FETAL ALCOHOL SPECTRUM DISORDER DECISION GUIDE

Recognizing FASD in the Criminal Legal System



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GETTING STARTED

Improving recognition and understanding of fetal alcohol spectrum disorder (FASD) within the criminal legal system (CLS) can help professionals better respond to the needs of affected individuals.[1-4]

The **FASD Decision Guide (FASD-DG)** was developed to support providers in recognizing indicators consistent with possible FASD in the CLS, enhancing understanding of individual strengths and needs, and informing appropriate accommodations, supports, and referrals for further assessment. The FASD-DG is designed to help support decision-making in everyday practice and should **not** be used as a substitute for a comprehensive FASD assessment or diagnosis.

The FASD-DG includes 10 items across three domains:

01

Diagnostic Items

Prenatal alcohol exposure, Possible FASD

02

Neurodevelopmental and Mental Health Items

Attention and executive functioning, Adaptive and social functioning, School and learning challenges, Multiple mental health challenges, Complex challenges with substance use

03

Life Events/Historical Items

Alternative living arrangements, Child intervention services involvement, School difficulties and learning challenges, Patterned CLS involvement

IMPORTANT NOTE ABOUT SCREENING/RECOGNITION TOOLS

Decision-support tools are designed to provide a structured and efficient way to help recognize individuals who may have a particular health condition, in this case FASD.[4-6] Because these tools are brief and intended for use in routine practice, they are not perfectly accurate and carry some risk of error. The FASD-DG is intended to support professional judgment when considering whether a comprehensive FASD diagnostic assessment may be warranted, as well as to inform next steps and responses.

The FASD-DG is not a diagnostic instrument and does not replace a comprehensive FASD assessment. If the rating form indicates that FASD may be likely, a referral for a comprehensive FASD evaluation is recommended. Consulting with approrpiate experts may also assist in determining the most suitable referral pathway.

AT A GLANCE

- 10 items across 3 domains
- Takes approximately 10-15 minutes to complete
- The decision tool is free to access and use
- Helps to support professional judgement and decision making about FASD
- It is not a diagnostic instrument

ETHICS IN PRACTICE

No two people with FASD are exactly alike.

People will differ not only in their strengths and challenges, but also in their life histories, previous experiences with screening, level of comfort talking about FASD, and whether they wish to explore conversations about FASD.[8]

Talking about FASD can be deeply personal, even if it is part of a routine set of questions. Each person will react differently to learning they may have FASD. For example, some may feel positive and validated, while others may feel distress, and this news may impact their self-understanding and relationships with family members.[7,9]

FASD is a unique disability as it links the effects of PAE with the birth mother/parent. As such, individuals with FASD as well as their families can experience judgement and stigma.[10-12] When using the FASD-DG, it is important to consider whether the benefits of identifying possible FASD outweigh any potential risks.[7-9]

No recognition approach or tool is perfectly accurate, and there is always a possibility that conclusions may be incorrect. This can happen in different ways, including:

- A person who has FASD may not be identified, which could mean their needs go unrecognized and they remain undersupported.[8]
- Conversely, a person who does not have FASD may be identified as possibly having FASD, which could lead to stress, stigma, impacts on family relationships, or referral for diagnostic assessment and services when that may not be the best fit.[7,9]

CORE PRINCIPLES

- No two people with FASD are exactly alike.
- A clear consent process that respects the person's autonomy, dignity, and integrity.
- Consider whether the benefits of identifying possible FASD outweigh any potential risks.
- Participation in screening should be voluntary.
- Some individuals may need more time, rapport, or trust, or may wish to talk with a support person or family member.

CONSENT

As with all health-related practices, it is important to have a clear consent process that respects the person's autonomy, dignity, and integrity. During consent, the possible risks and benefits of completing the recognition tool should be discussed.

POSSIBLE BENEFITS INCLUDE:[9]

- Greater understanding of a person's strengths and support needs (for the individual and those working with them).
- Adjustments to communication, expectations, and daily practice to better suit needs.
- More appropriate referrals and improved access to relevant services and resources, including a FASD assessment.

POSSIBLE RISKS INCLUDE:[7-9]

- Incorrect identification of possible FASD.
- Unintended labelling or stigma.
- Stress, shame, or strain within family relationships.
- Possible legal implications in the CLS (e.g., influencing court decisions).

Clients, and where appropriate, their care providers and circles of care, can be involved in personal goal setting and should provide ongoing consent throughout the process. **Participation in screening should be voluntary**. If someone chooses not to take part in FASD recognition activities or prefers not to answer certain questions, this should be respected and approached with sensitivity and compassion. Some individuals may need more time, rapport, or trust, or may wish to talk with a support person or family member.

