Chapter 2 Summary of Actionable Statements



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2.1 Actionable Statements Format

For clarity and consistency, the framework proposed by Lotfi et al. (2022) was adapted to develop and present the actionable statements (i.e., recommendations) in these guidelines.

Based on the systematic review of lived experiences of the assessment and diagnostic process (Hayes et al., 2023; <u>Lived Experiences of the Assessment and Diagnostic Process: Systematic Review and</u> <u>Qualitative Synthesis Report</u>), a novel statement category was introduced: 'lived experience statements.'

Each type of statement is colour-coded in the document, corresponding with the <u>Indigenous</u> <u>Framework</u> artwork. Figure 1 provides an overview of different types of actionable statements. More details are available in the <u>Administrative and Technical Report</u>.

GRADE-based Recommendations	Lived Experience Statements
 Evidence-based Based on systematic review and meta- analysis. Direct and clear links to research evidence. Includes formal ratings of certainty of the evidence. 	 Based on a systematic review and qualitative synthesis of lived experiences of the assessment and diagnostic process. Provide guidance for practitioners from the point of view of people with lived experience.
Good Practice Statements	Implementation Considerations, Tools, and Tips

Figure 1. Summary of actionable statement types included in the guidelines.

2.2 Defining GRADE-based Recommendations.

Two different types of GRADE-based recommendations are included in this document:

→ Strong recommendations

A strong recommendation implies that most or all individuals will be best served by the recommended course of action.

These recommendations are phased as:

"The Australian FASD Guidelines Development Group recommends."

\rightarrow Conditional recommendations

A conditional recommendation implies that not all individuals will be best served from the recommended course of action. Individual circumstances, preferences, and values need to be more carefully considered by practitioners. This is likely to require practitioners to allocate more time to shared decision-making, ensuring they clearly and comprehensively explain the potential benefits and harms to individuals, families, or support people.

These recommendations are phased as:

"The Australian FASD Guidelines Development Group suggests."

Important note from the GRADE Handbook: "Clinicians, patients, third-party payers, institutional review committees, other stakeholders, or the courts should never view recommendations as dictates. Even strong recommendations based on high-quality evidence will not apply to all circumstances and all patients."

2.2.1 Evidence synthesis and evidence-to-decision framework domains that contributed to the strength of a recommendation.

Chapter 11, Appendix B of the <u>Main Guidelines document</u>, the <u>Administrative and Technical Report</u>, the <u>Association Between Prenatal Alcohol Exposure</u>, <u>Physical Size</u>, <u>Dysmorphology and</u> <u>Neurodevelopment Systematic Review Report</u>, supplemental files, and the peer reviewed publication (Akison, Hayes et al. 2024) provide detailed information regarding the evidence review process and findings.

Figure 2 offers a visual overview of the evidence synthesis process underpinning the GRADE-based recommendations. Figure 3 provides a visual overview of the domains that contributed to the strength of a recommendation through the individual evidence-to-decision frameworks for each of the candidate diagnostic features and the overarching evidence-to-decision framework for the diagnostic criteria.



Exposure/Insult	Candidate Diagnostic Features
Studies examining prenatal alcohol exposure (PAE)	Studies examining all features included in current FASD diagnostic criteria and other possible features

Determine association between causative insult and each candidate diagnostic feature	
Exposure/Insult	Candidate Diagnostic Features
Light PAE	Physical size
Moderate PAE	Dysmorphology
Heavy PAE	Functional Neurodevelopment
Very Heavy PAE	Structural Neurodevelopment
Unquantifiable PAE	Neurological



Figure 2. Evidence synthesis process underpinning the GRADE-based recommendations.



