

## DEAR READERS.

We present to you our second publication this year under the series, "Effective Social Welfare Practices Applied in Gdynia". The first one, entitled "Family-Oriented Approach", addressed a number of significant topics related to providing effective, multi-faceted assistance to families and children in Gdynia through the use of family assistants, three-level social work, specialist facilities for parents and children and a well-developed network of family-type foster care. In our activities, we are supported by a broad coalition of municipal institutions, non-governmental organisations and representatives of socially responsible business in Gdynia. This publication focuses exclusively on one topic – Foetal Alcohol Spectrum Disorders (FASD), with Foetal Alcohol Syndrome (FAS) as the most severe form.

Many families across the whole world struggle with the difficulty of raising children born with rare diseases, defects or disorders, the origins of which sometimes cannot be explained, even by modern science. These conditions often cannot be foreseen, let alone prevented.

This is not the case with FAS. In order to avoid it, it is enough to have a strong will and to be aware of major lifelong consequences for the child exposed to alcohol during pregnancy. Health professionals speak with one voice here, repeating over and over again that total abstinence from alcohol throughout the whole pregnancy is the only sure and effective way to protect the child from FASD.

Unfortunately, as statistics show, over 30 percent of Polish women drink alcohol while pregnant. This is one of the reasons why we have decided to organise the social campaign "FASD — Caring for the Child" in Gdynia for the second time. Our intention is to educate the local community and to make people more sensitive to this issue.

We are aware that prevention and education are just one side of the coin. Over the years, Gdynia has adopted a systematic approach to FAS. In July 2009, a Municipal Programme for FAS Education and Therapy was developed. On 9th September 2010, the Gdynia Unit for FAS Diagnosis and Therapy was launched which has now been transformed into the Gdynia Centre for FASD Diagnosis and Therapy. This would never be possible without the understanding and trust of Gdynia's local authorities.



MIROSŁAWA JEZIOR

Director of the Municipal Social Services Centre
in Gdynia

In the following pages, Michał Guć, Vice-President of the City of Gdynia, presents a broader view of the social policy in our city. He explains why Gdynia is such a fertile ground for so many ideas to be developed dynamically and successfully implemented.

I would like to recommend the articles written by specialists with many years of experience with FAS in Poland, i.e. Teresa Jadczak-Szumiło and Krzysztof Liszcz. Krzysztof has been with us since the beginning, both as our good spirit and a strong supporter of our activities in Gdynia. We also present the story of little Nikola, who proves that nothing is ever a foregone conclusion, along with interesting reflections by Elżbieta Dudaref.

I have seen such cases many times and I know how much effort needs to be invested in children impaired by their mother's drinking to ensure that, in the future, they are not entirely dependent on other people and are able to function on their own as much as possible. Every day I get to see the wonderful effects that can be achieved with the determination of the care staff and support of specialists, backed up by an efficient municipal welfare system. With this in mind and with the commitment of many people who care deeply about the problem of FAS, I believe that I can be optimistic about the future.

# A (Not) Ugly Duckling

# BEATA PODLASEK

An educator, Manager of Residential Child Care Unit

I WOULD LIKE TO DEDICATE THIS FAIRY TALE TO MY DAUGHTER NIKOLA, WHO TEACHES ME EVERY DAY WHAT LIFE IS.

It was all dark, wet and everything had a strange smell. It was warm, but I was not comfortable.
I wanted to escape, get out as soon as possible.

I felt that somewhere else there was another world. Suddenly, there was a scream, a commotion and a rush. I knew that everything is going to change forever. Something strange is happening to the part of me that is me and the other one from which I come. We are getting separated. I can feel we are still together, but less and less now. An unimaginable force is pushing me into a strange dimension, into the unknown.

# I am.

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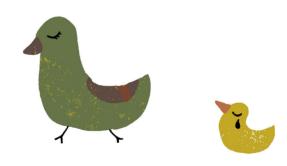
There she is. I can see her. Quickly, we have no time to lose. She is so small and so strange, let's save her. There she is.

Medical record: Birth weight 950 g, length 37 cm, head circumference 25 cm, chest circumference 22 cm. Apgar score: no entry... Blood alcohol content: 4.25 per mille.



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Oh, this is me. The other part, the one from which I came, is my mother. She gets up, walks away. I try to scream. I scream, I want to call after her: stay, take care of me. You can still fix it, we will manage. Don't leave me. I want to shout all these words, but I can't, they are only in my head, in my heart – only a strange, terrifying scream comes out of my mouth, filled with agonising despair. Mum, don't go, don't leave me, I'm scared. I try once again, but differently this time: mum, I am here, thank you. Again, only a cry comes out of my mouth.



# Medical record:

Born preterm. Newborn's condition due to maternal alcohol consumption. FAS. Hyperbilirubinaemia, CNS defect (absence of the corpus callosum), liver haematoma. Anaemia.

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The world is so strange, people, equipment, machines. I know that I am, I heard that I'm small and ill – but I want to carry on being. I come to a home of fairies; there are many of them, just like other small creatures – I want

to live, I want to be, I want to eat. And I can't. I can't suck - I am different. I am passed from hands to hands. they massage me, touch me, check me and press on me, I don't like them. There are too many of them. Sometimes good hands show up, too. They feel nice and safe, but they never stop for longer. As soon as I get used to them, they change again. I don't want this, I am scared - I try to say it, but the words in my head only turn into a scream. I know they don't like me here, I feel different, strange and out of place. Where is my place anyway? The fairies wait for my progress, some of them whisper nice words into my ear, others just mechanically try to condition me, make me better. And what about me? I can't keep up, I can't make it. I get dizzy. There are so many children. I feel like I'm falling down. I crumble. I'm falling apart. But I am here. I say this in my own way - I scream. Why does nobody understand my screams?

Medical record: Encephalopathy with a severe delay in psychomotor development, epilepsy, muscle tone disorders. Short stature. Gastrostomy (PEG) due to reduced body weight and poor weight gain. Visual impairment – myopic astigmatism. Bilateral hearing loss (50%). Orthoses used periodically for lower extremities.

