Building Bridges with Understanding :
Foetal Alcohol Spectrum Disorders (FASD) Project

The acquisition of Early Years Practitioner Knowledge in Relation to the Education and Support of Children with Foetal Alcohol Spectrum Disorders

Carolyn Blackburn, Research Assistant

ACKNOWLEDGEMENTS

I would like to thank all of the Worcestershire early years settings involved in this project, particularly those who gave up precious time to take part in an interview. I am grateful to the Worcestershire Practitioner Focus Group for ensuring that the project was grounded in current early years practice.

The project would not have been possible without funding from Worcestershire County Council (WCC). Alison Hitchins, Service Development Manager, Early Years and Childcare and Becky White, Inclusion Officer from WCC Early Years and Childcare Service (EYCS), have provided invaluable practical support and information without which the project could not have progressed to the satisfactory conclusion that it has.

Teresa Whitehurst, Research and Development Officer at Sunfield Research Institute, has been a constant source of inspiration and encouragement, as well as being an outstanding mentor to me personally throughout the project. Susan Fleisher, Executive Director of NOFAS-UK, has provided expert advice on the support and educational needs of children with Foetal Alcohol Spectrum Disorder (FASD). Sheila Robson, Occupational Therapy Assistant at Sunfield, assisted with interviews and provided encouragement and specialist knowledge about the sensory needs of children affected by FASD, and Jo Egerton, Research Fellow/Publications Manager at Sunfield Research Institute, has provided editing support.

I would also like to thank Barry Carpenter OBE, Professor of Early Childhood Intervention at the University of Worcester, who had the vision and foresight to instigate, with Alison, the commencement of the project, and whose enthusiastic encouragement always makes me believe in myself as a researcher.

INTRODUCTION

With an increasing number of children attending Early Years settings presenting unidentified and emerging Special Educational Needs (SEN), the opportunity and necessity for pre-school staff to provide support to vulnerable children and their families is immense. It is essential, therefore, that Early Years Practitioners have the confidence to identify and meet such needs, and that they are supported in these endeavours with information and resources aimed at improving outcomes for such children, through directed Early Childhood Intervention and adaptive teaching techniques.

Some of the children that practitioners encounter will present with a unique set of needs and behaviours that will leave many practitioners bewildered and challenged as to how best support the child. Children affected by Foetal Alcohol Spectrum Disorders (FASD) present a new and growing Early Childhood Intervention opportunity for the care and education system at a local, national and international level. Presently in the UK, little is known about FASD and how to educate children affected, particularly in their Early Years. This is a matter of concern as "early childhood is a time of vital importance in children's development" (DfES 2004) when significant improvements in outcomes can be achieved with appropriate interventions to the extent that there is "..unequivocal evidence that the declines in intellectual development that occur in the absence of systematic early intervention, can be substantially reduced by interventions implemented and evaluated during the first 5 years of life" (Guralnick 2004).

Foetal Alcohol Spectrum Disorders (FASD) is a broad spectrum of completely preventable intellectual and developmental deficits in individuals, resulting from maternal alcohol consumption during pregnancy. Alcohol is a teratogenic compound (ie a substance which interferes with the normal development of the embryo or foetus) that readily crosses the placenta. In the absence of a developed blood filtration system, the foetus is totally unprotected from alcohol circulating in the blood system (BMA 2007).

This prenatal exposure to alcohol results in clusters of physical and neurodevelopmental **primary disabilities** which are unique to each individual, and are largely a result of dosage and timing of alcohol exposure. The foetus is vulnerable to alcohol exposure throughout the

pregnancy and the impact of alcohol on the foetus will vary according to factors such as maternal physiology and general state of health, maternal hormonal cycle and genetic make-up.

These primary disabilities include **physical disabilities** such as major organ damage as well as hearing and vision impairments, and **neurodevelopmental disabilities** such as learning difficulties, poor language skills, memory impairment, attention deficits, poor consequential thinking, sensory impairments, poor planning ability, poor social skills and motor skills impairment.