GRADE-Informed, Evidence-Based Recommendations for Diagnostic Criteria



2.3 Overview of Actionable Statements (Recommendations)

GRADE-based Recommendation 1	The Australian FASD Guidelines Development Group suggests the following key diagnostic considerations:
Conditional	 evidence of prenatal alcohol exposure above a low risk level for diagnosis of FASD at any time during gestation. Or, in the absence of a confirmed history of PAE following exclusion of other causes, the presence of three sentinel facial features (short palpebral fissures, thin upper lip and smooth philtrum) presence of pervasive and clinically significant neurodevelopmental impairments the neurodevelopmental impairments result in functional impacts that necessitate significant supports across multiple areas the onset of neurodevelopmental impairments is evident during the developmental period an individual's presentation is not better attributed to another condition or exposure any of the relevant diagnostic specifiers are applied (i.e., physical size, head circumference and/or facial features) (Variable Certainty).
GRADE-based Recommendation 2 Conditional	The Australian FASD Guidelines Development Group suggests that birthweight, corrected for gestational age, according to the appropriate age- and sex-specific charts, be considered in the diagnosis of FASD and to account for individual variability it has been listed as a diagnostic specifier (Low to Moderate Certainty).
GRADE-based Recommendation 3 Conditional	The Australian FASD Guidelines Development Group suggests that birth length, corrected for gestational age, according to the appropriate age- and sex-specific charts, be considered in the diagnosis of FASD and to account for individual variability it has been listed as a diagnostic specifier (Very Low to Low Certainty).
GRADE-based Recommendation 4 Conditional	The Australian FASD Guidelines Development Group suggests that postnatal child weight, according to the appropriate age- and sex- specific charts, be considered in the diagnosis of FASD and to account for individual variability it has been listed as a diagnostic specifier (Very Low to Low Certainty).
GRADE-based Recommendation 5	The Australian FASD Guidelines Development Group suggests that postnatal height, according to the appropriate age- and sex-specific charts, be considered in the diagnosis of FASD and to account for

Conditional individual variability it has been listed as a diagnostic specifier (Very Low to Low Certainty).

GRADE-based The Australian FASD Guidelines Development Group suggests that **Recommendation 6** philtrum smoothness, vermilion thinness, and palpebral fissure length be considered in the diagnosis of FASD and to account for Conditional individual variability it has been listed as a diagnostic specifier (Very Low to Low Certainty).

GRADE-based Recommendation 7

Strong

GRADE-based

Conditional

GRADE-based

10

11a

Strong

Recommendation

The Australian FASD Guidelines Development recommends against including other congenital anomalies in the diagnostic criteria for FASD (Low to Low Certainty).

The Australian FASD Guidelines Development Group suggests that **Recommendation 8** head circumference, corrected for gestational age according to the appropriate age- and sex-specific charts, be considered in the diagnosis of FASD and to account for individual variability it has been listed as a diagnostic specifier (Very Low to Low Certainty).

GRADE-based The Australian FASD Guidelines Development Group recommends **Recommendation 9** against including structural brain abnormalities observed on clinical imaging in the diagnostic criteria for FASD (Very Low Certainty). Strong

> The Australian FASD Guidelines Development Group recommends against including neurological conditions of hearing and vision impairments, seizures, and cerebral palsy in the diagnostic criteria for FASD (Very Low to Low Certainty).

GRADE-based The Australian FASD Guidelines Development Group suggests that Recommendation neurodevelopmental outcomes of communication, motor skills, intellectual abilities, attention, memory, executive function, emotional and/or behavioural regulation, literacy and/or numeracy, Conditional and adaptive/social functioning, be considered in the diagnosis of FASD (Very Low to Low Certainty).

GRADE-based Recommendation 11b Strong

The Australian FASD Guidelines Development Group recommends against including neurodevelopmental outcomes of social cognition, social communication/pragmatics, motor speech impairments, speech-sound impairments, and sensory processing in the diagnostic criteria for FASD (Very Low to Low Certainty).

Lived ExperienceListen to, and take seriously, concerns raised by parents/caregiversStatement 1about their child's development and behaviour in the context of
prenatal alcohol exposure (Moderate to High Certainty).

Lived Experience Provide or refer for assessment if a parent/caregiver is concerned **Statement 2** about their child's development in the context of prenatal alcohol exposure (Moderate to High Certainty).

Lived Experience To reduce barriers experienced by individuals and families, Statement 3 To reduce barriers experienced by individuals and families, assessment can be provided across a range of settings. This includes, but is not limited to, specialist FASD services, child development services, adolescent and adult private and public health services, primary care, mental health, disability, justice, and child protection services (Moderate Certainty).

