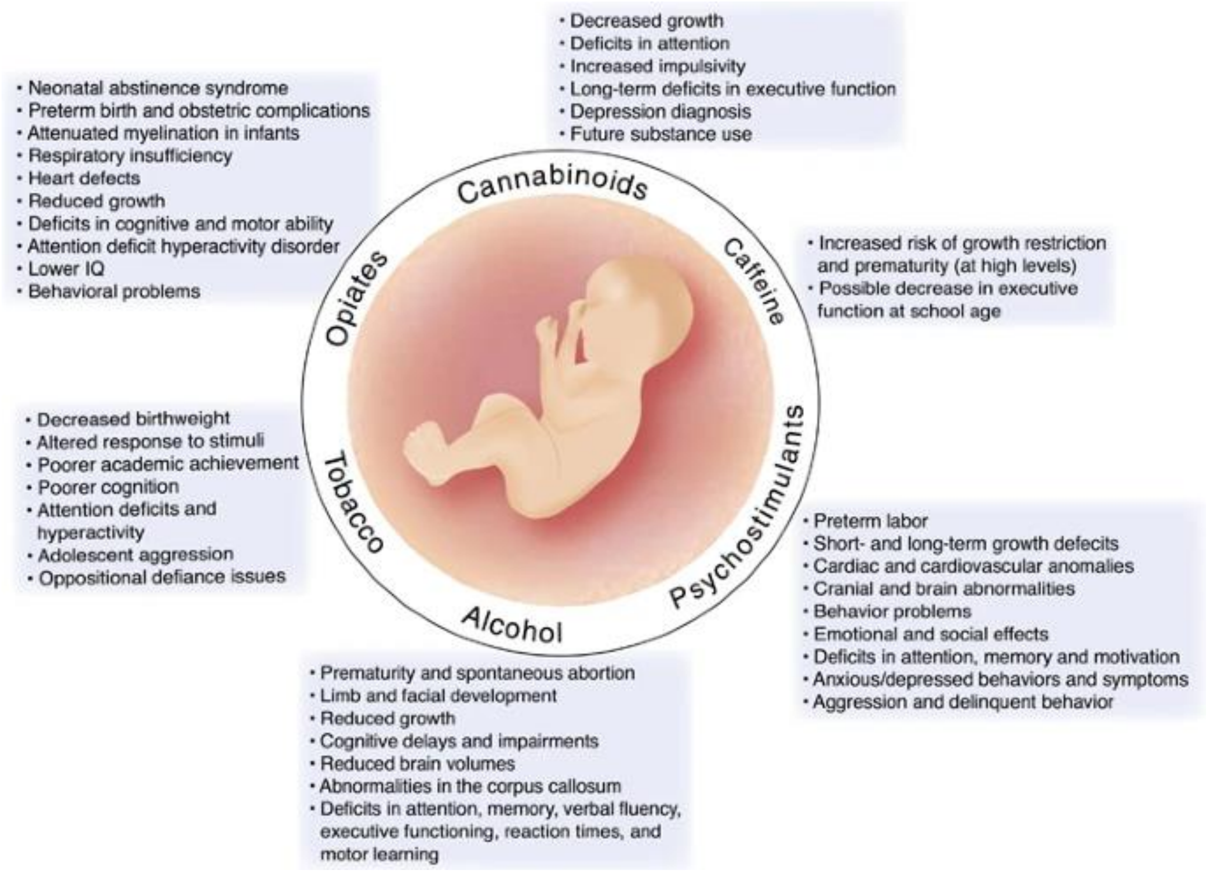
Not sure if in this question it is cannabis or a derivative, but a lot of people are saying it is helping both with cannabis and CBD; but I do not necessarily advocate for this.

It does make sense in the moment that it would help calm them but it has a knock on effect, reduced motivation and removes the sense of doing anything at all.

Julie asked if this is linked to people with FASD being predisposed to more addictive behaviours due to the fact the baby is made with drugs and alcohol being the tetragon/ prenatal substance abuse.

