Brain to Behavior: A Translational Science Need in Child Welfare

Good morning, afternoon, evening, depending on where you are when you're viewing this presentation.

Welcome to *Brain to Behavior: A Translational Science Need in Child Welfare*.

My name is Dr. William (Liam) Curran, and I'm an LCSW, a licensed clinical social worker, also Adjunct Professor, but I'm also an independent clinical professor at clinical practice, where I perform biosocial assessments with children with, or suspected of having, fetal alcohol.

You will see here on slide two, *Bridging the Gap, the Neurodevelopmental Impairments in Child Welfare and the System Response*.

A small selection of what is a considerable amount of literature that has been, for many years now, drawing attention to the fact that there is a significant issue in our child welfare system that is potentially not being addressed in any meaningful way.

You see there that Popova in 2019 noted that the potential for fetal alcohol in the child welfare system is 10 to 40 times higher than in the general population.

And it's not hard to imagine this because we know what the neurobehavioral presentation of fetal alcohol is in foster and adoptive homes. Therefore, we can understand how that neurobehavioral presentation is an antecedent to these children entering the state systems of care.

Again, evidence just continues to emerge. And sadly, the child welfare system globally is starting to see some significant failings. And you'll notice there, in brackets, child fatalities that are happening in our child welfare system.

And I think the danger is that if we don't acknowledge the child welfare system in its entirety and the context of fetal alcohol, then these collateral damage situations will continue to happen.

Now, I do think that for child welfare system, there is a controversial statement there, which is the time to move on from diagnosis and to adopt a social model of disability lens in terms of the child welfare need.

Because, again, the vast, vast majority of undiagnosed children will be residing in child welfare system, and they will be residing with a hidden disability.

And that hidden disability is notoriously difficult to diagnose.

So therefore, I think the child welfare system needs to kind of balance out its approach to fetal alcohol and not be too reliant or too focused on the issue of diagnosises.

And again, what is missing in child welfare system is the systemic approach to fetal alcohol. Again, this has been written about, this has been documented, and this has been advocated for many, many times.

Dorothy Badry here in Canada is potentially one of the leaders of calling for that systematic change in child welfare system.

We see our paper with the other social work professor, Choate, in 2015, and that paper was again documenting the tragic incidents of

a child in the system and the connection of fetal alcohol, and how that played out in that tragic system.

Again, if we don't look at child welfare system from a more holistic approach on the fetal alcohol spectrum, then we are potentially just helping these children to graduate into the juvenile system, into the adolescent, child and adolescent psych care.

We're going to graduate them into school failures.

We're going to graduate them into addiction because we're not willing to go there in terms of a system approach.

And again, when you talk about child welfare system and the context of FASD, it is not just the foster care narrative or the adoptive parent narrative, which is very, very important. And again, I work with foster and adoptive parents in terms of assessments. I know there's a burden falling on them.

But again, just looking at Ontario, there's 11,632 children in the care of the system.

Again, I talk my own country of Ireland, and we have 5,900.

84% of that is in the foster care system.

But it's the total amount of the children in child welfare system that we need to engage with.

I also talk about the need of culturally specific work and the need to engage with epidemiologists on what is the alcohol rate in pregnancy in any given culture.

Now, if anyone reads my qualitative work, you will very quickly see and understand that my qualitative work is based in Ireland.

And Ireland has one of the highest alcohol rates in pregnancy at 82%, or a shared joint rate of 75% between Ireland and the UK.

Therefore, my research and my qualitative research is very much different to perhaps what happens here in the US and Canada because of that very high rate of alcohol in pregnancy.

In my research and what I've developed, I've brought forward this proposed assessment pathway for the child welfare system.

The five-step screening model was designed specifically for child welfare.

It comes from qualitative work. It comes from data supplied by frontline social workers who really call for the need of something pragmatic and call for a pathway for when these children present on their caseload, they need to know which way to turn and what way to advance the case.

Again, you can see there in one to five, a genetic screen, behavioral screen, adaptive behavioral screen, and executive functioning screen, with a plan of safe care in step five.