A NOTE ABOUT YOUTH

Conversations about FASD with youth, including during consent, should be tailored to their developmental stage and level of understanding. Adolescents are often focused on immediate, practical concerns, and how information may affect their daily lives. Using a compassionate, non-judgmental approach can help youth feel supported, as they may be particularly sensitive to possible stigma, self-identity, and peer perceptions. Depending on their age and circumstances, caregivers may also need to be involved in the conversation and decision-making process.



USING THE FASD-DG

WHO, WHERE, AND WHEN

The FASD-DG is designed to be flexible. It may be used to recognize those who may have FASD in the CLS in a variety of contexts and at any stage of the legal process.

WHO SHOULD USE IT

The FASD-DG was developed for use by service providers and professionals working with youth and adults involved in the CLS, including probation officers, correctional officers, police officers, judges, lawyers, social workers, forensic nurses, doctors, psychiatrists, and psychologists. It may also be useful for others working in agencies that support people involved in the CLS.

Prior to using the FASD-DG, service providers and professions should have some base knowledge about FASD (see FASD Toolkit) and be familiar with the information provided about how to use the guide. It is important that there is a clear plan for next steps, such as making referrals, connecting individuals with appropriate community resources, and providing feedback and support to the person and their circle of care.

WITH WHOM, WHERE, AND WHEN

The guide can be used during pre-sentencing, post-adjudication, or during incarceration/treatment, and across various settings, including correctional institutions, courts, forensic mental health programs, and community supervision (e.g., probation or parole).

Developmental and person-centred considerations are woven throughout elements of the FASD-DG, including within item definitions, rating guidance, and support tools, to promote respectful and appropriate use. The FASD-DG is best used alongside the accompanying FASD Awareness, Recognition, and Response Toolkit, including the FASD-Informed Planning Tool, to support implementation of FASD-informed responses following decision making.

Although best practices emphasize the importance of early recognition to ensure appropriate supports for individuals with FASD, identification at any age or stage can still contribute to improved outcomes.[4,13-14]

INFORMATION, TIME AND COST

WHAT INFORMATION IS NEEDED

The FASD-DG can be completed using multiple sources of information, including materials typically gathered during intake or brief assessment processes. Information may be drawn from:

- Interviews with the individual (see Interview Guide).
- Interviews with trusted contacts or members of the individual's circle of care (see Interview Guide).
- Review of available records (e.g., school records, prior assessments, child welfare records, CLS records, birth and/or medical records).

HOW LONG DOES IT TAKE

The time required to gather information will vary by individual, however, completing the FASD-DG itself is intended to be brief, typically taking approximately 10 to 15 minutes.

The accompanying Interview Guide can support information gathering in a person-centred and FASD-informed manner. It may be used to discuss FASD with the individual and, where appropriate, with trusted contacts or members of their circle of care, but use of the Interview Guide is not required to complete the FASD-DG.

COST AND PERMISSIONS

The FASD-DG is **free to use**. There is no financial cost, and permissions are not required for routine use. The guide should be used as designed and not modified.

Ongoing research and evaluation activities are examining how well the guide performs across different groups and settings. If you plan to adopt the FASD-DG, we encourage you to contact the research team so we can stay informed about implementation:

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When used in research, please use the following citation for the FASD-DG Manual and Tool:

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HOW TO USE THE FASD-DG

A five step process for informed decision making

THE FIVE STEPS

01

Step 1 - Seek informed consent

Begin by obtaining informed consent. This ensures that the individual understands the purpose of the FASD-DG, the potential risks and benefits, and how their information, including their results, will be used. Providers should follow all applicable laws, policies, regulations, and professional standards, which may vary by profession, setting, jurisdiction, and between youth and adults. Any limits to confidentiality or required disclosures should be explained. Address any questions or concerns and ensure the person feels comfortable before proceeding. Where appropriate, consider involving a support person to help ensure information is understood and the individual feels supported.

02

Step 2 - Gather information

Gather the information needed to rate each item. Sources may include interviews, routine intake procedures, and available records. Extensive investigation is required. Refer to item definitions and rating notes for guidance on what information is necessary.

03

Step 3 - Review and rate each item

Review the item aim, definition, and rating notes, then consider all available information when determining whether each item is present, absent, or unknown. While some professional judgement is required, following the definitions and notes will help promote consistency. If information is conflicting, use your best judgment. When there is insufficient information to rate an item, mark it as unknown. If three or more items are rated as unknown, the resulting recommendations may be unreliable and should be interpreted with caution.