Cassie replied that research shows there is an increase in risk of addiction with thoise with alcohol exposure in-utero, this is to do with dopamine levels and the endocrine system, it is a danger and as we know starting cannabis doesn't always end with cannabis.

It is more important to get the right ADHD meds to negate the need for self-medicating with cannabis. If the young person is constantly craving or needing something then an ADHD drugs review is advised.



Cocaine is the double whammy regarding brain damage.
Overlap in presentation is difficult to unpick what causes what presentation.

Other drugs can have an effect but not as great as that of cocaine – knowledge of the drugs and their different forms and the likely impact enables clinician to understand likely impact

For more reading on FASD & drugs click link here

4. Could you explain what a neuropsychological assessment is and what age/stage do you recommend having it done?

The neuropsychological assessment is the most important part of the diagnosis of FASD. It is also useful at certain parts of childhood transition to understand what support they need at that stage.

It is an in-depth diagnostic tool and differs to an educational psychology report as that focuses on strengths and weaknesses, whereas a neuropsychological assessment links the

strengths and weaknesses and says why they are there and what support they need to achieve.
It doesn't just look at general intelligence it will look at adaptive ability, executive functioning and suggestibility.

Sign 156 & NICE Guidelines for FASD (the diagnostic standard used for FASD) uses 10 neurocognitive areas and to be diagnosed with FASD you have to have significant deficits in at least 3 of these areas. You then need to have a genetic microarray to rule out anything genetic, it is unlikely but has to be ruled out and the reason for that is genetics trumps all symptoms.

Diagnosis is much easier after age 6/7 years onwards as you need to separate out all brain domains and look at executive functioning, below 6/7years children don't have good executive functioning skills anyway, it is best at age 8 onwards
You can diagnose earlier especially if they have very obvious facial features or really obvious deficits.

It is important to have a neuropsychological assessment at transitional ages, so before high school, year 6 and again at 16/17 approaching adulthood, especially important for children in care approaching independent living. If needs change rapidly then tis could be considered again at other developmental stages.

Julie asked if, knowing the challenges in the SEND system, it was important to move the assessment forward as everything takes longer and then the planning meeting can be held in time.

Cassie replied saying, absolutely the neuropsychological assessment plays a key part in the transition plan but everyone who knows the child best are important too.

The assessment will look at for example ….are they able to learn with repetition how to make appointments, can they cook, can they dress, can they clean themselves, can they learn to manage finances, can they learn and retain that information.