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The world looks different today. The sun, the wind and the trees appear to be the same. And yet, I know that something is going to change. Today I am to meet my second mum. I had to wait for her for five long years; I almost lost hope. But there she is – she has finally found me. And she will stay forever, only me and her.

There she is. I don't know how to behave; she is nothing like my ideas and dreams. She doesn't know what to do either. I think she can see that I am different, that I am an ugly duckling – I heard the fairies call me that, she won't want me - probably she is looking for a beautiful swan. Mum, mum, it's me, says my inner voice, but my body doesn't react. I can't say this, I can't cuddle up, I can't walk. I can scream, so I scream. Here I am. But no one wants me to scream, the fairies come over and tell mum which spell to use to make me calm and quiet. She stands there, all alone among them, and I can feel that she doesn't understand anything. She's going to leave... Mum, mum, stay. I scream again desperately, terrifyingly, as loud as I can. She looks at me in astonishment – she leaves. Is she not coming back? She's going to walk away like my first mother. I'm scared and I scream, scream - as loud as I can. The fairies use their magic - I fall asleep.

She comes back - there she is. Mum. They pack my things. Mum reaches out her hands, hugs me, I can feel

her hands trembling. She is not alone. Doesn't matter. I'll be quiet, I'll do my best. Just take me with you, mum. We are at home. Others are here, too. I'm scared, mum, this is not how it was supposed to be. I'm scared and I scream. She can't understand my cries, either, I know, but... something strange happens. She hugs me, holds me tight, I know that she won't let go. She sings quietly into my ear: I love you, I love you – and you love me, you love me. This feels good, I fall asleep. Slowly I get to know my new home, my dad, other children. There are so many new things, I look around and I can see, the world is so beautiful.



Day 1. We go for a walk, my mother puts my legs in those shackles, they hurt and I don't want them. I keep screaming... Mum doesn't understand anything. I'm supposed to walk. Does mum also want to condition me? Mum, mum, I don't want it, I can't catch up, I won't make it. I scream. Mum looks at me and I can see that she has finally understood my voice. She set my aching feet free. Dad is here. He takes me to something green. He takes my shoes off and I can feel my bare feet sink into something wonderfully green, moist, fragrant – it's grass, mum says. I know I'm going to walk. I walk.

# I am and I can walk.

Day 2. It's in the evening and it's cold and dark. We are in a hurry. Mum and my sister. I'm scared and I'm going to scream. I'll just wait for a while. We go into a huge, beautiful room. It is wonderful. Mum leans over and whispers into my ear – it's a church and a concert. I can't stop the cry that comes straight from my heart – it is a cry of delight. Everyone turns around and... smiles... They realise that I screamed with delight. I do not know words. But I understand the language of music and beauty. Mum, this is wonderful.

I am, and I can see and hear.

**Day 3.** Mum is not here, I'm scared. I want to scream. Dad comes over to me. He hugs me, rocks me; it feels so good and blissful like never before. We stay like this.

# I am and I can cuddle up.

Day 4. Mum runs for the bus. She holds me in her hands; I'm scared, why is she running so fast. What is happening? She whispers a word into my ear: a kindergarten. Such a strange and terrible word. Mum says that I don't have to be afraid. She will wait for me. My sister is next to us. I'm going to trust her. The kindergarten is great. They like me, they say: a beautiful girl, they praise me. I learn, discover and admire. I don't have to do anything faster or better. I'm good, just as I am. For real.

# I am and I can relate to others.

**Day 5.** A bottle. With a white, warm, sweet liquid. I try it. It's delicious. I drink it. Everyone at home claps their hands.

# I am and I can eat like others.

**Day 6.** We are in a strange big car, mum whispers into my ear: it's a bus. You can look at everything. I don't want to. It's hot and the journey is so long. I want to get out of here. I cry. Mum doesn't react, I scream louder and louder. Mum tries to calm me down, but I don't want to be here. All of a sudden I can hear this horrible voice: get off, we have the right to travel in peace and quiet. Mum is crying. And I scream, scream, scream.

# I am and I have the right to be with you, just as I am.

Day 7. We get into the car. Mum sings, we travel for a long time, far away to another city. Mum says we're going to a therapy. There are two fairies waiting for us; they are wonderful, gentle, they understand me, they look and listen. They talk to me and about me with such respect like no-one before. Mum is moved, I can feel it, we've found a good place. There are so many good places for me. Mum and dad keep looking for them. Sometimes other people help.

# I am and I can learn.

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Mum, I will never turn into a swan. I know, I love you, my little pretty Duckling.

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There are more of us, (not) ugly ducklings. More than I can imagine or count.



What do we need in order to discover the truth about ourselves, to be able to live? Two magical ingredients: hard work and love.

Once we get them, everything is possible.



# Gdynia. A city open-minded to the problems of its inhabitants

MICHAŁ GUĆ

Vice-President of the City of Gdynia

MICHAŁ GUĆ, VICE-PRESIDENT OF GDY-NIA, TALKS ABOUT GDYNIA'S ACTIONS RELATED TO FAS AND THE COMMITMENT OF THE LOCAL AUTHORITIES TO SOLVING SOCIAL PROBLEMS.

• Gdynia is the only city in Poland that funds from its budget a facility where children with Foetal Alcohol Syndrome (FAS) are offered comprehensive help for free. How come FAS-related activities have found such a fertile ground in Gdynia?

Eight years ago a conference was held in the Franciscan Fathers' Church focusing on the problem of excessive alcohol consumption, also amongst pregnant women. The event was attended by Mirosława Jezior, Director of the Municipal Social Services Centre in Gdynia. Together with the conference organiser, Dr Grażyna Rymaszewska, she proposed working out a city programme focused on providing effective assistance to children with FAS in Gdynia. It was a very innovative project, albeit not an easy one to implement. Thanks to the open-minded attitude of the president of Gdynia, we were able to start working on it immediately. As early as in July 2009, a Municipal Programme for FAS Education and Therapy was developed in the Municipal Social Services Centre in Gdynia. The programme was then extended for the three consecutive years, until 2011. The longer we studied FAS, the more we were convinced that the fact that



some women drink alcohol during pregnancy and thus hurt their children could no longer by ignored. It had to be stated clearly that this problem was not limited to dysfunctional families or alcohol addicts. Thus, on the one hand we wanted to fight for the future life and health of children, while on the other hand we sought to tackle stereotypes.