Reminder: The FASD-DG can support decision-making and it is not a diagnostic instrument. Any uncertainties can be explored further through comprehensive assessment.

04

Step 4 - Make a decision

After rating all items, determine whether the guide indicates follow-up related to FASD. If any of the items are present for the client, this can help to inform next steps.

05

Step 5 - Plan next steps

Regardless of the guide's indication, use professional judgement to determine appropriate next steps. These may include referral for comprehensive FASD assessment, consultation with specialists, or adjustments to supports and services.

Many everyday practices can be adapted to better support individuals with brain-based differences, such as FASD, regardless of the guide's outcome. Before using the FASD-DG, review the overall process, including possible next steps,with the individual, and where appropriate, members of their circle of care. Ensure the individual knows that the results will be shared with them, that their perspectives are valued, and that planning will occur collaboratively.

WHAT TO DO AFTER USING THE FASD-DG

Discuss the recommendations

Regardless of the outcome, review the indications with the individual and explain what they mean. A positive indication does not confirm that a person has FASD, and a negative indication does not rule it out. Conversations may include:

- Reviewing and clarifying the findings.
- Discussing possible next steps (e.g., referral for FASD assessment or other evaluations).
- Identifying service or program options.
- Considering adjustments to planning or care.

Check-in about personal reactions

People may respond in different ways. Take the time to ask how the individual is feeling, listen actively and acknowledge their thoughts and emotions. Be prepared to offer FASD-informed supports and, where appropriate, referrals for the individual and members of their circle of care who may also be affected.

Plan next steps collaboratively

Engage the individual, and where appropriate, caregivers or care networks, in planning next steps. Understanding personal goals and priorities will help create a person-centred plan. While referral for a comprehensive FASD diagnostic assessment may appropriate in some cases, it may not be necessary or desired for everyone.

If the guide does not indicate follow-up for FASD, next steps may include:

- Referrals for other assessments (e.g., psychological, medical, occupational therapy) to clarify support needs.
- Referrals to services based on identified needs.
- Adjustments to practice or planning (e.g., accommodations, revise care goals; see Section 3 of Toolkit).
- Identifying and building on the individual's strengths.

If the guide indicates follow-up for FASD, next steps may include:

- Referral for a comprehensive FASD diagnostic assessment (click here for a list of FASD diagnostic clinics in Canada).
- Referrals for additional assessments (e.g., psychological, speech and language, behavioural).
- Referrals to FASD-informed supports, community organizations, and programs.
- Connection to peer-support opportunities (many do not require a formal FASD diagnosis).
- Implementation of FASD-informed practices (see Section 3 of Toolkit).
- Referrals based on identified needs (e.g., employment, housing, substance use, see FASD-informed planning tool).
- For youth, collaboration with schools for appropriate supports.
- Assistance with applications for disability benefits or other funding.
- Identifying and building on strengths.



ITEM DEFINITIONS, SCORING, AND RATIONALE

DIAGNOSTIC ITEMS

ITEM 1 · PRENATAL ALCOHOL EXPOSURE

ITEM 2 · POSSIBLE FASD

Item 1

PRENATAL ALCOHOL EXPOSURE

Aim and definition

Prenatal alcohol exposure (PAE) happens when alcohol is used at any time during pregnancy. This item looks for any signs that the individual may have been exposed to alcohol before birth, based on direct information or other indicators.

Rating notes

- You do not need to fully confirm PAE to rate this item. Detailed fact finding conversations are not required. More in-depth discussions about PAE are best handled by a specially trained member of an interdisciplinary diagnostic team.
- Gathering information about PAE can sometimes be difficult to obtain in CLS contexts. The FASD-DG can still indicate follow-up even if this item is rated unknown.

Scoring

Rate this item as present if there is evidence of **any** of the following:

- Alcohol exposure at any point during pregnancy.
- Information suggesting the birthing mother/parent had alcohol-related difficulties (e.g., alcohol use treatment or detox, diagnosis of alcohol use disorder, alcohol-health problems, or reports of alcohol use during the pregnancy).
- A biological sibling with FASD or confirmed prenatal alcohol exposure.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

FASD is diagnosed based on identifying the impacts of prenatal alcohol exposure on the brain and body development.[15-17] Research generally shows a 'dose-response' pattern, meaning higher exposure is often linked with greater developmental impact.[15,18-19] However, diagnostic guidelines differ on the exact level of exposure required for a diagnosis.[20-21]