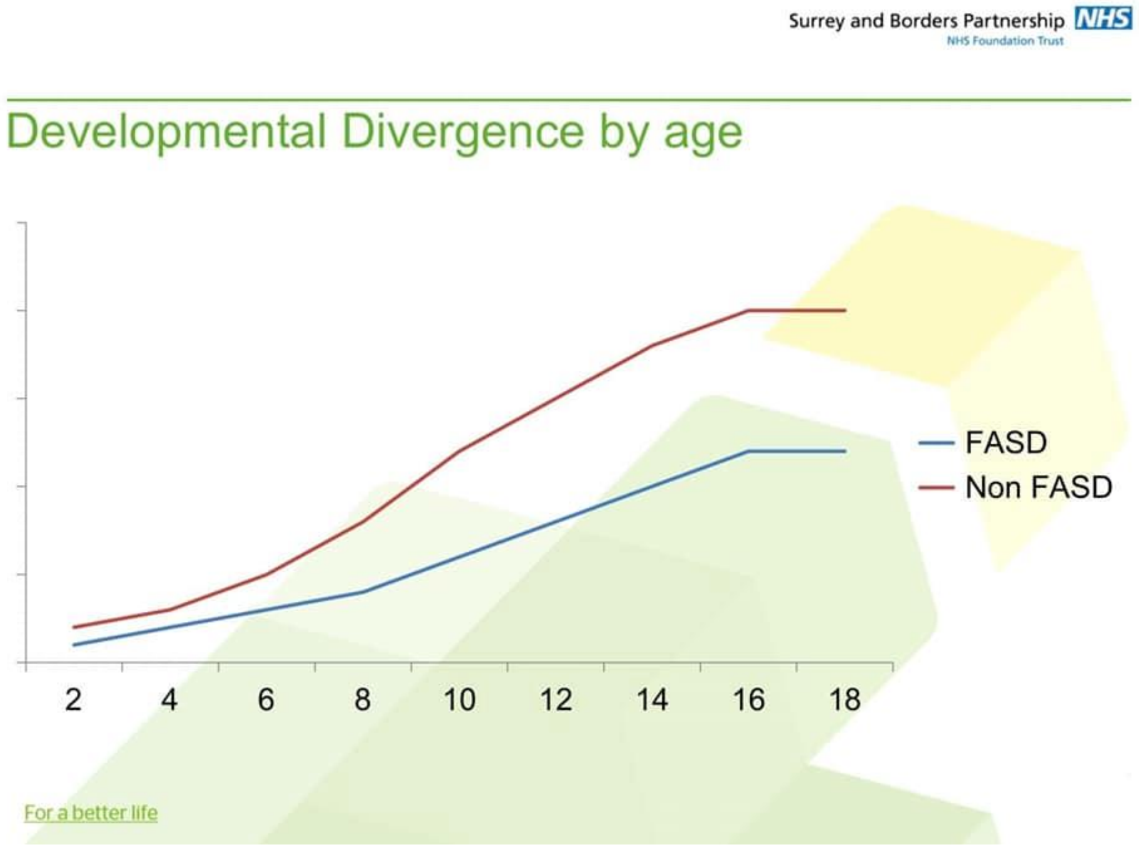
Julie asked if you can repeat this assessment when planning ahead for the next stage?

Cassie replied yes absolutely. Some tests you wouldn't repeat within a year due to practice effect but they tend to be different tests at those age stages as the actual tests will be age appropriate. Cassie does these tests and details will be sent out with the minutes.

Julie added it is important to redo the tests to see any differences and to identify any new emerging needs or regression.

Following a parent chat question around Neuropsychological Assessments: Cassie added she also does ADHD & Autism assessments.

Children with alcohol exposure develop on a different trajectory, the gap between a child with FASD and their neurotypical peers will widen with age, they are progressing but not as quick.



Data FASD Divergence graph with kind permission of the Surrey & Borders partnership NHS

Between 11 and 16 the IQ score can go down, they aren't losing skills in a dementia type way but the expectations are bigger, the numbers can change over the course of childhood so it is good to keep a track.

Julie stated she would send out a mapping link with an average guide, it is an average guide and therefore is not set for every child they are still individuals and FASD is a spectrum.

Cassie added it is more about the adaptive behaviour gap and the capacity of the child to live independently as you would expect for a child at that age, have they got social skills, can they look after themselves, it is not IQ based it is predicting adaptive behaviour which is linked to executive functioning. It is important to always separate IQ and function.

5. Why does autism show itself differently in FASD?

When Autism goes with FASD it looks different. With ASD (Autism Spectrum Disorder or ASC as it is now called Autism Spectrum Condition) there is a triad of deficits and sensory processing on top.

Language and communication, social skills and repetitive and restrictive behaviours. With FASD they are pro social instead of too little they are too much, too rough, can't read social cues, they are still impaired but it looks different, they tend to have more sensory based behaviours.

It's like ASD with empathy for example. That is why it is worth looking for a genetic component as there is a known genetic component with ASD but FASD is a brain injury, social cognition in the frontal cortex so it's not a surprise it looks different.

Julie added that professionals can miss this if they are not looking through and FASD lens first. FASD should be recognised as the primary diagnosis.

Cassie agreed and said if they don't look at FASD they may say the child has 'ASD traits' but won't diagnose ASD itself.

You could waste years being on an ASD pathway for it to be overlooked as it shows differently in those with FASD.

6. My daughter has both FASD and Autism. How do I know this is correct?

Answered above

7. Could you explain why some professionals might misinterpret sexual interest in those with FASD, how can this be supported?