• Speaking of stereotypes, you probably had to start with education.

Yes, it was very important. For years, no-one had associated children's behavioural disorders, physical disability and facial anomalies with their mother's drinking during pregnancy. Various explanations were supplied as to why such children had problems; for example, with concentration, memory or coping in a peer group. Even if the causal relationship between these two facts was known, no-one had the courage to talk about it. No-one knew how to tell the mother that she and the alcohol she had drunk during pregnancy were the root cause of her child's problems. Therefore, we started with training sessions involving foster parents, care staff, family assistants, teachers, psychologists, educators, doctors, case workers, etc. Once we had prepared them to identify FAS whenever they notice anything disturbing in children's behaviour, we began to think about opening a special unit in Gdynia which would specialise in diagnosing FAS in children. On 9th September 2010, i.e. the FASD Awareness Day, together with Dr Krzysztof Liszcz, a national expert in and an advocate of the problem of FAS in Poland, I opened the Diagnostic and Consultation Unit for children with FAS and their families. It was located in 65 Wejherowska Street at the Youth Care Facility. The city provided PLN 30,000 from its budget and we managed to obtain PLN 20,000 from the Ministry of Labour and Social Policy.

• At the same time the social campaign "Caring for the Child" was continued in Gdynia..

If you want to address social problems effectively you need to inform as many people about them as possible. It is necessary to make people more aware, shake them up a little and make them open their eyes.

Sometimes difficult issues have to be discussed in non-obvious places to force people to reflect upon them. Our campaign "Caring for the Child" was for example carried out in the means of public transport. Posters were placed inside the city buses and trolleybuses which warned passengers that any amount of alcohol consumed by a pregnant woman may affect the child's health. Similar materials could be found in medical clinics. We also asked priests from Gdynia parishes to give information about our campaign, at least at the end of the mass during the parish announcements. Our posters appeared on church noticeboards, while altar boys distributed the leaflets. A similar action was scheduled for September that same year. I have no doubt that these actions are effective, as step by step they contribute to raising people's awareness.

# • The programme ended in 2011...

... but we carried on. Gdunia provided additional funds from its budget for the Unit in Wejherowska Street and for the purchase of specialist diagnostic equipment. The staff of the Youth Care Facility conducted an information campaign at schools, addressed to students and teachers. All the children placed in foster care were diagnosed for FASD. Over a period of four years, until 2015, a total of 201 children were consulted. What is important, and I would like to particularly emphasise it, every diagnosis issued by our specialists is complete. It is not simply limited to stating that the child either "meets" or "does not meet the FASD criteria". If FASD is not confirmed, other possible causes are considered and recommendations for further therapy are provided. There is now substantial help given to parents or care staff who often feel lost or overwhelmed by their problems. We managed to achieve a state in which our educational, diagnostic and therapeutic activities grew larger and had a wider range. Fortunately, we did not have many serious cases of drunk women giving birth to intoxicated children. Nevertheless, the number of diagnoses issued or people treated in our Unit clearly indicated that FASD was not an exaggerated problem.

 With this in mind, you were only a step away from opening the Gdynia Centre for FASD Diagnosis and Therapy.

The growing needs led us to believe that we needed to take our FAS-related activities to the next level. Among the city-owned buildings, we found one which was ideal for this purpose. Opening at the beginning of the year in Morska Street in the district of Grabówek, the Gdynia Centre for FASD Diagnosis and Therapy has developed even further the work we started in Wejherowska Street. Its formal status has changed, but only to the benefit of its patients. The building seats the consulting rooms of a psychiatrist, a psychologist and a psychotherapist. In addition, the Centre employs

a neurologist and a physical therapist. Depending on the severity of their condition caused by prenatal alcohol consumption, children with FAS recover to a certain extent and are able to function despite their problems. With systematic professional help, such people do not have to constantly rely on the care staff or be forced to stay in a facility for the disabled. Children with FAS attend regular schools and do not necessarily require integration classes; later they graduate from universities and have jobs. Achieving such progress requires a lot of work and perseverance. They need to believe that they will succeed, that the hard work is worth it.

Parents and care staff of children with FAS require multi-faceted support, including that of a psychologist, as they will need a lot of strength to come to terms with the fact that, despite their best efforts, their child will never develop certain habits or acquire certain skills. This may make parents and care staff angry and frustrated; some of them might even want to give up. The Centre specialists are also there for them. They can explain the complex reality of children with FAS and offer directions which may or simply have to be followed in order to navigate around their world with them.

• Why are the authorities of Gdynia so open-minded to social problems? Where do you find the motivation to solve them in a way that often precedes systemic solutions?

We want everyone in Gdynia to enjoy a good, comfortable life. With this said, however, people's satisfaction does not only depend upon well-maintained pavements or a highly developed network of public transport, but also upon the municipal support they might receive in crisis situations. Although it is perhaps a cliché, our ethos has never ceased to lose its relevance; we have sought to provide a fishing rod rather than a fish. In other words, we never do other people's work for them. Our job is to provide support to them, motivate them, suggest solutions and reveal their good sides. We do not want to make anyone dependent on the welfare state, but we would like to make them believe that it is possible to find a way out of a difficult situation. It may not happen right away, and it may not always be a bed of roses, but these people have to have faith and fight for themselves.

When we saw, a few years ago, that the number of children placed in foster care in Gdynia was growing at an alarming rate, rather than sitting and waiting for the regulations to change, we introduced the position of a Family Assistant. We developed the programme "Rodzina Bliżej Siebie" (in English: "Family Closer Together"), obtained EU funding and started to work with families at risk of falling apart. When we ran

out of European resources, we managed to secure the necessary funds from the city budget. I cannot imagine ever ceasing activities which bring such tangible results: in 2007, 140 children were placed in foster care, compared with only 48 in 2015. We have not had a large institutional-type children's home in Gdynia for many years, as we now focus only on family-run facilities.