Studies in CLS settings show that although confirming PAE can be difficult, many individuals ultimately diagnosed with FASD have confirmed exposure above risk levels.[22-29]

Because confirmation can be challenging, related indicators, such as alcohol-related difficulties in the birth parent (particularly during the individual's early childhood) or a biological sibling with FASD, can help signal possible exposure and are recognized by professionals as useful factors to consider in CLS contexts.[28,30-32]

Item 2

POSSIBLE FASD

Aim and definition

This item assesses whether there has been any prior suggestion that the individual may have FASD. "Possible FASD" refers to previous documentation of, or reference to, any FASD diagnosis (e.g., Fetal Alcohol Syndrome, partial Fetal Alcohol Syndrome, Alcohol Related Neurodevelopmental Disorder).

Rating notes

- Prior suggestion may appear in professional records (e.g., medical, psychological, child welfare, school, or legal records).
- The individual or someone in their circle of care may report that they were told they have, or may have, FASD. Formal confirmation is not needed to rate this item.
- If there is clear documentation that the individual has already completed an FASD assessment and received a diagnosis, the FASD-DG does not need to be completed. Refer to Section 3 of the toolkit for FASD-informed strategies (Note: re-assessment at later life stages can still be helpful in understanding current strengths and support needs).

Scoring

Rate this item as present if there is evidence of **any** of the following:

- Previous documentation indicating the individual may have FASD.
- The individual reports being told they may have FASD.
- A trusted contact or member of the circle of care reports they were told the individual may have FASD.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

People with FASD often go unrecognized, with high rates of missed and misdiagnosis, particularly in the CLS.[4,24-25,33] This may be due in part to lack of FASD awareness amongst legal professionals, stigma associated with the diagnosis, and restricted access to specialized FASD assessment resources.[34-40]

Many FASD-informed support programs do not require a confirmed diagnosis, meaning past service access alone does not confirm a diagnosis.[41] Additionally, diagnostic information obtained in childhood may not always be communicated across systems or during key life transitions.[42-43] In CLS settings, indicators of "suspected or documented FASD" are associated with a significantly increased likelihood of later receiving an FASD diagnosis.[28]

NEURODEVELOPMENTAL AND MENTAL HEALTH ITEMS

ITEM 3 · ADAPTIVE FUNCTIONING: SOCIAL AND PRACTICAL
ITEM 4 · ATTENTION & EXECUTIVE FUNCTIONING
ITEM 5 · COMPLEX CHALLENGES WITH SUBSTANCE USE
ITEM 6 · MULTIPLE MENTAL HEALTH CHALLENGES

Item 3

ADAPTIVE FUNCTIONING: SOCIAL AND PRACTICAL

Aim and definition

This item assesses whether the individual has experienced meaningful and persistent difficulties in adaptive functioning in social and/or practical domains. Adaptive functioning refers to everyday skills that can support interdependence and participation in the community. Adaptive functioning is often broken down into three domains, social, practical, and conceptual skills. This item focuses on the first two.

Social skills are used for communication and relationships, such as understanding social cues and navigating social interactions.

Practical skills are needed for personal and community independence, such as personal care (e.g., hygiene, dressing, eating), managing daily routines, completing household tasks, using transportation, managing money, and meeting school or work responsibilities.

Rating notes

- Information may come from self-report, direct observation of the individuals behaviours and capacities, trusted contacts or members of the individual's circle of care, and records including past psychological, psychoeducational, neuropsychological, or developmental disability assessments, which may be particularly helpful.
- Apply a developmental lens when rating this item. Consider what level of independence would reasonably be expected given the individual's age, life stage, and experiences (e.g., money management for adults, vs. school responsibility for adolescents).
- Difficulties in reading, writing, and math, are addressed in Item 9 (School difficulties and learning challenges) and are not rated here.

Scoring

Rate this item as present if there is evidence of **any** of the following:

- **Social skills -** challenges related to empathy, social judgement, interpersonal communication, making and maintaining relationships, and social vulnerability (including susceptibility to influence from others).
- **Practical skills -** struggles with personal care, school, or job responsibilities (e.g., managing time, projects, tasks, organizing work), money management (e.g., budgeting, paying bills), organization and/or independent living.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Individuals with FASD may experience support needs related to adaptive functioning and daily living.[18,44-45] These needs may change from adolescence through adulthood as expectations for independence increase.[45-46]

Adaptive functioning challenges in FASD are not always fully explained by overall intellectual functioning (IQ). Individuals with average or higher IQ scores may still experience significant difficulty with everyday functioning.[4,44-46]