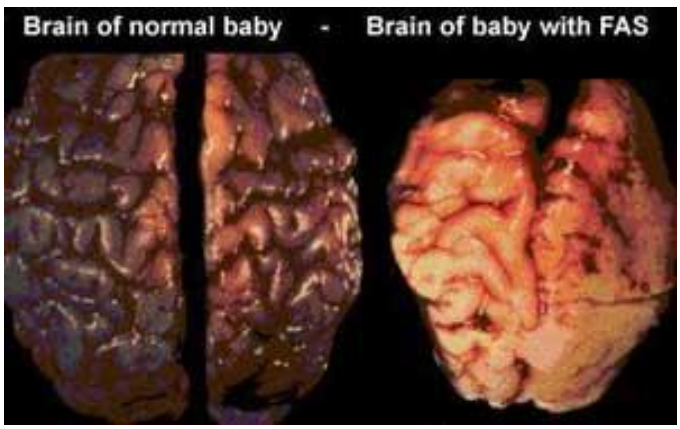


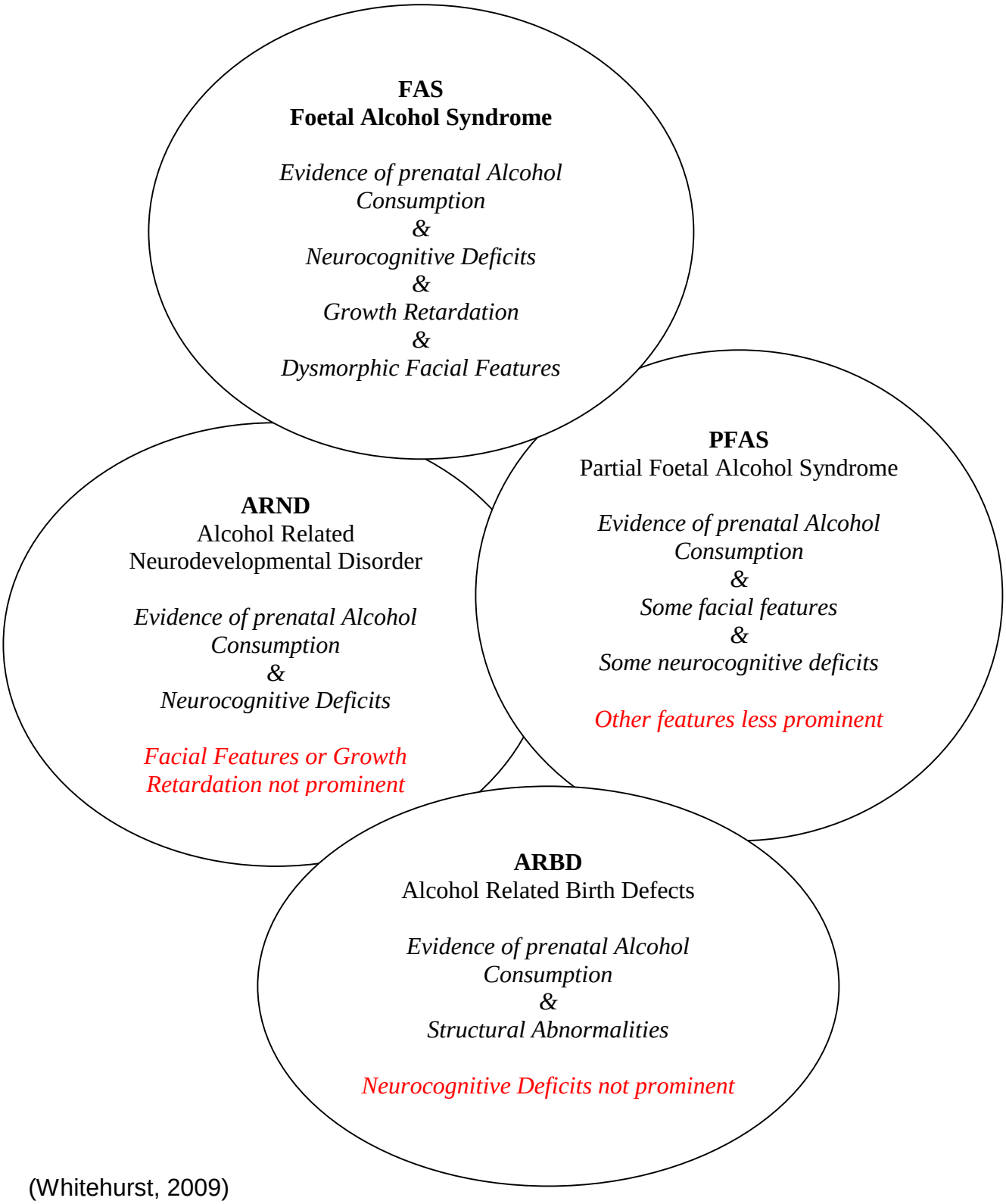
Photo: Sterling Clarren, MD

Comparison of the Brain of a baby with FAS with the Brain of a Normal Baby

Children with FASD will not grow out of their disability, it is not curable. Indeed undetected primary disabilities can in time, manifest as **secondary disabilities** or behaviours. These secondary behaviours have implications across all areas of society. Disrupted schooling, rising numbers in prison population groups, children in care placements, the homeless, inappropriate sexual behaviour, those with mental health problems, those experiencing problematic alcohol and other drug use are all possible indicators of undetected FASD.

The term FASD was coined in 2003 to reduce the confusion from the range of diagnostic terms in use at the time in relation to prenatal exposure to alcohol. FASD is an educational term rather than a diagnosis. Included in the Spectrum, however, is the diagnostic term Fetal Alcohol Syndrome (FAS) and other conditions such as Alcohol Related Brain Injury (ARBI); Alcohol Related Neurodevelopmental Disorder (ARND); Alcohol Related Birth Defects (ARBD). The diagram overleaf outlines the different perspectives of FASD.

Differentiating the presentation of FASD

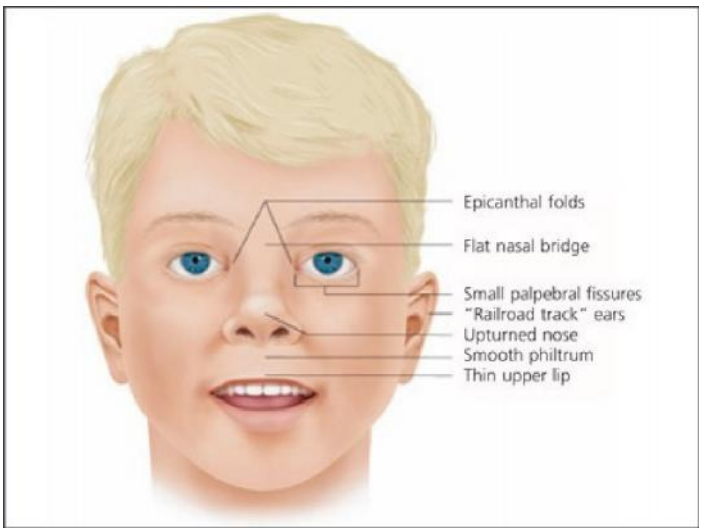


(Whitehurst, 2009)

Fetal Alcohol Syndrome is more recognisable than other conditions in the spectrum, and therefore more easily diagnosed, due to the constellation of three hallmark features of the condition that are specified for a diagnosis of FAS: central nervous system damage, growth deficiencies and facial anomalies with confirmed maternal alcohol use. However, it is not necessarily the severe end of the spectrum in terms of life outcomes.

The facial anomalies which are a distinctive hallmark of FAS include a flattened midface; a smooth philtrum (crease above lip and below nose) and a thin upper lip. Small eye openings are common with wider spacing than normal between the eyes.

The facial dysmorphology which typically makes the Syndrome noticeable in the post birth period and infancy can dissipate with age thus minimising the opportunity for a diagnosis if not detected in early life (Greenbaum *et al* 2002).



Facial features of a Child with a Full Diagnosis (FAS)

FASD can be a **co-occurring condition** with Autism and Asperger Syndrome, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder to name a few. This makes diagnosis complex and difficult. Indeed "the difficulty of diagnosis is further complicated by the fact that many genetic and malformation syndromes (e.g. Williams syndrome, Cornelia de Lange syndrome, Velocardiofacial syndrome) have similar clinical characteristics to those found in the range of FASD" (British Medical Association (BMA) 2007 p.32). It is thought that many of these children are undiagnosed or misdiagnosed with Autism or ADHD.

In the early years (0 – 5), children will present in the following ways:

Babies with FASD are often:

- Of low birthweight
- Over-sensitive to light, noise and touch
- Irritable
- Unable to suck effectively
- Slow to develop
- Vulnerable to ear infections
- Affected by poor sleep/wake cycles
- Too stiff or too floppy
- Resistant to accepting new situations.

As **toddlers and young children**, they are likely to have problems with:

- Poor muscle development and movement skills
- Coordination and balance
- Language
- Learning new skills that other children find easy
- Remembering
- Hyperactivity (they find it difficult to sit still)
- Lack of a sense of fear
- Understanding boundaries

- Their need for lots of physical contact
- Missing typical development milestones such as walking, toilet training, emotional development.

The life long implications for these children, their families and society as a whole should not be underestimated as “FASD are lifelong conditions that can significantly impact on the life of the individual and those around them” (BMA 2007). Neither should the prevalence. It would be a mistake to think that this is a disability only affecting certain sectors of society or socioeconomic groups. As Michael Dorris (adoptive father of a son with FAS) points out: “FAS is an equal opportunity affliction. Its victims have been born to women age fifteen up, of all nationalities and income groups, who ingested every type of liquor, including to some who neither smoked cigarettes nor took any drugs but alcohol during their pregnancies” (Dorris, M. 1989). Some might disagree with this argument, the BMA states that “data on the incidence of the full range of FASD are continuing to emerge and it is clear that some populations are more likely to have children affected by these disorders. The most at risk populations are those that experience high degrees of social deprivation and poverty such as indigenous or native populations (BMA, 2007).

Debate over which socio economic groups are affected aside, writers on the incidence and prevalence of FAS agree that this is a disability requiring attention, urging that it is currently “greater than Down syndrome, cerebral palsy and spina bifida combined” (Mitchell 2005). Indeed, foetal alcohol exposure is the leading known preventable cause of intellectual disabilities in the Western world (Abel & Sokel, 1987, Stratton, Howe & Battaglia, 1996). It is thought that FASD currently affects 1 in100 live births in Western countries (Autti-ramo 2002). With the number of female hospital admissions in the UK for alcohol related harm running at approximately 250,00 for the period 2006/07, 84% of mothers under 20 years of age reporting having unplanned pregnancies. (Dex and Joshi 2005) and 55% of pregnant women admitting to drinking alcohol whilst pregnant despite warnings it can lead to their children developing health problems (Daily Mail 24th May 2008), this is clearly a disability that health, education and social services professionals need to be aware of.