We have launched a number of individualised programmes aimed at those who have found themselves in a difficult housing situation or who are on the path out of homelessness. Consequently, the number of homeless people in Gdynia has stopped growing and instead of building another shelter, we are now planning to reduce the number of beds in the ones we already have.

• Your activities are very diversified. Where do you find people for so many different projects? We have a great team of people not only in the Municipal Social Services Centre, but also among our coalition partners, local self-government and government institutions, social organisations. We cooperate on a regular basis, rather than working from action to action. We build thematic platforms for the exchange of knowledge, information, statements and the implementation of joint projects. Gdynia is remarkable for its active local community. The number of people involved in our initiatives aimed at preventing violence, promoting health and civic activity keeps growing. Our social policy activities have produced effects and are therefore recognised and awarded both in Poland and abroad. For us, as the city authorities, it is a sign that we are on the right path, while for all the people involved it is a source of satisfaction and motivation to engage in further activity.



# 112B Morska Street. A place where children with FASD are offered a chance for a better life

DR N. MED. AGATA CICHOŃ-LENART

Head of the Gdynia Centre for FASD Diagnosis and Therapy

IT IS THE ONLY SUCH PLACE IN POLAND WHICH IS FULLY FUNDED FROM THE LOCAL BUDGET. IN FEBRUARY 2016, AFTER 10 YEARS OF OPERATION, THE CENTRE CHANGED ITS FORMULA AND MOVED TO ITS OWN NEW ADDRESS.

The Gdynia Centre for FASD Diagnosis and Therapy is "a baby" of Mirosława Jezior, Director of the Municipal Social Services Centre in Gdynia. In 2009, after having been in contact with Dr Krzysztof Liszcz and Dr Grażyna Rymaszewska, she clearly stated that the fact that pregnant women drink alcohol and, as a consequence, give birth to children with defects could no longer be hidden. In 2010, the Diagnostic and Consultation Unit for children with FAS was established. Over time it grew to such an extent that it was transformed into a separate facility. At the beginning of 2016, the Gdynia Centre for FASD Diagnosis and Therapy



DR N. MED. AGATA CICHOŃ-LENART

was launched. Following the international nomenclature, we have decided to use the abbreviation "FASD"

rather than "FAS", as the latter refers merely to one of the general spectrum of alcohol-related disorders. Our intention was to stress our interest in the whole range of impairments present in children exposed to alcohol during pregnancy.

In addition, we opted for this name because we wanted to emphasise that this is the only such place in Poland whose activity is fully funded from the local budget. It is a truly remarkable and unique thing that our local authorities can see this social problem so clearly. We have not received any funds from the National Health Fund (NFZ, i.e. the equivalent of the National Health Service in Poland). The Director of the State Agency for the Prevention of Alcohol-Related Problems (PARPA) has been trying to change it and the discussions at the central level are ongoing. This is what we need to do! After all, the problem does exist and it raises concern even if its official name is not widely known...

The Centre at 112B Morska Street in the district of Grabówek has been open to patients since 1st February 2016.

Our team consists of four people: Anna Piaskowska, a psychologist; Agnieszka Irzykowska, a physical therapist and a specialist in Sensory Integration Therapy; Marta Rejmert-Mozol, an educator; and Agata Cichoń-Lenart, a child and adolescent psychiatrist. We cooperate on a regular basis with Seweryna Konieczna, a neurologist.

We work with children aged from 18 months to almost 20 years. This year, the Centre has extended its care over more than 77 people. We have issued 25 complete diagnoses and confirmed FASD in 10 cases.

I am proud that our team has managed to work out its own procedures, in result of which our diagnosis is never limited to simply stating that the patient either "meets" or "does not meet the FASD criteria". Our children leave the Centre with a complete psychiatric diagnosis complemented by an opinion of a psychologist and a neurologist, if necessary. It specifies the child's dysfunctions and recommends a future treatment even if the child is not diagnosed with FASD, but with other disorders (e.g. attention deficit hyperactivity disorder, attachment disorder, sensory processing disorder).

Starting from September, preventive measures addressed to secondary school students will be implemented by our educator who will also coordinate the environment of children diagnosed with FASD. Acting as a key worker, she will encourage all the people close to the child to cooperate. She will evaluate which environment needs support and what kind of assistance should be provided – the one focused on educational functions (school), child-raising (care staff, school) or the one that requires for a psychologist or a psychiatrist from the FASD Centre to be involved.

The waiting time for the first consultation is about two months, while patients already in our care are admitted on a regular basis, depending on their needs. Every new patient is first consulted by our psychologist. During the visit, information is collected together with any medical documentation available, i.e. health records, discharge papers, opinions and information on the child's functioning. Based on clinical tests, a psychological diagnosis is formed, after which a general medical examination follows, including a psychiatric and, in some cases, neurological evaluation. The last consultation is with our physical therapist – an SI therapist. The Centre has an appropriately equipped playground to make the assessment of the child's sensory development possible already at the first visit.

After the series of consultations, we exchange the information and form a diagnosis together as a team. If the child's difficulties are confirmed to have been caused by prenatal alcohol exposure, the child, together with the care staff, becomes our regular client. No age restrictions apply as our specialist consultations are also available to those who have reached majority provided that they are still a student or a dependant supported by other family members.

The parents or care staff of children diagnosed with FASD stay with us, regularly and diligently attend follow-up consultations and carefully follow our instructions. Generally, I can evaluate our cooperation as very good. Caregivers who provide foster care to children from Gdynia, but live in other counties, visit us less frequently, which is understandable. They are not subject to our routine methodology; instead, they receive our recommendations in writing and follow them together with a psychiatrist or a psychologist available in their place of residence.

Children are referred to the Centre by family assistants (children living in their biological families) or members of our Youth Care Facility. Sometimes parents come to us by themselves because they have read about FAS in the Internet or they have seen the sign of the Centre as they were passing by. The way in which the diagnosis is communicated is also important. You can never make the child feel guilty or lower their self-esteem. Any moral assessment of the mother's conduct in the presence of the child is unacceptable.