In CLS contexts, adaptive challenges, such as deficits in social skills, poor judgement, limited self-help skills, problems understanding consequences, and challenges with independent living, have been shown to differentiate youth and adults with and without FASD.[32,45,49]

Item 4

ATTENTION & EXECUTIVE FUNCTIONING

Aim and definition

This item assesses whether the individual experiences difficulties with attention and/or executive functioning. Attention refers to the ability to focus, sustain focus, and ignore distractions (e.g., listening to instructions in a noisy room). Executive functioning refers to the higher-level thinking skills used to plan, solve problems, manage tasks, and regulate behaviour or emotions.

Rating notes

- Information may come from self-report, observation, trusted contacts, or available records. Past school, psychological, psycho-educational, or neuropsychological assessments may be helpful but are not required to rate this item.
- Evidence of Attention-Deficit Hyperactivity Disorder (ADHD) may be relevant. ADHD may be considered based on a documented diagnosis, credible self-report, or treatment history (e.g., prescribed ADHD medication).

Scoring

Rate this item as present there is there is evidence **any** of the following:

- Ongoing problems sustaining attention, high distractibility, diagnosis of ADHD or attention deficit disorder (ADD), or treatment for ADHD/ADD (e.g., prescribed medication).
- Difficulties with executive functioning, such as problems staying organized, getting started or finishing tasks, planning ahead, remembering information in the moment, adapting to change or shifting between tasks, accurately reading situational expectations, or regulating behaviour and emotions.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Individuals with FASD commonly experience challenges in executive functioning, including planning, problem solving, monitoring thought processes, impulsivity, and working memory.[18,50-51] Difficulties with attention can also be common, such as problems with concentration, and sustaining mental focus during visual or verbal/auditory tasks.[18, 52-53]

Many youth and adults with FASD also receive ADHD diagnoses, reflecting overlapping difficulties in attention, executive functioning, and self-regulation.[18,54]

In CLS settings, attention and executive functioning difficulties are reported at higher rates among individuals with FASD compared to those without FASD.[24-25,29,32,55-56]

Item 5

COMPLEX CHALLENGES WITH SUBSTANCE USE

Aim and definition

This item assesses whether the individual has experienced complex and sustained substance use challenges, beyond the common substance-use related difficulties often seen in CLS populations. "Complex" refers to a persistent and sustained pattern of problematic substance use, which may include early onset, multiple admissions to treatment or difficulty fully engaging or benefitting from treatment, significant harm related to substance use, a pattern of polysubstance use, or a diagnosis related to substance or alcohol use disorder.

Rating notes

- Information about substance use challenges may come from self report, trusted contacts or members of the individual's circle of care, or records (e.g., psychological assessments, pre-sentence reports, substance use treatment, medical records).
- A substance use disorder diagnosis can considered present based on either a documented diagnosis or credible self-report.

Scoring

Rate this item as present if there is evidence of **any** of the following:

- Early first age of substance use (i.e., before the age of 12).
- Multiple admissions to treatment, or difficulty fully engaging or benefitting from treatment.
- Significant harm resulting from substance use (e.g., multiple overdoses, injuries, ER visits, or other hospitalizations related to substance use).
- A pattern of polysubstance use.
- A diagnosis of substance use disorder or alcohol use disorder.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Prenatal alcohol exposure has been associated with elevated rates of substance use challenges later in life.[4,5,57-58] These difficulties are likely influenced by a combination of both biological and environmental factors.[57,59]

Although substance use challenges are common in CLS populations overall, certain patterns, such as early onset or co-occurring substance abuse disorder, greater difficulties benefitting from treatment, and experiencing more substance use related harms (e.g., overdoses or hospitalizations), may occur at higher rates among individuals with FASD.[26,49,60-62]

Item 6

MULTIPLE MENTAL HEALTH CHALLENGES

Aim and definition

This item assesses whether the individual has experienced two or more distinct mental health challenges or diagnoses across their lifetime. These may include (but are not limited to) anxiety disorders, oppositional defiant disorder, conduct disorder, post-traumatic stress disorder (PTSD), depression, suicidal ideation or attempts, self-harm, eating disorders, psychosis, schizophrenia, and bipolar disorder. Both past and current challenges are relevant.