Examples of 'sexual interest': there seems to be a pattern of children with alcohol exposure or diagnosed FASD being labelled with having 'sexually harmful behaviour'

Examples:

- *the child is found in School encouraging others to have sex*
- *child takes an interest in porn where it soon becomes all they can do as they hyperfocus on it*
- *child masturbates repetitively and just chats about it as if discussing a hobby or does it openly*

Wearing my child protection / expert witness hat I hear this so many times and it results in the child not allowed in the same toilets, followed around and there is a huge over reaction when sex may not be the motivation.

Young children can have sexualised behaviour and this should be ‘normalised’ and safeguarded if appropriate.

With FASD it is really important to be very careful of language as it can be huge and doesn't necessarily need to be.

With an interest in porn and masturbation it is more of an ASD trait with the repetitive and restrictive behaviours it becomes a compulsion. Management for this would be redirection and distraction.

The book, A5 is against the Law around social boundaries a Compassionate but Honest Guide for Teens and Young Adults by Kari Dunn Buron…..
is really useful in these as it can help grade the severity ie this behaviour is a 1 and this isn't, approach it in a really behavioural way but with no shame, ‘we do that here but not there’.
It helps young people grade what is ok and what isn’t.

Porn is really difficult to restrict access to especially when they have smartphones, it's the understanding that it isn't real and we can't expect our partners to do that just because we saw it on porn hub etc.

Parent restrictions can be used on internet but very often young people are very IT savy so this is worth monitoring.

It is a lot of communication and repetition about what is ok and what is real and what isn't’. Keep it behavioural and don't go into the abstract as it is harder for them to understand.

Julie added it would be the same as with any hyperfocus where you redirect the focus onto something else.

Cassie agreed but added that it is really hard to find a direct correlation to masturbation to find something else to do instead but this is probably a sensory need but again keep the talk behavioural.

Julie added that when children/young people are supported in school it is really important for professionals to get specialist advice as the wrong label can stay with a child for life which could prejudice their future. A neuropsychological assessment would support this specialist need well which is a highly specialised area due to the complexity of FASD.

Cassie stated that children / young people are not deviants and harmful if the behaviour is not coming from that place, which is why it is essential to be careful about the language used.

Julie added this is why it is so important to have a multidisciplinary assessment and/or neuropsychological assessment as the clinician will give clarity on that point and it shows that it is a vulnerability that needs to be understood by professionals supporting that child where reasonable adjustments would be made.

It is hard to get rid of ‘a label’ once it hits and EHCP but if a parent find this label in a report and then the neuropsychological assessment is then completed, the caseworker should then amend the new report to reflect this need with much more detail around recommendations to support and understand ‘normalised behaviours’.

The clinician would examine those ‘labelled’ reports which can be interrogated and can supersede the EHCP, it is so important as there is so much shame surrounding it and it sticks not just for the person but for the parent.

Cassie agreed and said the scale in the neuropsychological assessment shows the level of susceptibility and vulnerability of the child. Most important for professions to always refer to advise rather than jumping to conclusions.

Further reading on sexualised behaviours can be found by clicking the link here

8. Could you expand on how children and young people might be more vulnerable to physical victimisation?

This is huge for FASD because it comes from:
- Difficulties on reading the room
- Not understanding others motivation and that it may not be a healthy motivation
- Impulsivity and not understanding consequences
- A desperate need to want to make friends
- Unable to learn from past mistakes
- Motivated to please and liked and desperate for positive recognition, all of this makes for a very vulnerable person

The key is SUPERVISION and having a strong team around them that is seeing the child regularly.

Julie added it is important to capture this point in an EHCP as it is often missed but there is a specific safeguarding need to include it.

Cassie said if they are ever in trouble with the law the Gudjonsson Suggestibility Scale can demonstrate how likely children/young people/adults with alcohol exposure are to change their responses with pressure.

That alongside their tendency to embellish stories or to forget what they have said makes for very poor story tellers. This is important for the police to know and understand when they are asking questions.