The isolation and confusion faced by these children in their daily lives is perhaps best explained by Michael Dorris. In describing his son, Adam's general state of being, he says:

"My son will forever travel through a moonless night with only the roar of wind for company. Don't talk to him of mountains, of tropical beaches. Don't ask him to swoon at sunrises or marvel at the filter of light through leaves. He's never had time for such things, and he does not believe in them. He may pass by them close enough to touch on either side, but his hands are stretched forward, grasping for balance instead of pleasure. He doesn't wonder where he came from, where he's going. He doesn't ask who he is, or why. Questions are a luxury, the province of those at a distance from the periodic shock of rain. Gravity presses Adam so hard against reality that he doesn't feel the points at which he touches it. A drowning man is not separated from the lust for air by a bridge of thought – he is one with it – and my son, conceived and grown in an ethanol bath, lives each day in the act of drowning. For him there is no shore." (Dorris, M.1989)

The damage caused to the brain by prenatal alcohol exposure, together with possible physical disabilities can cause learning difficulties in the areas of gross and fine motor control, social and emotional development, hyperactivity and attention disorders, understanding rules and cause and effect, receptive and expressive language, and problem solving and numeracy.

Some of the learning difficulties experienced by children with FAS (which account for about 20% of children across the spectrum of alcohol damaged children) are thought by some to be compounded by the fact that 80% of these children are fostered or adopted (NOFAS-UK), leading to a deprivation of ".. some of the requisites for normal psychological development" (Newton Verrier 1993). Verrier argues that separation from a biological mother interrupts the natural evolutionary process which begins in utero and is a "continuum of physiological, psychological and spiritual events". The experience of separation, even if at birth, causes a sense of abandonment and loss which is "indelibly imprinted upon the conscious minds of children" causing a 'primal wound'. This primal wound, she believes, is responsible for some of the disruptive behaviour seen in children with FAS as they struggle to come to terms with the trauma of their unexplained sense of

loss. Verrier advocates that “studies should be done on non-adopted victims of FAS in order to discover which symptoms are related to FAS and which are primal wound issues that are complicated by FAS”.

Children with FASD will not follow general theories of learning or be able to generalise rules and principles learnt from one situation to another. They may dance the developmental ladder, often displaying strong verbal skills which can mask poor understanding of their environment and what is being asked of them. This is borne out in the fact that so many affected individuals present as ‘normal’, bright, friendly and articulate which paradoxically ‘masks’ the alcohol exposure (Streissguth et al 2002). Educating and caring for these children, therefore, needs a unique approach that relies on reflective practice and adaptive teaching techniques.

Given that ‘infancy may represent the greatest opportunity in a child’s life to prevent adverse mental health outcomes’ (Spieker 2007) it is imperative we ensure that Early Years Practitioners have the knowledge base, training and intervention tools required to support these children and improve social and educational outcomes. The BMA would seem to concur, arguing that “a lack of knowledge about FASD will limit opportunities for diagnosis, prevention and early intervention” (BMA 2007). Resources to achieve this aim are currently unavailable as “current knowledge and expertise regarding FASD amongst health and education practitioners in the UK is limited” (Carpenter 2005). Currently, information is not available for parents or educators about FASD in the Early Support Programme materials or in the new Inclusion Development Programme*

* (The Government’s Early Support Programme aims to achieve better co-ordinated, family focused services for young disabled children and their families. The Inclusion Development Programme (IDP) is a new project of confidence-raising training for teachers, support staff and early years practitioners, which aims to improve the skills of teachers by advising them on how to develop teaching strategies for children with special educational needs (SEN) and providing guidance on dealing with common classroom challenges).

PROJECT AIMS AND OBJECTIVES

The aim of this project was to assess and enhance the knowledge and understanding of Early Years Practitioners across Worcestershire about FASD and its implications for young

children to achieve expected childhood outcomes. It is not aimed at equipping practitioners diagnostically, but rather to provide them with a range of information and strategies to use when working with children they think may be affected by FASD. It is hoped that this will ensure that the learning environment provided will engage the child with FASD and enhance their potential for achievement through directed Early Childhood Intervention, thereby reducing the occurrence of secondary disabilities.

At its conclusion, the project will leave in place a nationwide training resource for Early Years Practitioners and a platform for developing support groups for both professionals and parents.

Specific Aims include:

- To establish best practice in supporting young children with FASD
- To develop a set of resources to enhance practitioner knowledge and skills to facilitate working with children with FASD
- To develop a one-day training course and materials for internal and external training

Specific Objectives include:

- To establish a Practitioner Focus Group to ensure the development of resources and literature are rooted in the practitioner perspective
- To develop resources to meet the needs of early years practitioners working in a variety of settings to support young children with FASD
- To conduct a literature review around best practice in the support of children with FASD in early years settings
- To develop a training course to support early years practitioners

Specific Research Questions include:

- What is the current best practice for working with young children with FASD?

- What resources could be developed to support early years practitioners working with children with FASD?
- How can this knowledge and practice be effectively disseminated?

RESEARCH METHODOLOGY

The research was planned to take place over a period of 12 months and to take the form of an exploratory case study of children affected by FASD based on a participatory action research model. Action research is concerned with practically changing an issue within the working environment to improve knowledge and practice. It is seen as a collaborative strategy as it often involves the participants of the research (such as early years practitioners) in planning and carrying out the research with the researcher. "It is thus democratic and inclusive" (Guy Roberts-Holmes, 2005).

The Research Assistant was supported by the Research and Training Team at Sunfield Research Institute as well as representatives from Worcestershire Early Years and Childcare Service and the Executive Director of NOFAS-UK (a parent support group). The research population consisted of Early Years Practitioners based in a range of settings across Worcestershire.

Primary data has been collected through an initial questionnaire designed to gather information about current practitioner knowledge of FASD, the children they are currently supporting in their settings, strategies they have used to meet children's needs and what kind of information and support they feel appropriate to meet children's needs in the future. In addition practitioners were asked if they had either currently or in the past supported a child with a diagnosis of FASD.

From responses to the initial questionnaire, settings were identified for face to face interview. Settings were selected to provide a representative sample in terms of geographical spread, type and nature of setting across the county. For each of the 6 distinct areas of Worcestershire (Bromsgrove, Malvern, Redditch, Worcester, Wychavon, and Wyre Forest) each of the following setting type was included:

- Childminder
- Children's Centre
- Full Day Care
- Maintained Nursery
- Sessional Pre-School

The interview questions were constructed to encourage practitioners to expand on the information provided in their initial questionnaire. Practitioners were also asked to read and evaluate a set of information sheets prepared at the beginning of the project, and a set of interventions/strategies compiled from information provided in the initial questionnaire, research from a range of international literature and researcher/practitioner knowledge. The information sheets cover topics such as How FASD Affects Children, How to Support Families, Understanding a Child with FASD, An Overview of Appropriate Strategies, How to Encourage Positive Behaviour and Health and Mental Health Issues for Children with FASD. The interventions/strategies are linked to the Every Child Matters (ECM) agenda as well as the Early Years Foundation Stage (EYFS) (discussed later in this report).

Interviews took place at the practitioners setting and in most cases (where adult to child ratios allowed) took place in a room separate from the children and other staff. All interviews were recorded with the participant's permission and transcribed verbatim to facilitate data analysis. A member of the Occupational Therapy team from Sunfield assisted with interviews.

A follow up questionnaire was used to assess the level of practitioner knowledge once they had evaluated the information sheets and strategies, and ascertain the need for further information and training.

In order to raise awareness of the project, the Research Assistant attended Early Years Manager's and Childminders forum arranged by WCC EYCS and submitted articles for the EYCS newsletter entitled 'Playcare'.

In addition a Practitioner Focus Group comprising representatives from Sunfield, WCC and early years settings across Worcestershire met 6 times throughout the project with the aim of ensuring that the project and all resulting resources were grounded in current practice.