Rating notes

- This item may be rated based on documented diagnoses, credible self-report, or clear descriptions of struggles in two or more areas of mental health functioning (e.g., anxiety and depression). Formal diagnoses are not required.
- Information may come from observation, reports from trusted contacts, or records (e.g., medical, school, psychological, or CLS documentation).
- If the symptoms are part of the same mental health condition (for example, worry and panic within anxiety), count them as one challenge.
- Do not count ADHD/ADD or substance/alcohol use disorder here (see Items 4 and 5).
- Do not include additional neurodevelopmental disorders here (i.e., intellectual disability, autism spectrum disorder, specific learning disorders, motor disorders, communication disorders, or tic disorders).

Scoring

Rate this item as present if there is evidence of **any** of the following:

- Two or more mental health diagnoses (past or current).
- Two or more distinct areas of mental health difficulty (with or without formal diagnosis).

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Mental health challenges are common among people with FASD, with high rates of co-occurring diagnoses across the lifespan.[54,63-65] Common concerns include depression, anxiety, conduct disorder, oppositional defiant disorder, and suicidality.[57,63,65] Mental health needs may change across developmental stages, highlighting the importance of ongoing supports.[65]

In CLS contexts, youth and adults with FASD (or possible FASD) may be more likely to have co-occuring mental health diagnoses compared to those without FASD.[27,29] Studies consistently show high rates of one or more mental health challenges among in CLS-involved individuals with FASD.[11,26,66]

HISTORICAL/LIFE EVENT ITEMS

ITEM 7 · ALTERNATIVE LIVING ARRANGEMENTS
ITEM 8 · CHILD INTERVENTION SERVICES
ITEM 9 · SCHOOL DIFFICULTIES & LEARNING CHALLENGES
ITEM 10 · PATTERNED CRIMINAL LEGAL INVOLVEMENT

Item 7

ALTERNATIVE LIVING ARRANGEMENTS

Aim and definition

This item assesses whether the individual is living or has lived with caregivers other than their biological parent(s) for an extended period during childhood or adolescence (up to age 18). Alternative living arrangements is defined broadly to include any carer other than biological parent(s), such as adoptive parent(s), kinship care, extended family or relatives, foster care or a group home, or periods of unstable housing situations (e.g., unhoused, couch surfing). The focus is on extended living, not short-term or occasional stays.

Rating notes

- Information may come from self-report, observation, trusted contacts, or available records.
- Short stays (e.g., a few days of respite) do not meet criteria. Living with another caregiver for several months would be included.
- In some cultural communities, living with extended family or informal adoption arrangements may be customary and stable. If the arrangement reflects typical cultural practice and does not represent disruption or instability, use professional judgment when rating this item.
- This item may be counted even if the arrangement resulted from child intervention services. It may also overlap with Item 8 if both criteria are met.
- Extensive investigation is not required. Discussions about alternative care arrangements can be sensitive and are often better explored in depth by a trained member of an interdisciplinary diagnostic team.

Scoring

Rate this item as present if there is evidence of the following:

- The individual is currently in, or previously experienced, an extended alternative living arrangement during childhood or adolescence (i.e., living for a sustained period with caregivers other than biological parent(s), including adoptive parent(s), kinship care, relatives, foster care, group homes, or unstable housing situations).

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Care disruptions and alternative living placements are common among youth with FASD though not always linked with child intervention services.[58,67] Children may live with grandparents, extended family, or adoptive caregivers for many reasons, including parental illness, death, housing instability, or mental health challenges.[64,68-70] For instance, a study found that a screening item related to history of adoption was endorsed more often by incarcerated women with FASD versus those without FASD.[32] Legal professionals have also identified having multiple caregivers or disruptions in caregiving as an important indicator that someone could have FASD.[71]

Item 8

CHILD INTERVENTION SERVICES

Aim and definition

This item assesses whether the individual is currently involved with or had contact with the child intervention services before they were 18. This may occur because of stressors in the family or caregiving environment, or because behavioural or legal concerns prompted child intervention involvement.

Child intervention services are also commonly referred to as child protection services or the child welfare system. Involvement can include multiple visits by child intervention workers, investigations or protection orders, removal from the home, placement in foster care or group homes, or other forms of supervision or support.

Rating notes

- Information may come from self-report, observation, trusted contacts, or documentation/records (e.g., child welfare, school records).
- Extensive investigation is not required. Because involvement with child intervention services can be a sensitive topic, more detailed conversations are often better carried out by a trained member of an interdisciplinary diagnostic team.

Scoring

Rate this item as present if there is evidence of the following:

- The individual is currently involved with, or has been previously involved with, child intervention services (e.g., multiple reports to child intervention services, investigations, or placement in foster care).