Parents or care staff should be concerned if the child falls behind their peers, not so much in

# terms of their educational progress, but in terms of their social adjustment.

Such children are more naive, childish and they hardly ever learn from their mistakes. Incapable of recognising the causal relationship, they are vulnerable to peer pressure and easily provoked.

Children with FASD often play with things intended for younger age groups. Their chaotic life and absent-mindedness can easily be mistaken for ADHD. Impaired brain structure leads to enormous memory deficits. Such children may never be capable of mastering the multiplication table.

Other problems include forgetting basic information about everyday life (e.g. that after the lesson the child has to pack their bag and leave the classroom). Children with FASD often get suspended in a void; without a clear instruction they do not know what to do. Any change (a different classroom or a cancelled lesson) makes them feel lost. They need guidance and cannot recognise certain nuances, while they have difficulty in understanding colloquial language and putting words in a context.

If a disability also affects the musculoskeletal system and is thus visible to other people, then the diagnostic process is typically faster and more extensive. Naturally, people want to find out why their child cannot walk, has tremor of the extremities, keeps falling down or walking into door frames. In the absence of a motor dysfunction, it is more difficult to get the diagnostic suspicion on the right track.

A person with FASD is not always intellectually impaired. Our tests show that although such children may be "blind" in certain areas, their intellect is normal or even above average.

In our work it is important to focus on the parts of the brain which were not damaged, despite the child's exposure to alcohol during pregnancy. An 18-month-old child starts with a physical therapy – the child's care staff and the physical therapist work on a greater integration of senses, improvement of the motor function and stimulation of the brain. In such small patients, the support of a psychologist is invaluable. The doctor will help obtain the necessary medical certificates and decisions (e.g. to apply for early development support or to refer the child to an early intervention centre).

Many of our clients are 2-, 3- and 4-year-olds. Diagnosing the child before they turn six is fundamental for a good prognosis. Working with FASD is primarily about preventing complications and discovering what works in the given case. Adverse effects can only be prevented if all the people from the child's environment are involved, including the child's quardians, biological or adoptive parents, care staff, teachers, psychologist, school counsellor, coach, foster care coordinator, family assistant, judicial officer, etc. Our actions are comprehensive. We always stress that you do not need to be highly knowledgeable about FASD. Not everyone has to become a specialist in diagnosing this type of disorders. Our training for employees of local social services centres lasts 90 minutes. This time is enough to learn how to recognise a possible link between the child's behaviour and FASD.

Teenagers come to us mainly when they show symptoms of behavioural disorders which may even take them to a youth court (e.g. due to an act of "demoralisation"). Typically, they are perceived by their teachers as disrespectful. These young people simply fool around to get attention, even if only for a very short time.

One of our clients, who is an adult now, came to us when she was a teenager. She lives in a foster family that is closely related to her. She gave birth as a minor. We work together so that one day, when the child is a little older, she can start her own family with her child and find a place on her own to become fully independent. She does not need any medication or psychological therapy. We simply talk to her and answer any questions she might have, even if they seem obvious. She is doing fine!

She knows that she has FASD and that it is not her fault, which is very important. She is aware of her deficits, mainly in terms of concentration, memory and cause-effect thinking. She writes everything down in her notebook and together we anticipate various situations, consider their effects and make a list of solutions. She has her own guidebook and in her case this system really works.

We also teach parents how to deal with their children in everyday life. We provide precise explanations of the areas where their children need support. We give them tips or guidelines, but we never do their work for them. This is the hardest part, when parents or care staff

try to shift their responsibility on us. We always have to keep the boundaries correctly. By carrying out our recommendations, caregivers become therapists to their children, both in their everyday work and relations. In fact, every caregiver who knows that they raise a child with FASD becomes their child's therapist. It is unavoidable.

Another important element of the relationship with our clients is our openness to negative emotions that accompany our joint educational effort. Adult caregivers need to hear that all their doubts and frustrations are normal and that we are there to admire, not to condemn them. We never point out what they have not done, but how much they have already achieved. This is crucial because they need to hear it from a specialist that, "Yes, such behaviour is normal in children with FASD". Theu have to be told that sometimes it will feel like playing a game to which nobody knows the rules, but they should never doubt that it makes sense. Some children might need our intervention at school, where their deficits are not always understood, mostly due to ignorance rather than out of spite. Sometimes we go to schools and talk to teachers. Such interventions are very productive. The methods addressed to children with FASD are also useful in work with healthy children and may be applied to the whole class. Sometimes the child's deficits also need to be communicated to distant relatives.

FASD may not necessarily be caused by drinking alcohol throughout the whole pregnancy. It is enough that it is consumed sporadically or indeed even incidentally. In the first weeks or months of pregnancy, many women do not even know that they are expecting a baby. Sometimes they feel it, but they have a problem accepting this information. They might negate it, live in denial.

It is a myth that children
with FAS are born by
women who are alcoholics
or who come from
pathological environments.
Children with FASD are
also born by women whose
economic or social status
is high, but who have
emotional problems, feel

# lonely or have no support. They often soothe their problem with pregnancy with a drink after work.

Unfortunately, FASD is a highly disruptive factor in the formation of a bond between biological parents and their children. Without such bond established at early stage, the child's further development is hindered. If the pregnancy is not wanted the woman might carry on drinking. The child is rejected already in the prenatal period, while labour hardly ever changes anything in such situation. On top of being born with deficits, these children will not have their basic needs satisfied. Children with FASD need more and more frequently, but instead they receive less and receive it very rarely.

Adoptive parents who decide to look after a child with FASD do not always have a full knowledge about the condition. Problems appear when the child is still small; all of a sudden they are confronted with an avalanche of unpleasant experiences. They might feel cheated, disappointed, let down.

They need to re-process this totally new situation. The moment when they are told that they have not failed as parents, but their child has FASD, may change them a lot, giving them new energy and strength.

I must admit that this line of work always comes with a heavy load. We have a supervision every four months. Our supervisor is from Żywiec and our meetings also contain elements of training.