Lived ExperienceProvide non-judgemental and non-stigmatising support thatStatement 4acknowledges and respects the individuals', and their
parent/caregivers,' experiences and concerns (Moderate Certainty).

Lived ExperienceUnderstand that receiving a diagnosis can bring about mixedStatement 5emotions. Plan feedback and recommendations with this in mind
(High Certainty).

Lived Experience Assessment results help understand behaviour. When communicating outcomes, provide specific information and examples clearly linking assessment results to observed or reported challenges in daily functioning to support understanding and insight (High Certainty).

Lived ExperienceRecognise an individual's strengths and challenges to identify theStatement 7most appropriate supports to facilitate positive outcomes post-
assessment (High Certainty).

Lived ExperienceBe mindful that parents/caregivers and family members can have
concerns regarding their child's future diagnosis. Provide
recommendations to relevant local services that can provide
emotional supports (Moderate to High Certainty).

Lived ExperienceTailor feedback sessions and reports to individual and family needs,Statement 9including relevant social and cultural factors (High Certainty).

Lived ExperienceWhen writing reports, emphasise the individual's strengths and interests,Statement 10whilst also addressing areas needing support (High Certainty).

Lived Experience Statement 11

When writing reports, prioritise recommendations that are important for the individual/family, and limit recommendations to those that are practical and achievable in their household and community (High Certainty).

- Good PracticeIf there is information suggesting prenatal alcohol exposure above aStatement 1low risk level, including before pregnancy recognition, discuss
assessment options, and after obtaining informed consent, provide
assessment information or support access to assessment.
- Good PracticeIf there is information documenting clinically significant
neurodevelopmental impairments, distinctive facial features, and/or
confirmed or suspected prenatal alcohol exposure above a low risk
level, discuss assessment options, and after informed consent,
provide assessment information and support to access appropriate
assessment.
- Good PracticeSensitively and respectfully include discussions about alcohol use andStatement 3potential risks as part of routine antenatal and postnatal care.
- Good PracticeAsk about alcohol use as part of routine pregnancy history taking,
alongside other prenatal exposures and events (e.g., medications,
tobacco, illicit drugs, infections, diet, exercise, stress, and pregnancy
complications).
- Good PracticeTo support accurate assessment of risk, assess prenatal alcoholStatement 5exposure both before and after pregnancy recognition. Standardised
screening tools, such as the AUDIT-C, are recommended to assess
alcohol intake.
- Good PracticeExplain what a standard drink of alcohol is before asking about
alcohol use, and consider using a standard drinks guide to help obtain
accurate information on intake (e.g., see the NHMRC Alcohol
Guidelines). Where appropriate, practitioners can also gather
information on intake and later convert the amount consumed to
standard drinks.
- Good PracticeBe mindful there are many factors that may have influenced alcoholStatement 7use during pregnancy, and it is important to collect information in a
supportive, compassionate, and non-judgemental way.

Good PracticeRecognise that individuals might face ongoing challenges with alcoholStatement 8or other complex issues and provide appropriate support and
referrals.

Good PracticeContact biological parents directly, if possible and appropriate, to
assess prenatal alcohol exposure. Otherwise, carefully review other
sources of information (e.g., reliable observer reports, medical or
legal records). Note that a history of alcohol use without evidence of
consumption during pregnancy is not sufficient to confirm exposure.

Good Practice Consider that self-reports of prenatal alcohol exposure may be influenced by a range of factors. For example, the context in which information was collected (e.g., child protection settings), and the timing (e.g., during pregnancy, reported in antenatal records, or later in the child's life). Practitioners may wish to re-contact biological parents to check previously collected information.

Good PracticeSometimes there may be inconsistencies in the available information
about prenatal alcohol exposure. In instances where information is
collected directly from the pregnant individual during an assessment,
this information should be prioritised over other sources.
Practitioners can document inconsistencies in information and
indicate that re-assessment may be considered should additional
information arise.

Good PracticePractitioners should consider the appropriateness of all aspects of a
medical assessment for the individual and their family, and ideally
collaborate with individuals and families to make decisions about
what the assessment will involve.