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Children with FASD are overrepresented in child intervention service settings. In Canada estimates suggest that 3-11% of children in care may have FASD, compared with about 4-5% in the general population.[72-73] This overrepresentation may partly reflect the challenges associated with FASD, which can increase stress for families, while also intersecting with systemic racism, trauma, and the broader impacts of colonialism and systemic inequities in Canada.[74-77]

In CLS settings, youth and adults with FASD may be more likely to have had involvement with child intervention services than those without FASD.[32-49] Studies have identified foster care placement, particularly multiple placements, as a common experience for people with FASD compared to those without FASD.[29, 56] Legal professionals working in CLS contexts similarly identify involvement with child intervention services as an important screening indicator for FASD.[78]

Item 9

SCHOOL DIFFICULTIES & LEARNING CHALLENGES

Aim and definition

This item assesses whether the individual has experienced difficulties in school due to behavioural or learning challenges.

Behavioural challenges at school may include disruptions in the classroom, multiple suspensions or expulsions, or leaving early and not completing school.

Learning challenges may include a history of receiving learning supports at school, poor academic performance, or a diagnosed learning disability in a specific area such as reading, writing, or math.

Rating notes

- Information may come from self-report, trusted contacts (e.g., parent or teacher report), or records from school or psycho-educational assessment reports.
- Formal academic testing results may also be used, but are not required to rate this item.

Scoring

Rate this item as present if there is evidence of **any** of the following:

- Behavioural challenges in school, such as disruptions in the classroom, multiple suspensions or expulsions, or leaving school early and not completing school.
- Learning challenges in school, such as a history of learning supports, poor academic performance, or a diagnosed learning disability in a specific area, such as reading, writing, or math.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

The neurodevelopmental difficulties associated with FASD can affect learning and engagement at school, and youth with FASD often experience school disruption, academic challenges, and a need for educational supports.[4,5,58,79-83]

In CLS settings, learning difficulties and problems in school are reported at higher rates among youth with FASD (or possible FASD) compare to those without FASD (or possible FASD), and these difficulties strongly differentiate those with and without FASD.[27,32,56] Studies also show that many CLS-involved indviduals with FASD have low educational attainment and challenges in academic subjects, and professionals identify school and learning difficulties as an important indicator when trying to identifying those who may have FASD.[28,45,78]

Item 10

PATTERNED CRIMINAL LEGAL INVOLVEMENT

Aim and definition

This item assesses whether the individual has experienced repeated or patterned CLS involvement. This may include difficulties following supervision orders (frequent breaches), repeating the same offence or offence pattern in ways that do not appear logical (e.g., breaking into the same home multiple times), or a long and varied history of CLS involvement (e.g., an extensive record or many placements in custody).

Rating notes

- Information may be drawn from self-report, observation, trusted contacts, or records.
- Although formal CLS records may be helpful, they are not required to rate this item.

Scoring

Rate this item as present if there is evidence of **any** of the following:

- A pattern of administration of justice charges, such as repeatedly breaching probation conditions or failing to comply with court orders.
- A pattern of repeated charges for the same offence, or offences showing limited planning and/or poor judgment (e.g., crimes where someone would be easily be caught, or repeatedly committing the same offence in the same way).
- Extensive CLS involvement, such as a long and varied criminal record (many different types of offences) or multiple placements in custody.

Decision rule

Present	If **any** indicators are present
Absent	If **none** are present
Unknown	If information is insufficient

EVIDENCE SNAPSHOT

Although research on offending patterns among people with FASD is still emerging, studies suggest that some CLS-involved individuals with FASD may experience more complex patterns of CLS involvement, including earlier first CLS-involvement, more convictions across the lifespan, greater challenges with supervision or custody, and higher rates of re-incarceration than those without FASD.[29,49,71,84-86]

CLS professionals and experts have identifed difficulty following supervision conditions, repeated similar offences, patterns of recidivism, and offences showing limited planning or poor judgment, as important indicators of possible FASD in legal settings.[78] Broad factors such as systemic racism, health and social inequities, and the ongoing impacts of colonization may also influence patterns of CLS involvement for Indigenous and other racialized groups, and should be considered when interpreting these indicators.[87-91]

THE FASD-DG RATING FORM

The FASD-DG helps professionals recognize people in the criminal legal system who may have FASD to improve understanding and response. It is not a diagnostic tool. Referral to a diagnostic assessment is recommended where FASD may be indicated.