When can we say that we have succeeded? When we manage to change the adult's approach to and perception of the child with FASD, and adjust their expectations to the child's abilities. Nonetheless, a full acceptance of the child is just the beginning of this very challenging road...



AGNIESZKA IRZYKOWSKA A physical therapist

I am a sensory integration therapist and I work with children "one to one". We meet once a week and our work is mostly playtime. In the therapy I mainly use suspended equipment which is effective in vestibular stimulation. Children with FAS have huge memory deficits, so our job is to support their cognitive development by stimulating the respective areas of the central nervous system. Owing to the experience of frequent severe tactile and auditory deficits, the therapy has always to be adjusted to the specific difficulties and needs of every child.



ANNA PIASKOWSKA A psychologist

Children are mainly referred to our Centre because of behaviour, learning, reading or writing difficulties. Disorders related to prenatal alcohol exposure may adopt different masks. At the beginning of our activity, our primary concern was to establish the diagnosis. Over time, as we gained more experience, we realised that our patients needed something more, particularly in terms of intervention. Today we focus mainly on providing support to our clients, either through a therapy or psycho-educational classes, both for parents and health professionals working with children and family. We organise meetings of support groups for parents, psycho-educational courses for psychologists, school counsellors, foster care coordinators, judicial officers, social workers, etc. In order to significantly improve the living conditions of children with FAS, it is crucial to promote knowledge about the origins of their developmental problems, the impact they have on their everyday life and, perhaps most importantly, ways in which their environment can be better adjusted to their needs.

In my opinion, it is particularly important to provide emotional support to the care staff. With the diagnosis in hand, they still have to face multiple difficulties every day. They are alone in caring for children with FAS. They often hear that they are incompetent and that they should try harder. Biological parents feel guilty and responsible for their child's condition, while foster or adoptive parents want to find out what to do, but they also have doubts about their decision.



# Everyday life is difficult, but not impossible

DR KRZYSZTOF LISZCZ

Aksjomat, Toruń

AN INCREASING NUMBER OF CHILDREN AND YOUNG PEOPLE DIAGNOSED WITH FASD ARE RAISED IN ADOPTIVE FAMI-LIES, FOSTER CARE AND RESIDENTIAL CARE. SUCH FAMILIES ACCOUNT FOR THE MAJORITY OF THOSE IN NEED OF MEDI-CAL, PSYCHOLOGICAL OR EDUCATIONAL ASSISTANCE, MOST CHILDREN WITH FASD ARE BORN IN FAMILIES OF LOW SOCIAL STATUS, WITH ALCOHOL PROBLEMS AND ADDICTED TO NICOTINE - THEY ARE NOT ABLE TO SEEK HELP FOR EXACTLY THE SAME REASONS OR BECAUSE OF THE FEEL-ING OF GUILT AND SHAME WHICH DO NOT GO AWAY EVEN IF NOW THEY LIVE IN ABSTINENCE. IN POLAND SUCH MOTHERS ARE TYPICALLY REJECTED AND STIGMA-TISED AS "HEARTLESS, BLAMEWORTHY. INHUMAN". IT IS SAID THAT THEY DE-SERVE TO BE PUNISHED AND KEPT UNDER SCRUTINY.

Foster/adoptive parents and teachers link children's school and educational problems to their dramatic family history prior to the adoption (blaming them on "bad" genes or child's "demoralisation"). Few health professionals and parents have a basic knowledge of FASD and how to approach problems related to this type of disorders.

Impaired memory and short attention span are the major reason for such children's difficulties at school. However, when they talk, their rich vocabulary, reduced distance and lower level of criticism are perceived as a sign of brightness and intelligence. In fact, they may



have a limited understanding of a dialogue or a text in a book, which they often "conceal" by excessive talking. As a consequence, more is expected of them and they are overloaded with too complex and too difficult tasks, both during lessons, i.e. in terms of studying and acquisition of skills, and during tests or exams. Eventually, they cannot deliver and can never achieve satisfaction with their marks. On the social level, due to their naivety, these children fall victim to pranks of peers or adults, sometimes even of professionals. Rejected, they feel dispirited and often show symptoms of depressive disorders, meaning that they become aggressive towards others and themselves. As in Poland, children's behaviour, both at school and at home, is assessed based on their educational progress, most children with FASD are evaluated in negative categories and are labelled as "insubordinate", "clever but lazy", "liars" or "unreliable". This leads to the appearance of secondary symptoms related to low self-esteem, such as seeking attention by breaking the rules or engaging in risky behaviour (e.g. "12-year-old Patryk constructed a dummy bomb and used it to threaten people at school").

When looking for ways of working or dealing with children with FASD, it is worth using the following set of rules forming a sort of "a Decalogue".

They will help compensate adequately for the child's deficits and deficiencies present in the activities of caregivers at home, at school or in their future job.

10 fundamental truths for raising and teaching children with FASD:

- (1) Concrete messages;
- (2) Stability; (3) Repetition;
  - (4) Daily routines;
- (5) Simplicity; (6) Attention to detail; (7) Rules;
  - (8) Supervision and constant monitoring;
- (9) Presence and attention; (10) Acceptance and putting up with difficult behaviour.

# 1. CONCRETE MESSAGES

Memory function, attention span and ability of abstract thinking are considerably reduced in most children with

FASD. They therefore need to be instructed and have all the messages and expectations communicated to them in a specific way. When talking to them or giving them instructions, use short sentences, with a clear description of their tasks and expected results. It is good to repeat the instructions, present them in a graphical form which is on display somewhere within the child's working area, give prompts and guide from one thing to another. Longer actions should be divided into stages and supervised. Do not count on children with FASD to guess what you mean, surprise you in a positive way or respond creatively to your expectations. The reality is a challenge for them and they have to cope with it every day. As the results of their actions typically evoke impatience and dissatisfaction, their family and caregivers may be inclined to do things for them. Their disappointment is all the greater when the child gives the impression of being competent, sensible and responsible because of their speech flow and a casual way of being. Therefore, clear instructions like "go there", "do this", "pass it", "write it down", "pick it up", will be more effective than saying "I was hoping you knew what to do when I was not around".