Now, I know that some people are a bit confused by step one as a genetic screen because fetal alcohol is not genetic.

But I think people can accept that our child welfare system is absorbing a very high rate of neurodisabilities, not just fetal alcohol. And as neurodisabilities, they are hidden to the naked eye.

We have many, many kind of disabilities that can look like fetal alcohol.

And therefore, my recommendation is that we do a genetic screen because some of these neurobehavioral presentations on our caseloads and in child welfare are recognized neurodisabilities.

One of the recent ones that came on board was Menkes syndrome, which is a copper deficiency.

The children with Menkes syndrome or Menkes disease will actually look very like fetal alcohol in terms of the neurobehavioral presentation.

So a genetic screen is vitally important to rule out other neurodisabilities.

Yes, fetal alcohol is not genetic.

Again, in the paper that is explained, and the paper ref will be at the end of this presentation.

But I say that the implementation of the five-step screening model in child welfare, it needs the triple P of policy, procedure, and protocol.

That triple P is there to support social work and to give social work a pathway to take these cases from initial presentation through to plans of safe care and placement in the community.

The call for PPP in child welfare screening practice is for fetal alcohol harm to be standardized practice. It helps to identify functional vulnerabilities and inform disability-responsive interventions.

Embedded in routine FASD-informed assessment, it can improve interventions, planning, and interprofessional collaboration.

Screening turns identification into it’s value lies not only in facilitating diagnosis but translating a child's functional profile into informed interventions, appropriate accommodations, and measurable support outcomes.

We need neurodevelopmental literacy. It's both a practice and organizational imperative.

And that is about competency, professional-level training going into our system.

Some of you will know that I used to deliver full-day training programs in Europe for social workers.

In those full days, they were very commonly evaluated as needing two days.

That tells you how complex this disability is on the front line of social work in our child welfare system.

And it tells the corporate parent that social work does need support.

Social work needs guidance, and they need the triple P in order to be effective in assessing and planning the safe care of these children.

The triple P, if done through a systemic lens, it strengthens the agency's ability to work as corporate parents and to collaborate with other key services that is needed for the planning of safe care.

It strengthens caregiver understanding, again, where professional competency-based education is happening.

It promotes interdisciplinary collaboration. Policy, procedure, and protocol-driven screening supports social work practice.

And again, we have the research, but we need translational science to bring evidence to life. Now, I'm working on a paper on translational science and fetal alcohol, and I hope to have that out later in the year.

And again, the translational science is an area that I think that fetal alcohol needs to be kind of engaged with.

So ultimately, folks, the questions that often are presented in child welfare is what is wrong with this child? And I'm trying to get the system to say, "What does this child need to succeed?"

What we know is that early recognition and appropriate environmental adaptions, every child will present with uniquely different presentations. Interventions, care plans need to be tailored to a unique individual profile.

Applying the five-step neurodevelopmental screening tool can reduce escalating crisis services, youth justice involvement, homelessness, substance misuse, and adverse lifelong outcomes.

That is the kind of challenge of our child welfare system.

The research is very, very clear that if we don't intervene, then those secondary disabilities become a significant burden on society.

And we know from the research here in Canada by Johansson that fetal alcohol is estimated to cost $10 billion a year in the service needs that are required to meet those secondary disabilities as they prevail in society.

Now, if you want to read more about the five-step please have a look at *"Capturing Visibility: Child Welfare, Social Workers, Interventions, and Assessment Planning in Presentation of Fetal Alcohol Spectrum Disorders."* And that's in the *Advances in Dual Diagnosis*.

And I want to thank my colleague, Matt Danbrook, who is a psychologist here in Ontario, for collaborating with me on that paper.

So yeah, folks, that's a very brief overview of *From Brain to Behavior* presentation.

My email is on the front slide, and I would ask you to connect with me and to reach out if you have any questions or queries that are not covered in this brief presentation.

Thank you very much, and take care. Bye-bye.