Please check whether each item is present, absent, or unknown based on scoring instructions. *Click on each item for additional information*

SECTION A. DIAGNOSTIC ITEMS

ITEM	SCORING: RATE AS PRESENT IF ANY CRITERION IS PRESENT	PRESENT	ABSENT	UNKNOWN
Prenatal alcohol exposure	• Alcohol exposure at any point during pregnancy. • Information suggesting the birth mother/parent had alcohol-related difficulties (e.g., alcohol use treatment or detox, diagnosis of alcohol use disorder, alcohol-health problems, or reports of alcohol use during the pregnancy). • A biological sibling with FASD or confirmed PAE.	☐	☐	☐
Possible FASD	• Previous documentation indicating possible FASD. • The individual reports being told they may have FASD. • A trusted contact or member of the circle of care reports they were told the individual may have FASD.	☐	☐	☐
	NUMBER OF ITEMS PRESENT IN THIS SECTION			☐

SECTION B. NEURODEVELOPMENTAL & MENTAL HEALTH ITEMS

ITEM	SCORING: RATE AS PRESENT IF ANY CRITERION IS PRESENT	PRESENT	ABSENT	UNKNOWN
Adaptive functioning	• **Social skills** - challenges related to empathy, social judgement, interpersonal communication, making and maintaining relationships, and social vulnerability (including susceptibility to influence from others). • **Practical skills** - struggles with personal care, school, or job responsibilities (e.g., managing time, projects, tasks, organizing work), money management (e.g., budgeting, paying bills), organization and/or independent living.	☐	☐	☐
Attention & executive functioning	• Ongoing problems sustaining attention, high distractibility, diagnosis of ADHD or attention deficit disorder (ADD), or treatment for ADHD/ADD (e.g., prescribed medication). • Difficulties with executive functioning, such as problems staying organized, getting started or finishing tasks, planning ahead, remembering information in the moment, adapting to change or shifting between tasks, accurately reading situational expectations, or regulating behaviour and emotions.	☐	☐	☐
Complex challenges with substance use	• Early first age of substance use (i.e., before the age of 12). • Multiple admissions to treatment or difficulty fully engaging or benefitting from treatment. • Significant harm resulting from substance use (e.g., multiple overdoses, injuries, ER visits, or other hospitalizations related to substance use) • A pattern of polysubstance use. • A diagnosis of substance use disorder or alcohol use disorder.	☐	☐	☐
Multiple mental health challenges	• Two or more mental health diagnoses (past or current). • Two or more distinct areas of mental health difficulty (with or without formal diagnosis).	☐	☐	☐
	NUMBER OF ITEMS PRESENT IN THIS SECTION			☐

SECTION C. HISTORICAL / LIFE EVENT ITEMS

ITEM		PRESENT	ABSENT	UNKNOWN
Alternative living arrangement	• The individual is currently in, or previously experienced, an extended alternative living arrangement during childhood or adolescence (i.e., living for a sustained period with caregivers other than biological parent(s), including adoptive parent(s), kinship care, relatives, foster care, group homes, or unstable housing situations.	☐	☐	☐
Child intervention services involvement	• The individual is currently involved with, or has been previously involved with, child intervention services (e.g., multiple reports to child intervention services, investigations, or placement in foster care).	☐	☐	☐
School difficulties and/or learning challenges	• Behavioural challenges in school, such as disruptions in the classroom, multiple suspensions or expulsions, or leaving school early and not completing school. • Learning challenges in school, such as a history of learning supports, poor academic performance, or a diagnosed learning disability such as in reading, writing, or math.	☐	☐	☐
Patterned criminal legal involvement	• A pattern of administration of justice charges, such as repeatedly breaching probation conditions or failing to comply with court orders. • A pattern of repeated charges for the same offence, or offences showing limited planning, poor judgment (e.g., crimes where someone would be easily be caught, or repeatedly committing the same offence in the same way). • Extensive CLS involvement, such as a long and varied criminal record (many different types of offences) or multiple placements in custody.	☐	☐	☐
	NUMBER OF ITEMS PRESENT IN THIS SECTION			☐

FASD may be indicated if either of the following criteria are met:

- [ ] 1 Diagnostic item (section A) AND 1 Neurodevelopment and Mental Health Item (section B);
- [ ] 3 Neurodevelopmental and Mental Health Items (Section B) AND 1 Historical/Life Event Item (Section C)

For more information on next steps click here.

Note: If information is unknown for three or more items, it is likely that decisions made using the FASD-DG would not be reliable.

DECISION

- [ ] FASD follow-up indicated
- [ ] FASD follow-up not indicated
- [ ] Results unreliable (3+ unknown items)

Next Steps

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