Julie mention the **FASD Guidebook for Police Officers linked here** &

'I am a vulnerable young person' ID card free download here all resources available on the FASD South West & FASD Friends website *(best downloaded on a PC not a phone due to lots of documents stored on the site where a phone will struggle to view)*

Julie explained that we will jump to question 11 now and that all of the missed questions have already been covered.

9. Transition planning from Primary to Secondary, Secondary to College or supported internships etc …..when should this ideally start? What should it include?

10. I have a question relating to cortisol. Following a recent blood test, my sons cortisol levels were low, which resulted in him having a short synacthen test, which I am pleased to say came back OK, with no further investigations needed. So, I wonder if FASD can affect the brain, messaging the pituitary glands to produce cortisol.
Also, can persistent high levels of cortisol when living in adverse conditions, especially domestic violence, and the constant living in "fight/flight" mode affect cortisol levels?

11. Also, we know about FASD children having growth deficiencies, but can it also work the other way? My son presents 2 years ahead of his age in growth, so at 12 years, he has the body of a 14-year-old.

Some professionals might think that children with FASD are all born small when this is not always the case; FASD is a spectrum.

People expect growth factors with smaller babies but it is not necessarily the case and some are super tall or larger framed.

Cassie explains that the pituitary and adrenal glands are affected and that will impact puberty when it starts. Some studies say it will start earlier and some later although this is more likely to start earlier in girls but it is really variable. Lots of studies show effects but it can be either way.

There is a narrow range of specific effects that can be used as a diagnostic tool as effects are so variable for example having eyesight problems is more likely in children with FASD but not in all cases, some can have hearing problems but not in all cases so they cant be used as a diagnostic tool. It is not always the case and are related to individual cases.

Julie asked if the baby is born small will that trend continue throughout life?

Cassie said yes if they are born small the growth issue will continue.

Julie stated so if the curve stays throughout life then professionals need to understand that as some parents are accused of not feeding their children enough for example.

Cassie said it is a small proportion but not insignificant that they can be on the high percentile too, everyone should keep an open mind, such as the old view that *'if you don't have the facial features you can't have FASD'*, this is not correct as less than 10% do…..you need to keep an open mind with growth effects too.

Julie stated…so if they are not small at birth they can still have FASD, it is a spectrum.

Cassie said we need to get away from the 'textbook list of symptoms' keep a pragmatic view.

Julie added to move away from 'blaming parents' and the prejudice that goes with it.

12. Please could I ask if any research has been done into serotonin and dopamine levels in the FASD brain. I'm convinced my son has low serotonin and high dopamine levels.

This has links to the HPA axis that we have covered earlier. Dopamine is linked with the higher reward and increased addiction also some studies have shown low serotonin so it is not inaccurate to make that assumption. This can lead into the sensory seeking behaviours we see.

13. We’re looking at semi-independent living / residential college options for our almost 18 year old. Despite a neuro psychological assessment in October 2021, when she almost 15 (with good evidence of need) professionals continue to take what she says she can do at face value. In our view this places her at risk, in their opinion they’re listening to voice of the child. Could I add that we know her views need to be listened to but balanced with what we know she can or in fact really wants?

This has been answered by previous questions. There is a need for a neuropsychological assessment and details will be shared in the minutes.

14. ‘How do you decide whether to choose a mainstream provision and push for 121 and a high degree of scaffolding, or settle for a less than suitable specialist setting?
Child is academically able but struggles with emotional regulation. We have an ehcp which is being tightened up.

It is really difficult to navigate this question as the SEND system is not straight forwards where every child is different, it should be about finding the best fit for that child when there is often no best fit. Its about balance.

Many children thrive in a bespoke arrangement through EOTAS or ‘alternative provision’, others need Specialist Support or work well at home supported by alternative provision.