FINDINGS

Initial Questionnaire

The initial questionnaire was sent to over 400 settings registered with WCC Early Years and Childcare Service. A total of 161 replies were received.

1. We asked Practitioners to tell us about their knowledge of FASD.

Degree of Practitioner Knowledge of FASD		
Low Degree of Knowledge	**Medium Degree of Knowledge**	**High Degree of Knowledge**
Number of Settings	Number of Settings	Number of Settings
125 (78%) *	28 (17%)	8 (5%)

Table 1: Degree of Practitioner Knowledge of FASD

* Included in the number of settings reporting a low degree of knowledge are 49 settings (30%) who were not aware of FASD at all.

In view of the general lack of knowledge about FASD, it is not surprising that 78% of settings reported a low degree of knowledge about FASD including 30% who had no knowledge at all.

2. We asked Practitioners with knowledge of FASD what the source of that knowledge had been.

Source of Practitioners Knowledge	Percentage of Settings
Internet	1%
Course at Sunfield Professional Development Centre	3%
Talking to Other Professionals	3%
Ante-Natal Sessions	3%
Experience of Working with a Child with FASD	4%
Training for Early Years Degree	5%
Involvement in Project Practitioner Focus Group	4%
Previous Nursing/Social Services Training	5%
WCC EYCS *	29%
Media	43%

Table 2: Source of Practitioner Knowledge about FASD

* This includes attendance at the Early Years Conference on Early Intervention, attendance at the Managers and Childminders forums where the Research Assistant talked about FASD, Area SENCo training, Quality Award presentation evening, reading Playcare.

Whilst it is not surprising that awareness amongst Practitioners about FASD has been mostly generated by the Media, there is inconsistency in the presentation of information as well as advice about alcohol intake and safe limits during pregnancy throughout the media. This was evident from responses given to questions during interviews and is discussed in more detail later in this report.

3. We asked practitioners to tell us about the children they are currently supporting:

A total 64 settings (40%) state that they are supporting children with behaviours such as:

- Challenging social behaviour
- Poor receptive and expressive language

- Lack of compliance/apparent lack of comprehension
- No sense of danger
- Poor co-ordination
- Clumsiness/lack of spatial awareness
- Obsessive behaviour/repetitive behaviour
- Hyperactivity/disruptive behaviour
- Aggressiveness and emotional outbursts

Some of these children have a working diagnosis of Asperger's Syndrome, Autism and ADHD. Although settings have introduced strategies to support these children, few have found anything that is effective consistently. These children will enter the formal education system in September 2008 or 2009.

None of the children attending settings at the time of the questionnaire had a diagnosis of FASD. However, three practitioners indicated that they had supported a child with a diagnosis in the past. These practitioners were interviewed in addition to the thirty representative settings and were asked additional questions about their experiences of supporting a child with FASD.

Interviews

The face to face interviews were transcribed verbatim and a thematic approach was used to analyse the data obtained to enable the research to be grounded in practitioners own experiences. Of the 33 practitioners interviewed 3 are members of the Worcestershire Practitioner Focus Group, 3 had supported children with FASD in the past and a further 9 have attended training events (run either by Worcestershire EYCS or Sunfield) or early years forums where FASD has been discussed. All practitioners interviewed were female and 31 of the 33 were mothers. The general themes arising from the interviews were:

- Enthusiasm amongst Worcestershire Early Years Practitioners for this research project driven by dedication and commitment to improving outcomes for vulnerable children in their care

- A lack of knowledge about FASD by Early Years Practitioners and other professionals (i.e. health and social work professionals) with whom they liaise in order to support children

- Mixed messages from the Media and Official Bodies about safe alcohol limits for pregnant women

- Uncertainty about how a child with FASD might access an early years curriculum such as the Early Years Foundation Stage (EYFS) in a typical early years setting

- High and increasing numbers of children entering early years settings with a range of needs including speech and language delays and impairments, behavioural problems including unusually immature children, children with needs in the area of hyperactivity, complying with boundaries and poor social skills

- A need for very visual and concrete strategies to support an increasing number of children with emerging needs in settings

- A need for further information, training and specific strategies for supporting children with FASD and clarification for women about safe and appropriate alcohol intake whilst pregnant.

These themes are discussed below.

Enthusiasm for the Project

All of the practitioners interviewed expressed enthusiasm for the Worcestershire FASD project. On initial contact with the practitioners the Research Assistant asked them if they could spare 30 minutes to talk about FASD. However, most interviews lasted between 30 minutes and 2 hours, mainly due to practitioners' curiosity and interest in the project, and

their desire to talk about the children they are currently supporting, with one practitioner saying:

"*This just makes so much sense, some of the children here come from environments where irresponsible drinking goes on and the things you're saying about these children are just so familiar*".

Lack of Knowledge about FASD

Although some practitioners were aware of FASD, either through supporting children, attendance at training events and forums or through membership of the Practitioner Focus Group, over half of the practitioners interviewed had only a vague idea that FASD is related to maternal alcohol consumption, with two very honest practitioners admitting that they knew "*absolutely nothing*" demonstrating the lack of knowledge available to early years and other professionals about FASD.

One practitioner went further than this admitting "*this is all news to me to be honest, I feel really ignorant to be a practitioner in a Children's Centre and not know about something like this*".

Other practitioners were aware that FASD was linked to maternal alcohol consumption, but were confused about how much alcohol consumption was necessary to damage a developing foetus, and which members of society are affected making statements such as:

"*It's mums that drink heavily during pregnancy, so that when their children are born, they have a lot of learning problems"*

"*It's when parents are drinking quite a lot during pregnancy and obviously the child is then affected by that. When the child comes out of the womb they would have been exposed to alcohol the same as the parent and would have alcohol poisoning"*

"My understanding would be children who may have been affected by parents who took drugs or alcohol or are just addicted to something because something has cropped up with the children at any stage, whether it's birth or maybe when they're a little bit older and there may be no obvious reason for it. I'm not sure whether it's small amounts of alcohol or large amounts"

"To me it means behaviours or a disability that a child has because their parent drank more alcohol than the Government would like you to drink whilst expecting a baby".

"It always seems as though the very young mums and girls are affected more, with the younger mums that you see stood on the street corners, thinking it's a good idea to have a baby and not realising the effect that alcohol has on the baby".

"It's damage to the child's brain caused by alcohol at that particular time when the brain is developing in the early weeks".

"Drinking too much, being an alcoholic, both before and after conception, but it needs to be heavy drinking, I don't think the odd glass of wine hurts, but more than that you could be prone to damaging your baby"

Clearly there is understanding that FASD is caused by maternal alcohol consumption, but a lack of clarity exists about which stage(s) of the pregnancy the foetus is vulnerable, how much alcohol it is safe to drink during pregnancy or the extent of the damage caused to the foetus.

Mixed Messages from the Media and Official Bodies about Safe Alcohol Limits

As suggested earlier, the messages about maternal alcohol consumption, safe limits for pregnant women and the potential damage caused to a developing foetus are confusing for women as evidenced by comments made, such as:

"Some people I've spoken to seem to think it's only in the first few weeks that the baby can be affected, but then I've read other stuff that says that alcohol is easily passed to the baby throughout the pregnancy. I think it's confusing to parents, because there's so much advice, should you drink, should you not, some people say there isn't a safe limit, then you read information that says it is ok to have the occasional glass of wine. Some people will say don't have anything at all, then a doctor will say it's ok just to have one".

The press and media report regularly on issues such as binge drinking in Britain, the rise in binge drinking amongst women of child bearing age and the damage caused to the nation's health by excess alcohol.