Good PracticeWhen assessing facial features, the University of Washington (UW)Statement 13Lip-Philtrum Guide is recommended. Guide 1 (Caucasian) is
recommended for less full lips, and Guide 2 (African American) for
fuller lips.

Good PracticeWhen assessing facial features, the Strömland et al. (1999) palpebralStatement 14fissure norms are recommended. These norms are the best availablefor all Australians, and span birth to adulthood.

Good PracticeUse the University of Washington facial analysis software to measureStatement 15palpebral fissure length and/or take measurements by hand using a
small, clear plastic ruler, if facial analysis software is not available.

Good Practice Photographs and/or clinical measurements and analysis can be undertaken by practitioners with specific facial feature measurement training, and/or with instruction provided by experienced practitioners. Adequacy and interpretation of photographs needs to be considered in conjunction with an experienced medical practitioner.

Good PracticeExamine and document any dysmorphic features of the face and theStatement 17body, and record any major birth defects of the central nervous,
cardiac, renal, neurological, visual, auditory, and skeletal systems.

Good PracticeConsider other syndromes, genetic conditions, or teratogenicStatement 18disorders in which dysmorphic features and/or neurodevelopmental
impairment can also be present. If unsure, refer to a clinical geneticist
for review.

Good PracticeWith informed consent and assent, as clinically appropriate and inStatement 19line with local health service guidelines, request chromosome
microarray (CMA) and DNA test for fragile X syndrome (FXS). These
tests can be done using blood or buccal swabs. Refer to a local genetic
health service for guidance if abnormalities are reported.

Good PracticeMedical professionals should complete and request additional testsStatement 20as clinically indicated to identify and monitor current physical health
(e.g., cardiovascular-kidney-metabolic health), and exclude other
potential impacts on functioning, such as thyroid tests, vitamin B12,
iron studies and imaging.

Good PracticePhysical size can vary due to a wide range of demographic, maternal,
placental, and fetal factors. Identifying what is an atypical physical
size should be based on a combination of medical assessment and
consideration of individual risk factors, rather than relying exclusively
on growth charts.

Good PracticeThe WHO (2006) growth standards are recommended to assess birthStatement 22weight, length, and head circumference of full-term infants.Information may be available in hospital birth records or a baby's
personal health records (e.g., red, blue, or yellow books).

Good PracticeThe Fenton growth charts are recommended to assess birth weight,Statement 23length, and head circumference corrected for gestational age of
preterm infants. Information may be available in hospital birth
records or a baby's personal health records (e.g., red, blue, or yellow

books). Gestational age correction is completed until the baby is 24 months of age.

Good PracticeFor children up to 2 years of age, assess postnatal weight, height and
head circumference using the WHO (2006) growth standards. For
children over 2 years of age, follow local health service guidelines, as
there is some variation across states and territories. For example,
most jurisdictions use CDC growth charts. The Northern Territory has
adopted the WHO (2006) growth standards for all children.

Good PracticeWhen available, review an individual's overall trajectory of weight-Statement 25for-age, length/height-for-age and weight-for-length/height, or BMI-for-age (over 2 years), to assess how they are developing physically.

Good PracticeTake a holistic needs-based and family-centred approach toStatement 26Take a holistic needs-based and family-centred approach toassessment. This can involve considering strengths and challenges,
functioning, wellbeing, environment, culture, participation and
supports. Gather this information in ways that work best for the
individual and their family/support network.

Good PracticeCollaborative goal setting and talking/yarning with individuals and
their support network can help practitioners take a holistic approach
to assessment. This allows for gathering personalised information
about child and family strengths, interests, available resources, and
future hopes and plans for both the individual and family.

Good Practice Each person attending for assessment should have a plan tailored to their specific developmental needs. This plan should consider current concerns, developmental age, history, past assessments, and other source documents (e.g., available medical and school records), ability to engage in an assessment, assessment adaptations, including interpreters, and any other relevant cultural and social factors. Assessment should include hearing and vision tests if these have not been done before.

Good Practice There are no standardised tools specific for the diagnosis of FASD. Statement 29 Where appropriate, practitioners should use discipline specific standardised tools relevant to the neurodevelopmental domain being assessed. Practitioners need to apply their discipline specific knowledge, professional expertise, and clinical judgement to determine the most appropriate approaches for examining the individual within the context of the assessment. Allied health practitioners have specialist knowledge and skills to assess the neurodevelopmental domains. If unsure, practitioners should seek clinical supervision.