The Timpson review of School Exclusion says….
"Commissioning alternative provision: The best AP offers some of the greatest expertise of working with children with challenging behaviour and additional needs, and is used not as a last resort but a ‘first resort’ – offering advice, outreach and short-term placements that help children get back on track and help divert them from the pathway to exclusion" pg 74

I see so many children struggling in School where they literally are having trauma responses to keep safe or mask to blend in. It is exhausting for these children where they are not learning effectively because all of their energy is going elsewhere. Often these children come home into their ‘safe space’ and explode as their sensory needs have not been met in School. Often education professionals who are not trained to tune in will not spot signs of tapping or ticking, holding their anxiety in or masking responses including freeze in school. They may ‘perform’ in School and be really hard to support at home because home is ‘safe’.

Beacon House have provided a great paper to support Schools where they describe well the brainstem response of ‘blending in’: linked here

If the child is academically able and are supported into specialist provisions where their emotional needs will be met but they won't be pushed academically or they will go to an SEMH provision where some don't have the understanding of FASD and only look through a trauma lens not FASD.

Some have great motivation but don't understand that trauma and FASD need to be supported differently.

If you talk to Schools about this and suggest they have some training in FASD….see what their reaction is to this and it may give you an idea if it is the right placement.

There are mainstream schools with a nurture unit within which can be a useful half way house where they can access mainstream for part of the day and then get some regulation for the rest of the day through alternative provision in a more regulating environment but children should not be kept separated from others and should have a good mix of experiences.

EOTAS & Alternative Provision work very well in this case where other things may have been tried. A balance of needs should to be looked at where there is much educational discussion on how beneficial alternative provision is for children Previously Looked After (PLAC) or Adverse Childhood Experiences (ACE), and those with special needs.

All have challenges. Most children with FASD are in mainstream schools but that is not because they necessarily should be, you need to see how motivated the School is to provide the high level of support needed.

This is harder in secondary school as there is more than 1 teacher to talk to and have a good understanding. An EHCP is essential to support this need, which is why a neuropsychological assessment can help this transition point to put in reasonable adjustments.

The Neuropsychological assessment will help highlight if the child is able to organise themselves, get themselves dressed for PE, what they will do at lunchtimes etc they will be assessed for what they can manage and check their level of adaptability or vulnerability etc.

Julie added this is especially difficult if the child has already been failed by mainstream over and over again where there is a pattern of failure where a specialist provision is then needed. Often EOTAS is supported to act as a scaffold towards a more bespoke provision.

Cassie stated finding the right provision is also down to what is available in your area as provisions vary.

A mix of alternative provisions are perfect!

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Julie asked so an opportunity to do forest school, equine therapy or a EOTAS package works for FASD?

Cassie replied yes, they are really regulating environments and children/young people do really well, great at regulating emotional aspects and adding bits into support mainstream provisions for example forest school instead of French.

Julie said…for example if their hyperfocus is drama they can swap that in.

Cassie said exactly and that is part of the encouraging strengths, find that child's niche, some are really creative, some really into sports, that physical aspect is really regulating and practical tasks really suit others. Nurture those skills, find something they are good at and tell them they are good at it.

It also helps them to meet other peers where they don't feel so different which is why the groups meetups are so important.

Also having that scaffolding in place, in the EHCP outcomes it often says and after 6 months of having the scaffolding they will have achieved everything and it will all be ok and lets remove it. It needs to be there to help that child reach their potential and then keep it level.

Cassie said…. SEMH schools do not often work well for those with FASD or those Schools that use a behavioural based approach, the reason for this is that well referenced in the paper that defines behavioural approaches in FASD.
"Shaping behaviour within school is often performed using reward-based incentive models which carry a social and moral common ground to encourage desired positive behaviour. Reward and behavioural systems, intended as positive behavioural modelling, become problematic for those children (with FASD) who find it difficult to comprehend and maintain the expectations of emotional and behavioural regulation required within the classroom, leading to exclusions. *The personal meaning and emotion tied up in the motivation to achieve the reward evoke hot Executive functioning to navigate such challenges, processes such as inhibiting and regulating emotional responses. Challenges in hot executive function can lead to reward-based strategies being problematic in those with FASD, leading to high levels of frustration ; this is exacerbated when a co-occurrence of ODD, ADHD, and ASD characteristics are present.*

Further reading can be found following the linked medical paper 'Heated Behaviour in the Classroom for Children with FASD: The Relationship between

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Characteristics Associated with ADHD, ODD and ASD, Hot Executive Function and Classroom Based Reward Systems' Andrea Carrick and Colin J. Hamilton

It is important to remember as we often focus on the negative aspects of FASD, where children and young people have lots of skills and can all go on to have happy and fulfilling lives.