For example, on Wednesday 14th November 2007, the Daily Mail reported that "Mothers who binge don't harm their unborn baby". The report was based on a study by researchers from the University of Oxford and University of Aarhus, Denmark.

The NHS response to the study was to point out that a 'binge' is not clearly defined and that the "findings on birth defects and growth restriction were inconclusive" (NHS 17.11.2008).

The Independent reported on 19th April 2008 that "Women who drink when pregnant have violent children". The Mail On Sunday reported on 20th April 2008 that "Alcohol is now the world's most common cause of learning difficulties – a time bomb, with thousands of children affected each year".

Current UK Government Guidelines state that it's "Wiser not to drink (when pregnant) but if you do drink keep to one or two units once or twice a week". The BMA states that "Women who are pregnant, or who are considering a pregnancy, should be advised not to consume any alcohol". (BMA 2007).

The confusion caused by such conflicting headlines and general advice from government and media has an impact on people's perceptions, confidence in their own knowledge and information they pass onto others.

Uncertainty about How a Child with FASD May Access the EYFS

Some practitioners accurately surmised that a child with FASD would lack concentration skills and be easily distracted. Others knew that a child with FASD would need to be taught concepts more than once and that "*you may think you cracked it and that child does everything that's expected of them, but then another day they could be all over the place*". A number of practitioners were aware of the facial anomalies and small stature that children with FAS may present with.

There was a general consensus that speech and language would be delayed or impaired and that mixing with other children could be difficult. Some practitioners were aware that each child with FASD would have their own individual difficulties according to the specific damage caused during pregnancy and how neurologically damaged they were, and that what they need to look for is a child who is not progressing developmentally at an acceptable rate.

Other practitioners were honest enough to admit that they and their colleagues "*would not have been aware of a child with FASD in this setting" and in particular the setting SENCo "would have no idea about this (FASD)".*

Insightfully, one practitioner acknowledged that "*because there's so little understanding and so little awareness (about FASD) at the moment, it would be difficult for staff to plan for these children, because they haven't had the training to support them*".

Another practitioner felt that the issue of whether child had FASD or other needs was to some extent irrelevant, stating "*at the end of the day, it's about Every Child Matters and how that child is meeting those outcomes, that's what we would be looking at*".

Children Currently Being Supported in Settings Across Worcestershire

The learning environment that early years settings provide for the children in their care is to some extent dependent upon the range of children and families who wish to access their provision.

However, they must also follow the principles and guidelines set out in the Early Years Foundation Stage (EYFS) in order to comply with Ofsted requirements. The EYFS "emphasises that each child's progress is individual to them and that different children develop at different rates. A child does not suddenly move from one phase (of development) to another, and they do not make progress in all areas at the same time. However, there are some important 'steps' for each child to take along their own developmental pathway" (DfES 2007).

Throughout the EYFS emphasis is placed upon understanding each child and their family as unique, with different needs and concerns. Children's development is presented under six overlapping phases (see below). This overlap is intended to emphasise the fact that there can be big differences between the development of children of similar ages. At the same time age can be a cue, when taken with all other factors, to indicate that development may be atypical and that a child may need extra support. (DfES 2007)

The six broad developmental phases outlined in the EYFS are:

- Birth to 11 months
- 8 – 20 months
- 16 – 26 months
- 22 – 26 months
- 30 – 50 months
- 40 – 60 months

There are also four **Themes** designed to express important **Principles** underpinning effective practice in the care, development and learning of young children, namely:

- A Unique Child
- Positive Relationships
- Enabling Environment
- Learning and Development.

These themes, together with the six areas of **Learning and Development** (see below)**,** ensure that children are supported in meeting the five outcomes of the Every Child Matters Agenda:

- Problem Solving Reasoning and Numeracy
- Personal Social and Emotional Development
- Communication, Language and Literacy
- Creative Development
- Physical Development
- Knowledge and Understanding of the World.

Every Child Matters

Every Child Matters is the government agenda which focuses on bringing together services to support children and families. It sets out five major outcomes for children:

- being healthy;
- staying safe;
- enjoying and achieving;
- making a positive contribution;
- economic well-being.

When assessing and evaluating children in their setting, practitioners will be mindful of all of these factors, and it is important to understand the principles outlined above when discussing the range of children that practitioners are currently supporting and the strategies they will use to support such children.

The range of needs and behaviours that practitioners are meeting with children attending their settings are common across the geographical spread and type of setting. In the majority of cases, the development phases of the children referred to by practitioners are the in the 22 – 60 month age range.

The predominant challenges they face currently are:

Type of Behaviour/Need	Number of Settings Reporting Behaviour/Need (of 33)
Speech and Language Delay/Impairment (receptive and expressive)	33 (100%)
Undesirable Behaviour	33 (100%)
Poor Social Skills	25 (76%)
Poor Listening Skills/Inattention/Not being Engaged	16 (48%)
Excessive Immaturity including Being in Nappies at Age 4	12 (36%)
Specific Diagnosis including ADHD, ASD, Dyspraxia, Cerebral Palsy and Mitochondria	10 (30%)
Poor Short Term Memory/Lack of Appropriate Progression	7 (21%)
Poor Sleep Patterns	6 (18%)
Global Developmental Delay	5 (15%)

Table 3: Range of Needs that Practitioners are Supporting

All of the 33 settings reported having an increasing number of children with difficulties and delays in the area speech and language, both receptive and expressive, and all settings felt that much of the undesirable behaviour they are faced with is related directly to poor understanding and children's inability to express themselves adequately.

Many of the settings felt that delayed speech was impacted by an inability to listen or focus on an activity, reporting on children who found it difficult to hold a simple two way

conversation at age 3 or 4. Social and emotional skills are felt by most practitioners to be one of the most important areas for children to master before they enter compulsory education. Many settings (76%) are reporting high numbers of children displaying poor social skills, including turn taking, sharing, lack of co-operative and associative play even amongst those children in the 40 – 60 month developmental phase.

In meeting the needs of such children, practitioners will follow a formal process which includes contacting their Local Authority Area SENCo and placing the child on their Special Needs Register for 'Early Years Action'.

Early Years Action / Early Years Action Plus

These are formal terms used to describe the levels of extra help that are given when an early years setting, such as a nursery, decides that a child has special educational needs (SEN) and needs extra or different help (see Appendix 3).

At the time of interview there were 78 children at Early Years Action Plus across the 33 settings who took part, making a total of 145 children at Early Years Action or Early Years Action Plus. The average number of children with additional needs per setting, therefore, is 4. One pre-school manager said that a third of the children attending her setting had "some sort of difficulty".

The rise in the number of children entering settings with additional needs has caused some practitioners to comment on the lack or decline of provision for the under 3's in their area:

"There's very little for the under 3's on this estate. There used to be a playgroup that fed into our Nursery, but that closed down, I think these places are shutting faster than people realise"

"I feel that a lot of problems are not picked up because the 3 year health check (previously conducted by Health Visitors) no longer happens. This has a knock on effect and impact on the number of children referred to a setting like this by Health Visitors, and many of those children need to be somewhere like this".

"I am concerned about the 5% of children who don't take up their National Education Funding, who are marginalised and effectively disappear from the Early Childhood radar. These children would have been seen by the Health Visitor at one time, but now it's expected that Early Years Staff will be responsible for identifying children's needs".

"What I would really like to do is catch children with needs earlier, there aren't any Toddler groups accessible for our parents, so we're thinking of setting up a Stay and Play session of our own, just so that we can identify children sooner and get them the support they need".

