



Do we want “FAS clinics”?

This summer, I was invited to participate in the Asian Pacific Society for Research on Alcohol and Addiction’s conference in Australia focused on Fetal Alcohol Spectrum Disorders (FASDs). As I listened to representatives from a wide variety of Pacific nations present their work on FASDs, a common theme quickly became evident: all countries were having difficulty obtaining political, financial, and popular support to develop clinics dedicated to the assessment and treatment of children affected by prenatal alcohol exposure. As I listened to the presentations, a question occurred to me: *Do we really need – or want – “FAS clinics”?* This is an important question to consider from a strategic as well as a clinical perspective.

As most readers of this newsletter know, it is very difficult to get political or popular will behind a clinic that specifically serves children with FASDs. Alcohol use in pregnancy is not a very attractive topic, and significant portions of the general population (and, unfortunately, a number of health professionals) discount alcohol as a teratogen. The most common attitude on the part of the public often is a combination of denial and benign neglect. So should we forge ahead and expend our energy trying to convince people to support specialized “FAS clinics?” I say, “No.”

Clinically, if we label our clinical programs as specialized FAS clinics, we run the risk of never seeing the great majority of children affected by prenatal alcohol exposure. As we documented in our recent article published in *Pediatrics* this last February, most children with FASDs are not recognized as such. Based on data from our study, if our clinic in Chicago were branded as an FAS clinic, 80% of the children that we diagnosed within FASDs never would have been referred to us.¹



From its inception, we have identified our program as a neurodevelopmental clinic, open to all children with developmental, behavioral, or mental health difficulties. We are recognized for our specialized expertise in assessing and treating children with FASDs, but over all, only about one-third of the children referred to us meet criteria for a diagnosis related to prenatal alcohol exposure. The others have a wide variety of deficits and challenges unrelated to prenatal exposures and most often complicated by the effects of early trauma.

So, both from a strategic and clinical perspective, my advice is to forego trying to build a program restricted to caring for children with prenatal alcohol exposure and open your clinical care to all children at risk due to neurodevelopmental deficits. You will see numerous children with FASDs, and you're your staff must have the ability to conduct comprehensive and appropriate assessments of children affected by FASDs. But if you restrict your branding and identity as working only with children affected by prenatal alcohol exposure, you will never see the great majority of affected children. And, politically, a broader neurodevelopmental clinic is a much easier sell than an FAS clinic. This translates into a win for you and a win for the children of your community.

¹ Chasnoff IJ, Wells AM, King L. Misdiagnosis and missed diagnoses in foster and adopted children with prenatal alcohol exposure. *Pediatrics*. 2015; 135:264-270.