- Good PracticeDepending on a person's presentation, conducting assessment acrossStatement 30different timepoints can assist in determining whether challenges are
persistent. These assessments can happen in various places, including
primary health care, schools, and private practice, not just at
specialist services.
- Good Practice While it can be helpful to do a comprehensive assessment to understand developmental challenges, sometimes it may not be possible or appropriate. Practitioners should decide the neurodevelopmental domains to prioritise based on functioning, and how much assessment is necessary to determine whether there are clinically significant impairments, and whether they meet criteria for diagnosis.
- Good PracticeIt is important to consider the neurodevelopmental challenges in the
context of environmental factors. Interpreting assessment results
requires a holistic approach, including considering how valid
measures are for different groups of people, and the range of
prenatal and postnatal factors that can influence outcomes.
- Good Practice It is advantageous to assess neurodevelopmental domains Statement 33 concurrently. However, at practitioners' discretion, previous assessments may be used (e.g., in situations where impairment levels are unlikely to have changed, where there have been multiple previous assessments supporting the same results, or current assessment is unable to be completed due to significant behavioural challenges). The decision to retest an individual will depend on the context, referral question and the individual's needs.
- Good PracticeAssessment will naturally vary based on the availability of resources.Statement 34Where multi-disciplinary services are not available or cannot be
accessed, engagement with other services through a shared-care
approach is suggested to support accessibility to assessment and
diagnostic services.
- Good PracticeBring together information from the assessment to create anStatement 35individualised holistic profile. This should summarise the key
developmental factors. It is best if practitioners from different
disciplines review this information.

Good PracticePractitioners should consider, offer, and explain one or moreStatement 36diagnostic possibilities in their formulation, summarising what is
most likely, after considering what is less likely or unlikely, given the
individual's presenting concerns and assessment findings.

Good Practice Involve individuals and families in diagnostic decisions. Individuals **Statement 37** and families have the right to decide if diagnoses are appropriate for them, and the diagnostic terminology that is applied, given their personal, social, and cultural context and beliefs. Sometimes, challenges can arise balancing the rights of the individual and the rights of the parent/caregiver; actively engaging and supporting all parties throughout the assessment can help to overcome these challenges.

Good PracticeWith consent, provide developmentally appropriate feedback toStatement 38individuals attending for assessment, in coordination with
parents/caregivers and/or other support people.

Good PracticeRecognise that observed challenges might have multiple explanationsStatement 39and communicate this to individuals and families to enable effective
supports.

Good PracticeInclude individuals and families in the development of reportStatement 40recommendations, respecting their preferences and needs, given
their personal, social, and cultural context.

Implementation
Consideration,
Tool, and Tip 1Practitioners can integrate the International Classification of
Functioning, Disability, and Health (ICF) into their assessments. The
background history taking, and case formulation templates provided
in Appendix D of the main guidelines document include some of the
relevant ICF areas.

ImplementationPractitioners are encouraged to use shared decision making. SeeConsideration,Shared decision making: an overview of the main guidelinesTool, and Tip 2document for further general information.

'Finding your way' is a shared decision-making resource created with, and for, Aboriginal and Torres Strait Islander people through the NSW Agency for Clinical Innovation. Learn more about the model here: https://aci.health.nsw.gov.au/shared-decision-making, in the assessment process section of the main guidelines document, and in the <u>FASD Indigenous Framework</u>.