Three of the 33 practitioners interviewed had supported a child with FASD in the past, though not necessarily in their current setting. When asked about the behaviour and needs of such children they refer to issues such as:

Physical

- Impaired sight
- Facial anomalies
- Small stature
- Delayed Gross Motor Development/Clumsiness

Behavioural/Intellectual

- Hyperactivity/inattention
- Discalcula
- Inability to grasp abstract concepts
- Poor Short Term Memory
- Poor receptive language/understanding
- Impulsivity/no sense of danger
- Excessive Immaturity
- Poor Social Skills

As can be see from Table 4, there are similarities between some of the behaviours described above, and the types of needs that practitioners are facing with the children they are currently supporting.

CHILDREN WITH FASD IN THE EARLY YEARS	**CHILDREN CURRENTLY BEING SUPPORTED BY WORCESTERSHIRE EARLY YEARS PRACTITIONERS**
Poor Language Skills	Speech and Language Delay/Impairment
Poor understanding of boundaries and non compliance	Undesirable Behaviour
Inappropriate Social Skills (over friendly 'in your face')	Poor Social Skills
Hyperactivity/Inattention Will 'follow the crowd' Skills/Inattention/Not Being Engaged	Poor Listening
Impulsive, no sense of danger, missed or delayed milestones such as walking, toilet training	Excessive Immaturity including still being in nappies at Age 4/Global Developmental Delay
Poor Short Term memory	Poor Short Term Memory/Lack of Appropriate Progression
Affected by poor sleep/wake cycles	Poor Sleep Patterns
Delayed Gross and Fine Motor Skills, Small Stature, Weak Immune System, Poor General Health	Clumsiness, awkward gait when walking, smaller than peers, medical treatment for impaired vision
Often misdiagnosed with Autism or ADHD	Specific diagnosis of: ADHD, ASD, Dyspraxia, Cerebral Palsy and Mitochondria

Table 4: Comparison of Children with FASD in the Early Years and Children Currently Being Supported in Worcestershire

A need for very visual and concrete strategies to support an increasing number of children with emerging needs in settings

This project was designed initially to take the form of an exploratory case study of children affected by FASD based on a participatory action research model.

However, our initial questionnaire and interviews did not highlight any such children. They did highlight however, a number of children attending settings with emerging and undiagnosed needs for which practitioners had no consistently effective strategies to support their needs (see Table 3).

The methodology thus shifted to exploring the range of children practitioners are currently supporting in their settings, being mindful that any of these children could have been affected by maternal alcohol consumption. As has already been explained, such children are often undiagnosed or misdiagnosed, and in light of the lack of knowledge already outlined by practitioners, could easily be labelled as disruptive or behaviourally difficult, without the true nature of their needs being identified and acknowledged.

Through interviews, the settings have therefore shared their experiences of supporting children in their settings, including providing insight into the types of strategies they have found to be effective, areas where they would like more information and gaps in their own knowledge and training.

The project has thus become an information sharing exercise for supporting children with a range of needs, such that the resource pack subsequently put together is a “bible of good practice” (Focus Group Member) when supporting any developmentally young child in an early years setting. Practitioners advocated a range of strategies for supporting children with needs in their settings, for example:

"What's worked is very very good observations from staff, we have meetings around the observations so that you're always a step ahead, you should be watching and scanning the room all the time. Our room is set up such that there are always sufficient activities to keep the children busy".

"We need to keep group sizes really small for our activities, ideally 1:1, but also making sure that they're getting their own set of instructions, so any instruction that you're giving needs to be backed up with a visual clue or gesture and the adult needs to be aware that they need to reinforce with that child specifically. Visual timetable is probably one of the best things, so constantly returning to that and reinforcing it. We find just constant repetition, selecting vocabulary that's relevant to the topic or theme that we're doing at the time. We perhaps choose just 5 key words at a time and then revisit them over and over and over again and we're finding that they'll come back to those 5 words probably, but they won't remember all 5. They'll remember a different perhaps 3 or possibly 4 out of the 5 each time. We try to do just a little bit of 1:1 with each of these children at least 3 times a week. They'll have a little routine activity that they'll return to each time"

"What we have is photographs attached to our belts, so that we can show the children, that's worked fantastically and that's something that we adopted, because we knew there was no way we were ever going to get the children to the wall to see a visual timetable, that was never going to work".

"The praise puppy works well, we've made a kennel for him and the children love that, they can pet him and they respond really well to that and we have individual puppets for each group so that's their group puppet and they really respond well to puppets, particularly the children with more significant needs".

"We've worked hard on reducing our language and using positive simple language. But it takes time to think 'write on the paper' rather than 'don't write on the wall' but I saw them use it at the CDC and how well it works there, so we're working on that".

"We have one child who we supervise very closely. She's very controlled here and always followed, I know they're not supposed to be followed all the time,, but we feel that's important to keep her safe. We've always been told that with children with Autism for example you're not meant to shadow the child, but this child is very different and we feel we have to watch her constantly".

The main strategies suggested by practitioners (including those practitioners who had supported a child with a diagnosis of FASD) were:

- Use clear, concrete, simple language backed up with visual clues
- Be consistent with language, rewards and routines
- Be prepared to repeat instructions and rules
- Implement and adhere to a routine
- Provide structure and constant supervision
- Employ adaptive teaching techniques that focus on the child's strengths, interests and developmental stage
- Provide plenty of praise

These strategies are encompassed in the 'Focus on Strategies' document resulting from the project.

Need for Further Information and Training about FASD

All of the settings involved in interview stated that they would like further information and training about FASD. Preference for the type of information they would like to access was predominantly:

- Information about FASD, symptoms and signs to look for,how it affects children's learning, how it affects families
- Strategies for supporting children affected by FASD
- Specific activities designed to support children affected by FASD

- Information which they could pass onto other professionals, such as Health Visitors to inform them about FASD

The type, format and timing of preferred training was reasonably consistent across the range of settings. The table below shows the range of training times and types of session suggested together with the percentage of practitioners who expressed a preference for that option.

	Time of Day		
Length of Session	Morning (% of 33)	Afternoon (% of 33)	Early Evening (% of 33)
Two Hour or Half Day Session		9%	93%

Table 5: Practitioners Preferred Time and Length of Training

Nearly all of the settings stated that early evening would be best time for training, as finding staff cover during the day can be difficult and the need to maintain adult to child ratios can restrict the number of staff who can attend a session. Some of the maintained nurseries stated that a late afternoon session at approximately 4.30 – 6.30 would be helpful, but most practitioners, and particularly childminders said that they could not attend training before 7.00 – 7.30 in the evening. Practitioners felt that a 2 – 3 hour session would be adequate for the purpose.

Some practitioners suggested that training could take place at Early Years Conferences, Providers Forums, Children's Centres or be Setting based, although they appreciated that this may be difficult from a practical viewpoint.

Evaluation of Information Sheets and Strategies

A resource pack containing a set of information sheets and interventions/ strategies was left with each setting at the end of the interview, together with an evaluation sheet.

Practitioners were asked to honestly evaluate the resource pack and provide feedback on areas that they liked/disliked together with suggestions for changes or additions they felt necessary to make the pack more accessible and useful for its intended purpose. In particular, they were asked to rate the 'ease of reading' and 'usefulness of information' All 33 settings returned their evaluation sheet.

	Ease of Reading Percentage of Practitioners (% of 33)			**Usefulness Percentage of Practitioners (% of 33)**		
	Very Easy to Read	Easy to Read	Difficult to Read	Very Useful	Useful	Not Useful
Information Sheets	91%	9%	0%	91%	9%	0%
Interventions/Strategies	94%	6%	0%	94%	6%	0%

Table 6: Practitioners rating of the resource pack

Table 5 shows that the majority of practitioners (over 90%) rated the contents of the resource pack as very easy to read and very useful with comments such as:

Information Sheets

"I really liked the layout of these, they are logical and easy to navigate. Breaking the information down is a good idea as it makes it much more manageable to understand and makes it clear that children may have some or all aspects"

"All the sheets are exceptionally clear, there is a good deal of information and all most useful".