There was one of these sessions where a question came up saying ‘is there hope?’ And that really stuck with me, yes absolutely there is hope it is easy to focus on the tricky stuff as that is what we are here to discuss, especially when you are in the thick of it but yes absolutely there is hope and we hear great success stories all the time!

Finding the superpower…..

Julie added one of her son’s really loves stacking logs, he is really, really good at it and he feels really good about himself for being good something and that can lead to other things like being a forestry worker.
He celebrates the fact he is good at it with everyone he sees; he find now that he has an inner strength, a conversation starter and something to be proud of.

Another parent told us how their son found his superpower by listening to hospital radio where with his parent they went to have a look at how the music comes through the headphones. Together Mum found ways for him to experiment with sound, where he now has his own decks in his room, where he went to an ‘alternative provision’ that taught him how to mix music and how to convert it digitally…. where now he hosts a hospital radio show, is a DJ and is hosting a music sharing site where other digital musicians are using his site to host their sounds. He absolutely has found his superpower!

Cassie said these skills are not necessarily found within school, where often their skills are not academic and where you need to encourage a SENCO to then factor it in by using alternative provisions to find what these interests naturally are. The curriculum should be adapted if it is not working or where no strengths or interests have been found….. look for them in things outside of the box.

Cassie added that the spiky profile can work in the real world but you need to find the strength and think outside of the box to find it. This gives real hope for mental and physical wellbeing.

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Contact details for Dr Cassie Jackson’s clinic: http://www.pcea.co.uk/

Contact details for FASD training or support: https://www.fasdsouthwest.org/training

DATES FOR YOUR DIARY:

‘Strategies that Support FASD’: 29th April 8:15-9:15pm Dr Cassie Jackson & Director of FASD Julie Furney: Limited tickets available so **book now** for the next ‘Ask the Expert’ where we will expand on similar themes and dig deeper into supporting strategies for FASD, please send your questions to Julie at: info@fasdinformed.co.uk

‘Tuning into FASD Superpowers’: 21st May 1:00- 2:00pm *Clinical Psychologist Dr Naomi Fisher & Director of FASD Julie Furney will be running a session in our May ‘Ask the Expert’ looking at this ‘out of the box’ PDA approach where you can secure your ticket now by* ***booking HERE***
Please send your questions to Julie at: info@fasdinformed.co.uk

Dr Naomi Fisher is a Clinical Psychologist, author of many books to support neurodiversity including 'Changing our Minds' & 'A Different Way to Learn'. She has over 17 years clinical experience in the NHS, third sector and private practice where she specialises in trauma, autism and 'alternative education'.

Dr Naomi Fisher & the Director of FASD Julie Furney will chat to us about what they see in supporting many families with neurodevelopmental conditions linked to Fetal Alcohol Spectrum Disorder.

This is a unique opportunity to look at how we can hyperfocus on FASD strengths and dig deep into why an approach of 'what works .... works! '

Naomi is passionate about 'tuning into superpowers' where she discusses ways you can encourage, scaffold and expand on this.

She has much experience in the use of PDA strategies and the benefits of supporting the whole person by carefully waiting until the child or young person is ready. This approach has supported many children with complex needs read, write and find their strengths.

Ticket holders are encouraged to email in ahead of the evening to ask confidential questions that will be asked for you by Julie, where a wide range of topics will be discussed openly.

You won’t be disappointed as not only do we have a full evening planned in great company, but we take detailed notes and follow up with providing linked resources to every topic covered.