Implementation Culturally responsive care is different for every individual and family. Practitioners should not make assumptions about the type of care a Consideration, Tool, and Tip 3 person would prefer because they are Aboriginal, Torres Strait Islander, or culturally and linguistically diverse. "There are many Aboriginal families that are comfortable to use western biomedical systems and in fact, work really well and engage best that way. And then we have families that definitely do not, and they need more cultural supports and safety. It's all on a spectrum" (Aboriginal Health Practitioner). See the Australian Indigenous FASD Framework for detailed suggestions regarding how practitioners can reflect and adjust their practice to provide culturally responsive assessments. Implementation For individuals and families where English is a second/additional Consideration, language, it is a requirement of The National Safety and Quality Tool, and Tip 4 Health Service Standards that interpreting services are available where appropriate. https://www.safetyandquality.gov.au/standards/nsqhs-standards Implementation Assessment and diagnosis of FASD can be undertaken using the MBS Consideration, items for complex neurodevelopmental disorders, introduced 1 March 2023. For more details Tool, and Tip 5 see https://www.servicesaustralia.gov.au/medicare-items-for-complexneurodevelopmental-disorders-and-eligible-disabilities In line with the FASD Indigenous Framework, the informed consent Implementation Consideration, and assent process needs to provide information in a way that can be Tool, and Tip 6 meaningfully understood. It is also critical that the person and/or family feels comfortable and safe during this process. This requires respectful communication that is two-way and avoids using medical jargon. Two-way communication involves listening with genuine respect and interest to what another person shares, verbally and nonverbally, to increase understanding and share meaningfully. Two-way communication is an exchange where participants are equally valued. To support a culturally comfortable and safe environment, practitioners can incorporate information and visual resources to explain: what the referral and/or assessment is for what the assessment process generally involves

- what the potential outcomes and follow-up from the assessment may involve
- the potential benefits and risks.

Where appropriate, this may include the use of other languages, and support from an interpreter or cultural consultant. The informed consent process should be inclusive of appropriate family/support people (i.e., recognising everyone's unique kinship and familial system), with the goal of ensuring that all people involved have genuine control over decisions about their healthcare. This can only be achieved if the person and their family have been supported to make an informed choice about whether an assessment is something they want to undertake.

ImplementationDifferent approaches to informed consent and assent may be
required depending on the assessment context. For example, where
the referral question is about assessing the possibility of FASD,
informed consent and assent specific to FASD should be obtained at
the outset. In circumstances where information about PAE emerges
later in the assessment process (i.e., is not the basis of the referral),
obtaining additional informed consent and assent related to FASD
assessment is warranted.

Implementation
Consideration,
Tool, and Tip 8To support early identification of prenatal factors that can influence
developmental outcomes, information that could affect longer-term
health outcomes for children be transferred from the pregnancy
record to the child's health record. This information should be kept to
the minimum required to support the wellbeing of the child and no
personal or identifying information on the parents should be
included.

The Advisory Groups reported that transfer of information from the pregnancy record is occurring systematically in Western Australia, through the Midwives Notification System (Mutch et al., 2015)

<u>https://ww2.health.wa.gov.au/Articles/J_M/Midwives- Notification-System,</u> and in Victoria, where information from the Birthing Outcomes system is automatically copied from the maternal discharge to the newborn discharge.

During the guideline development process, a procedure was also established in Queensland to support the automatic transfer of a minimum amount of prenatal information through the integrated Electronic Medical Record.

Implementation Consideration, Tool, and Tip 9

Prenatal alcohol exposure can adversely impact people across all groups in our society. Members of the Advisory Groups noted that it is important for people to be aware that PAE is *"everyone's business and everyone's responsibility."*

Practitioners need to be mindful of bias in the referral and assessment process and be careful not to make assumptions about the likelihood of prenatal alcohol exposure or FASD based on an individual's sociodemographic features.

Members of the Living Experience Advisory Group described experiences where they were not asked about prenatal alcohol exposure due to practitioners assuming they *"knew not to drink"* based on their sociodemographic features.

Members of the Clinical Advisory Group reported concerns regarding inappropriate referrals for assessments that were based on an individual's sociodemographic background, rather than accurate information being collected about prenatal alcohol exposure.

Implementation
Consideration,
Tool, and Tip 10A practitioner resource in Appendix D of the main guidelines
document provides an overview of the Alcohol Use Disorders
Identification Test-Consumption (AUDIT-C) tool structured to collect
information on alcohol consumption pre- and post-pregnancy
recognition.

ImplementationSome states/territories have, or are establishing, electronic referral
systems (e.g., between primary and tertiary health services). These
systems are designed to provide practitioners with up-to-date
evidence-based assessment, management, and referral information
in an easy to access web format. Where these electronic referral
systems are available, information regarding FASD is sometimes
included (as reported by the Advisory Groups). Where available, we
suggest that information about FASD and local services can be
uploaded to Health Pathways or other available electronic referral
systems to support provision of information to primary health care
professionals and facilitate streamlined assessment processes.