"It's good that the emphasis is not on diagnosis"

"Like the useful contacts, would be better if all the contact information was on this page rather than at the bottom of the sheets"

Interventions/Strategies

"Excellent links to EYFS – will make planning for the child more meaningful".

"Good links to Every Child Matters".

"Very useful, particularly as it was sectioned into problems that parents and practitioners may be having".

"These sheets gave clear ideas to help the various areas of development and behaviour".

"Good and concise for practitioners"

"Very useful, presented practically and I think most settings will find this really valuable"
"These are really useful in managing such children practically on an ongoing basis. Really good, the strength of the pack"

"The whole package was very good. We liked the information sheets for background info and the strategies for ideas to overcome problems"

"We would welcome this pack as a useful tool in our Nursery".

One practitioner was keen to point out that "..these strategies are appropriate for children experiencing these difficulties for whatever reason, we don't need to keep them until there is a diagnosis of FASD".

Some practitioners provided suggestions for improvements to the resource pack, such as:

"Too many sheets, with too much information, maybe more bullet points, more illustrations.

"More images and photographs would help and maybe a case study of a real life situation and a parents and practitioners experience" Too much reading required"

"Not happy with 'what families need', not happy with 'if you think a child has FASD – it's not about diagnosis"

"Good, more pictures, back up what you're saying"

The resource pack has been amended and edited accordingly to take practitioners suggestions into account, ensuring that the pack is grounded in practice and more useful and meaningful for its target audience. A family case study and practitioner case study have also been developed to comply with practitioner requests.

Follow Up Questionnaire

In order to further assess the effectiveness of the resource pack in raising awareness of FASD, equipping practitioners with knowledge and inspiring them to learn more, a follow up questionnaire was sent to the practitioners involved in interviews. We also expanded on our earlier questions about training requirements and asked for general comments about the project. Thirty of the settings interviewed returned their follow up questionnaire.

1. Raising Awareness

We asked Practitioners to tell us about their knowledge of FASD now that they have read the resource pack.

Degree of Practitioner Knowledge of FASD after Reading the Resource Pack		
Low Degree of Knowledge	**Medium to High Degree of Knowledge**	**High Degree of Knowledge**
Number of Settings	Number of Settings	Number of Settings
2 (7%)	27 (90%)	1 (3%)

Table 7: Degree of practitioner knowledge after reading the resource pack

A total of 93% of practitioners felt that they had a medium to high degree of knowledge after reading the project resource pack,offering:

"I was unaware of this condition, reading the resource pack has enlightened me of the effects of FASD".

"We are pleased to have the knowledge you have provided us with, we feel more confident about advising parents"

This compares with 22% reporting a medium to high degree of knowledge from the initial questionnaire (see Table 1).

None of the practitioners felt that they had no knowledge at all, but 2 practitioners felt that their knowledge would only improve after supporting a child with FASD saying:

"I found the information pack very useful as I had little knowledge on FASD, however, I feel that experience of working with children that have FASD would be necessary for a better understanding".

2. Inspiring Practitioners to Research Further

Twenty eight (93%) of the practitioners stated that they had been motivated by the interview and resource pack to find out more about FASD from a variety of sources, including:

- Internet research
- Discussion with colleagues and other professionals
- National Press
- Books
- Professional Journals
- Medical Research Reports

3. Further Information and Training

Twenty six of the practitioners interviewed (79%) said that they would like further information and training about FASD, specifically:

Area of Training	Number of Practitioners Interested (out of 26)
An Overview of FASD	21 (81%)
Attention/Concentration in Young Children	20 (77%)
Strategies That Work	17 (65%)
Observations	12 (46%)
Making Resources	12 (46%)
Individual Education Plans (IEP's)	10 (22/%)

Table 8: Training of Interest to Practitioners

Over half of the practitioners (53%) stated that training is easiest to attend in the evening, although some (20%) said that late afternoon (between 4.30 – 6.30) would be easier.

When asked for general comments about the project, practitioners reiterated their enthusiasm for the project:

"Looking forward to reading the research"

"We have found your project very interesting and it has made us more aware of the condition".

"You have provided us with really useful knowledge to build our professional store".

"I think it is important for all staff working with young children to have knowledge and understanding about FASD"

"Thank you for the hard work you have put into the project, it will go a long way towards raising awareness of FASD and help us to support children who have some aspects of the spectrum".

"I think it is interesting to realise that some behaviours we see could be due to FASD".

DISCUSSION

The Early Years and Childcare team at Worcestershire County Council and Early Years practitioners across Worcestershire have demonstrated enthusiasm for supporting and including children with additional needs in settings. This is evidenced by WCC taking the initiative to fund and provide staff support for this project, and practitioners eagerness to commit time and effort for interviews, evaluations and focus group meetings.

Early years settings are supporting an increasing number of children who need additional support to enable them to achieve and meet the outcomes contained in the Every Child Matters agenda and the EYFS. Practitioners need to be skilled and equipped to support a range of needs and behaviours, and are keen to gain the knowledge they require to identify and support children who may have been affected by maternal alcohol consumption.

The ideal setting for children with FASD is one where practitioners will have realistic expectations of children with FASD. The main strategies suggested by the practitioners to support children with FASD are:

- Use clear, concrete, simple language backed up with visual clues
- Be consistent with language, rewards and routines
- Be prepared to repeat instructions and rules
- Implement and adhere to a routine
- Provide structure and constant supervision
- Employ adaptive teaching techniques that focus on the child's strengths, interests and developmental stage.

- Provide plenty of praise.

These concepts are encompassed in the ‘Focus on Strategies’ document resulting from the project, which is linked to the following areas of development/behaviour:

- Hyperactivity
- Coordination
- Sleep Patterns and Eating Habits
- Complying with Routines and Boundaries/Understanding Danger
- Expressive and Receptive Language
- Appearing Overwhelmed
- Attention/Concentration
- Short Term Memory
- Disruptive/Impulsive/Aggressive Behaviour
- Problem Solving Reasoning and Numeracy

In addition, a development chart shows appropriate expectations of children with FASD according to chronological and developmental age, and a further chart shows common misinterpretation of behavioural responses in children with FASD.

To disseminate the research and raise awareness of FASD amongst a range of professionals, a one day National Conference will be hosted by WCC in February 2009 and a half day training session for Worcestershire Early Years Practitioners will be held in March 2009.

CONCLUSION

Best practice in supporting children with FASD in their early years would seem to rest on the basic principles of consistency, simplicity, structure, repetition, routine, constant supervision and valuing the child for their achievements and strengths.

Writers on the subject of educating children with FASD would seem to concur with Worcestershire practitioners, advocating:

"STRUCTURE! STRUCTURE! STRUCTURE!" Those caretakers who have established clear, consistent expectations and behavioural consequences are the ones who have the least problems and whose children appear to have done the best socially… The use of immediate consequences, for both positive and negative behaviour, is extremely important. Setting clear, concrete limits is critical" (Streissguth, A.P. quoted in Dorris, M. 1989)

(Children with FAS need) … special pre-schools where teachers carefully supervise children all the times, routines are clear and unvarying, classroom spaces are clearly marked and visual information supplements verbal directions" (Kleinfeld, J. and Wescott, S. 1993).