# 2. STABILITY

Most children with FASD have a disrupted feeling of the day rhythm, poor sense of passing time, limited ability to "detect incentives" and problems with making a choice (e.g. relevant vs. irrelevant). They also have a reduced sense of their influence on the course of events - they will either try to sleep through the rush of events or take action without considering its consequences. Their sleep is easily disturbed, and their attention frequently distracted; hence the need for stable expectations, a fixed plan of the day, including mealtimes and school lessons. Stability is certainty, free of the need to search, while it gives security and makes it easier to follow what is happening and what comes next. The care staff should not change, neither should they surprise the child with new ideas and rising expectations, or refer to the abilities or skills that the child "is supposed to have".

# 3. REPETITION

Since their short-term memory is limited and their experiential learning does not give permanent results, they need our help in the form of prompts and reminders which they can hold on to. Do not be afraid to repeat the same instructions every day, e.g. "Get up, it is 7 am", or "Go to the bathroom and brush your teeth". Otherwise, the child will oversleep and then, after a row, they will rush out in anger and go to school unwashed and without breakfast. The aim of the repetition is to keep the child's attention. This is necessary not because of

the child's intellectual deficits, but because of their memory and attention disorders. In this respect, it is also similar to rather obvious announcements played, for example, at railway stations in order to make it easier for travellers to find the right train, not to forget their personal belongings or to keep them informed about a train delay. It is particularly difficult for children and young people with FASD to learn from books, other people's notes or to learn by heart; often they are not capable of succeeding in doing it. However, they will gladly follow clearly defined procedures, e.g. assembly instructions, a recipe or a tour description in a guidebook. They can do things, but only step by step, while it is preferable if, on that path, they are accompanied by someone supportive.

# 4. DAILY ROUTINES

Following the previous three elements, i.e. concrete messages, stability and repetition, daily routines should be developed in order to regulate the child's day, the time of meals, time to study, time for household chores and hobbies. The routines will make the child feel at the right place, reduce the frustration of others and prevent an irresponsible or dangerous behaviour. Gymnastic routines, later performed in front of relatives and peers, certain sports, model-making, weaving or taking care of animals - all of these can become everyday activities serving as a source of satisfaction and an introduction to the future job, e.g. as a medical technician following the specific instructions of a nurse. The same person working as a doctor or a nurse could be a disaster both to their patients and themselves. The use of routines results from the need for an adult to help in assessing the situation, planning a sequence of actions and understanding the importance and hierarchy of problems. Independence and safe functioning are hindered by some difficulty in evaluating the significance of various actions, and understanding their gravity and priorities.

# 5. SIMPLICITY

Simple, simplified and clear do not mean primitive or sloppy. The genius of simplicity, clarity of communication and concrete instructions are expected and needed by all of us; in particular, those with FASD. They have problems understanding other people's speech and written texts, following inaccurate instructions, especially if they require "reading between the lines" or guessing what someone had in mind. They need a text which is simple, i.e. clear, offers written instructions which can be checked at any time, a description of actions presented step by step or in consecutive stages the achievement of which is monitored. As these children find it difficult to tell the difference between things and decide on their

importance, any "noise" which might distract them and divert their attention from the main activity must be eliminated, e.g. when they work they should not be disturbed by TV, other employees talking, new instructions, frequent changes of tasks or place in the classroom, etc.

# 6. ATTENTION TO DETAIL

Keep your utterances and instructions straightforward. They cannot be too general and they should offer details as concretely as possible. Say exactly what you expect and what needs to be done. Do not refer to analogies, your own experience or the child's previous experience. Say "Do this" precisely and step by step. Keep your communication simple; do not show off with elaborate sentences or make the child feel inferior, but point to their abilities and confirm every success, even the smallest one.

## 7. RULES

In order to discover the meaning of the world, children with FASD need to accommodate certain rules which will help them organise how they think about themselves and the world. For example, after work there comes a reward; we eat at certain times; on even days I do my homework with dad, on odd days with mum; on Saturdays I go to the swimming pool if I was not late for school this week; if I did not set the table I wash up after the meal; this is my room, so I clean it; no one swears, smokes or raises their voice at home; we take care of our animals and plants.

# 8. SUPERVISION AND CONSTANT MONITORING

As they have difficulty in planning actions and predicting their consequences, many children with FASD can engage in activities or behaviour which may be dangerous to them, involving other people, the household or their place of study. Playing with fire, water, cleaning agents and electricity, in combination with their poor assessment of risk, requires constant supervision, regardless of the child's age. To give you an example, a boy was asked to "Put the kettle on", so he filled the electric kettle with water and put it on the gas cooker, immediately setting it on fire. When asked why he did it, he replied: "You didn't ask me to turn the kettle on, but to put it on".

# 9. FOLLOWING THESE RULES, ANY INTERVENTION REQUIRES CONSTANT PRESENCE AND ATTENTION

Being alert all the time is exhausting and a burden. You keep asking yourself: "How long will I have to keep an eye on my child - is it ever going to end?". In some cases, caregivers feel and show aggression making their

actions ineffective and destructive, both to them and their bond with the child. If this happens to you, follow the **EMERGENCY RULE**:

- Whatever you are doing
   stop now, stop talking,
   gesticulating, shouting
   or threatening;
- **Observe** eliminate the danger, e.g. turn off the gas, electricity, close the window, etc.;
- Listen to the child carefully, try to understand their problem;
- Ask yourself what is it that your child finds difficult at the moment and what you can do to help;
- Rephrase your instruction, thank them for what went right and help fix what went wrong.

# 10. ACCEPTANCE - A DAILY SURVIVAL METHOD

It is difficult for parents and care staff to accept much of the behaviour of children and youth with FASD. They often perceive them as the child's desire to get angry, pay

back for what happened before or test the boundaries, or theu link the child's behaviour to their characteropathu or ADHD. It needs to be kept in mind that most of this behaviour is steered by the brain coping with a number of disorders affecting the child's sensory and cognitive functions, reflexes, spatial orientation, sense of time. sense of touch and proprioception, visual field, quality of hearing and many others. Additionally, they have to deal with emotional disorders resulting from the experience of being rejected by their biological parents. Depressed moods, irritability, loneliness, idealisation of biological parents, followed by secondary symptoms developed in response to the lack of understanding from others. All of these problems make the child think of their life as difficult, with no chance of success and that aggression is the only form of communication that works ("I am here and now you have to deal with my presence"). If you do not want to set it off, follow the ten rules presented above.