Implementation
Consideration,
Tool, and Tip 12Challenges with gathering prenatal history for children in out-of-
home care were discussed as a major barrier to assessment across
Advisory Groups. To support collection of accurate prenatal alcohol
exposure information the following implementation considerations
are noted:

- Information about prenatal alcohol exposure should be documented alongside other relevant prenatal factors (e.g., other drug exposures, domestic violence, family medical history).
- As part of training resources for child protection staff, include information on how to collect and document information accurately on prenatal alcohol exposure, as well as local referral pathways.
- Prenatal alcohol exposure is not a reason for a child to be placed into out-of-home care. There can be many reasons why prenatal alcohol exposure occurs, including exposure that occurred before an individual knew they were pregnant, pre-existing alcohol use disorder or drinking to cope with domestic violence, or other traumatic circumstances. Pregnant individuals need to feel safe to discuss their concerns and to seek help for themselves and their children, without the fear of their children being removed.
- Information about assessment, diagnosis, and recommendations should be incorporated into a child's health management plan and this information be provided to foster and kinship carers.

Implementation
Consideration,
Tool, and Tip 13Challenges with collecting prenatal history were also noted in the
Advisory Groups for individuals involved with the justice system,
including collecting this information through court-ordered
assessments within restricted timeframes.

Notably, the United Nations Convention on the Rights of the Child (UNCRC) General Comment No. 24 states: "Children with developmental delays or neurodevelopmental disorders or disabilities (for example, autism spectrum disorder, fetal alcohol spectrum disorders, or acquired brain injuries) should not be in the child justice system at all, even if they have reached the minimum age of criminal responsibility. If not automatically excluded, such children should be individually assessed." While the UNCRC comment concerns children, this should also be considered in the context of adult justice.

It is also important to acknowledge that irrespective of age, and disability type, people with disabilities are proportionally overrepresented in the criminal justice system as offenders and victims, and often reach this status and experience greater negative consequences due to inherent structural biases within those systems and the underpinning frameworks (Baidawi et al., 2022).

To facilitate collection of accurate prenatal alcohol exposure information in these contexts, and the provision of appropriate supports, the following implementation considerations are noted:

	 Where appropriate, collect and document information about prenatal alcohol exposure alongside other relevant prenatal (e.g., other illicit substance exposure, domestic violence, family medical history) and postnatal factors, and use this to inform referrals to appropriate assessment providers. Provide information and training about accurate collection and documentation of prenatal alcohol exposure and local referral pathways to all professionals in legal and justice contexts. Where consent/assent is provided, information about plans for assessment, assessment/diagnostic outcomes, and support planning, should be documented on an individual's police and justice records to help inform approaches to support.
	Consider non-custodial therapeutic diversionary options where possible, including appropriate place-based culturally responsive programs for individuals identified with impairments and neurodevelopmental conditions, including FASD.
Implementation	More information about the University of Washington Lip-Philtrum
Consideration,	Guides is available from their website, including instructions
Tool, and Tip 14	regarding how to order the electronic versions: https://depts.washington.edu/fasdpn/htmls/lip-philtrum- guides.htm
Implementation	A palpebral fissure norm calculator can be accessed from the
Consideration,	University of Washington website:
Tool, and Tip 15	https://depts.washington.edu/fasdpn/htmls/diagnostic-tools.htm
Implementation	Appendix D of the main guidelines document provides an example
Consideration,	history taking template that includes prenatal, developmental,
Tool, and Tip 16	behavioural, functional, wellbeing and participation domains that could be adapted to suit different clinical contexts.
Implementation	Appendix D of the main guidelines document provides a holistic
Consideration,	profile and diagnostic formulation template that can be adapted to
Tool, and Tip 17	suit different clinical contexts.
Implementation	Appendix E of the main guidelines document provides information
Consideration,	regarding and example resources to support collaborative goal
Tool, and Tip 18	setting, which can be used to develop tailored recommendations.