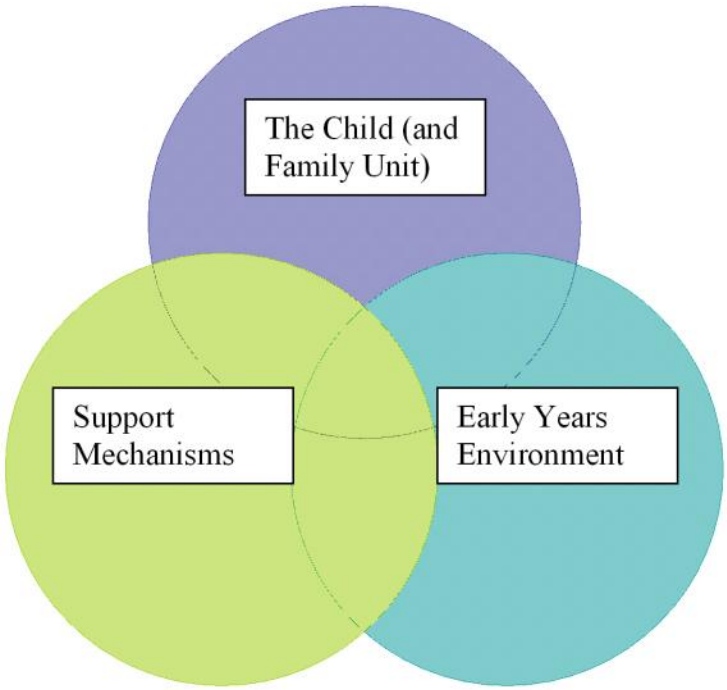
The model overleaf demonstrates the link between children's needs, the early years environment and the supported offered to practitioners via a range of authority and government initiatives designed to support inclusive practice.

The DfES advocates that early years practitioners employ knowledge, reflective practice and an empathetic outlook to support children in their care, informing us that:

"Effective practice in the early years requires committed, enthusiastic and reflective practitioners with a breadth and depth of knowledge, skills and understanding" and that "effective practitioners use their own learning to improve their work with young children and their families in ways which are sensitive, positive and non-judgemental" (DfES 2005). The C4EO through extensive research into how to 'narrow the gap in outcomes for young children through effective practices in the early years' has drawn a similar conclusion, stating that "effective pre-schools are characterised by a focus on individual children's needs, both in terms of learning and social development" (Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) 2009.

FASD IN THE EARLY YEARS

Needs in the area of:
Gross and Fine Motor Control; Language Skills; Hyperactivity/Inattention; Short Term memory; Social and Emotional Skills; Sequential Thinking and Problem Solving; General Health Issues; Signposting to Other Agencies



Local Authority (LA); Early Years Foundation Stage (EYFS); Every Child Matters (ECM); Every Disabled Child Matters (EDCM); Effective Provision of Pre-School Education (EPPE); Key Elements of Effective Practice (KEEP); Inclusion Development Programme (IDP); Early Support Programme (ESP); Common Assessment Framework (CAF); Other Professionals

Consistency; Structure; Simplicity; Concrete; Visual; Sensory; Routine; Praise and Supervision; Developmentally Appropriate; Adaptive Teaching; Reflective Practice

Blackburn 2009

By reading the information sheets and observing the basic rules outlined in the ‘Focus on Strategies’ document resulting from this project, practitioners can ensure that the learning environment they provide will engage children with FASD, and enhance their potential for achievement through directed Early Childhood Intervention and improve families experience of their child’s early years education. This will have implications for children with FASD throughout their lives as "a child's experience in the early years has a major impact on their future life chances. A secure, safe and happy childhood is important in its own right, and it provides the foundation for children to make the most of their abilities and talents as they grow up.” (DfES 2007).

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In addition a number of **conferences** attended have informed the strategies in this document:

- Supporting the FASD child in a Pre-School Setting, Woodstock, Oxfordshire , FASD Trust
- Binge Britain: Significant Harm for the Unborn Child, Ormskirk, Liverpool, Parents for Children
- Tackling the Challenge of FASD, London, NOFAS-UK

APPENDIX 1

Members of the Practitioner Focus Group

Sharon Andrews, Area SENCo, WCC
Janet Arnold, Supervisor, Avonvale Special Needs Playgroup
Carole Baker, Assistant, Avonvale Special Needs Playgroup
Carolyn Blackburn, Research Assistant, FASD Project, Sunfield Special School
Sharon Bryan, Manager, In-B-Tweenies Pre-School
Alyson Burton, Nursery Manager, Ducklings Day Nursery
Gill Buttle, Nursery Teacher, Gorse Hill community Primary School
Sally Hearn, Nursery Integration Worker, Early Years and Childcare Service, WCC
Alison Hitchins, Service Development Manager, Early Years and Childcare, WCC
Caroline Murray, Manager, Playdays Pre-School
Sheila Robson, Occupational Therapy Assistant, Sunfield Special School
Sian Webster, Nursery Integration Worker, Early Years and Childcare Service, WCC
Becky White, Inclusion Officer, Early Years and Childcare Service, WCC
Teresa Whitehurst, Research and Development Officer, Sunfield Special School

APPENDIX 2

Worcestershire Early Years Settings Who Participated in Interviews

3 Bears Pre-School, Wychavon
Avonvale Special Needs Pre-School, Wychavon
Abacus Nursery School, Bromsgrove
Abbey wood First School, Redditch
Cookley Primary School, Wyre Forest
Fairfield Day Nursery, Worcester
Gorse Hill Community Primary School – Nursery Class, Worcester
Ducklings Day Nursery, Bromsgrove
Holly Trees Day Nursery, Redditch
Kidderminster Road Home Nursery, Bromsgrove
King's Hawford Kindergarten, Wychavon
In-B-Tweenies Pre-School, Wyre Forest
Jacky Howard, Childminder, Redditch
Lickey Hills Primary School, Bromsgrove
Little Angels Nursery UK Ltd, Redditch
London Road Playgroup and Pre-School, Worcester
Mount Carmel Pre-School, Redditch
Pauline Smith, Childminder, Wychavon
The Lenches, Pre-School Group, Wychavon
The Playhouse Pre-School, Wychavon
Playspace Nursery, Malvern
Poppins Day Nursery, Worcester
Sidemoor Pre-School, Bromsgrove
Sonia Tyler, Childminder, Malvern
St. Mathias C.E. Primary School, Malvern
St. Oswalds Nursery and Wrap Around Care, Wyre Forest
Sugarbrook Pre-School, Bromsgrove
Theresa Murphy, Childminder, Wyre Forest

Upton Pre-School, Malvern

Walnut Cottage Nursery, Malvern

WANDS Nursery, Wychavon

Westlands First School, Wychavon

726 Nursery @ Franche Children's Centre, Wyre Forest

APPENDIX 3

Early Years Action and Early Years Action Plus

Early Years Action

Early years action is the first stage of concern about a child's progress and happens when a parent/carer or early years practitioner thinks that a child's needs are not being met by the usual provision in an early years setting. This is likely to be because a child:

- Makes little or no progress
- Has difficulty with language
- Has emotional or behavioural difficulties
- Has communications difficulties
- Has sensory or physical problems.

Early Years Action Plus

If a child does not make enough progress through interventions and strategies put in place at Early Years Action, the child's key worker or the SENCO would normally talk to parents/carers about asking for advice from other people outside the early years setting such as:

- Area SENCo
- Specialist teacher
- Educational psychologist
- Speech and language therapist
- Health professionals
- Sensory specialist
- Behaviour specialist

They will look at the child's records to get a full picture of their progress, the strategies already used by the early years setting and targets that have been set and achieved. Together with the early years setting and parents, the specialists will develop a plan for the child.