Based on the educational materials prepared by:

- 1 M. Klecka (Lędziny, 2005), Fundacja "Daj Szansę", Toruń, 2006.
- 2 K. Liszcz, "Dziecko z FAS w szkole i w domu", Wydawnictwo Rubikon, Cracow, 2011.



# A child with FAS. What do you see as a parent who is a teacher?

# ELŻBIETA DUDAREF

Director of Youth Centre No 1 in Gdynia

# BEFORE I BECAME A FOSTER MOTHER...

My interest in discovering, studying and learning more about the problem of FAS started on the day when I adopted my daughter. When I decided on the adoption, I knew that the child would probably come with some history and health problems. They tell you this at the training. The reality looks different. Getting to know your child means going deeper and deeper into their psyche, problems and ways in which they overcome their difficulties, how they cope with their limitations. My now 8-year-old daughter could not understand why she had problems with memory, concentration or sitting in one place for at least five minutes. Why she had to work three times as hard as others to become who she is today.

I adopted Marysia [short for "Maria" in Polish] when she was 16 months old. She was a withdrawn, repressed and timid child. I had problems feeding her, she did not want to eat, which worried me very much, as her body weight was below 9 kg. She was tiny, petite and skinny. I went to specialists in Warsaw for help. We were referred to the Same-Day Paediatric Care Clinic at the Institute of Mother and Child where they ran a series of tests. The test results, even the neurological ones, revealed nothing – clearly Marysia was a healthy child with an oversensitive mother. At that time, I worked as a primary school teacher in grades 1–3 and I noticed that my daughter required a greater stimulation and closer guidance than other children. We did minor therapeutic exercises at home,



such as lingual frenulum massages, evening massages with a spiky therapy ball, crawling together on the floor to look for objects hidden under the furniture, reading a lot of books, fairy tales, stories for children, etc.

After a few years, we decided with my husband to become foster parents. When I came to Gdynia, I finally learned about FAS and started exploring this topic. I found specialists here who explained to me how exactly I should deal with my child. I did notice and guessed many things before on my own; however, I was still in the dark. My previous ideas got confirmed and today

I can be sure that what I do with my child is correct. At the beginning Marysia was developing much more slowly than her peers, but today she is a very athletic girl (she trains artistic gymnastics), has top marks at school, her behaviour at school is assessed as excellent and she is liked by her peers and has many friends. I am very proud of her, but I also know that it requires a lot of work, love and patience. My husband's support is crucial – every day he studies with Marysia, drives her to trainings and helps her with everything. I have learned to use concrete, clear utterances when talking to my daughter, not to use words with double meaning or figurative terms. I tru to work with the school as often as possible, using the same methods. I repeat many times the information that she needs to learn. Marysia has a fixed schedule hanged over her desk, her daily and weekly responsibilities are clearly organised. When I want her to clean her room, I need to inform her about it or write down all the things she needs to do, step by step. It is essential that she has clear, stable rules which we establish together; they have to bring order and meaning to her life, but most importantly they need to be explicit and comprehensible to her. I can see how she thrives and how she has developed good habits; nevertheless, I believe that a child with FAS needs constant supervision and support, their behaviour has to be monitored all the time. This enables a faster evolution towards the desired behaviour.

When I look at my child,
I think about my previous
work as a teacher. I see
now that I had worked
with children with FAS
before, but I did not
have the knowledge
and experience which
I have today and which
I have gained by working
with my daughter and
supporting her in her
development.

I remember one student who had big problems with writing letters within the provided space. Her problem continued all the way to the third grade. I motivated her and she worked very hard, but her level remained low, below the average. I also had a student who had reading difficulties. Throughout the third grade she kept reading by breaking the words into sounds without being able to put them together into one word, she did not even understand the text read by the teacher. Both girls behaved in a way pointing to hyperactivity disorder; they had a reduced intellectual ability and were promoted to the next grade only with the teacher's help. They also showed significant mathematic difficulties and problems with logical and abstract reasoning.

I can also remember a student with severely impaired memory functions. Even the smallest effort would frustrate and discourage him. He had poor relations with his peers, so in conflict situations he would resort to aggression and behaviour inadequate to the circumstances. He needed a highly individualised approach and support. He would ask me if he could stay after the lesson to help me clean the classroom. I took him to the social therapy day-care centre which I also ran at the time. He was asocial and sought direct contact with adults who would understand and direct him.

Generally, boys are more likely to exhibit aggressive behaviour in crisis situations, while girls react with helplessness and withdrawal. Such girls tend to have low self-esteem and often isolate themselves from the group or, in the opposite sense, are too absorbing and possessive, typically in relation to an adult. These children often do not understand other people's reactions to their behaviour. I tried to talk to them and explain the situation, but I knew that it was partially ineffective because these students were incapable of reflection and drawing conclusions. With time I learned to show them examples of correct behaviour and teach them good habits.

With today's knowledge and experience could I perhaps adopt a different approach to teaching and evaluating these students? Maybe I would use different methods if I could learn more about the source and causes of their problems with studying and social behaviour, also through a thorough analysis of their peer group? I know that it is often difficult for a teacher to implement the appropriate therapeutic measures as not all counselling centres providing psychological and pedagogical assistance can correctly diagnose FAS. Our job is to learn more about it to offer assistance in raising children and education to parents who receive no help or support from other people and institutions.

# Children with FASD – diagnosis and therapeutic assistance

TERESA JADCZAK-SZUMIŁO, PHD IN SOCIAL SCIENCES

A psychologist

# THE SITUATION OF CHILDREN WITH FASD IN POLAND

Child problems related to defects caused by prenatal alcohol exposure are not a marginal phenomenon. Although officially only 16 children with FAS were registered in Poland (from: Medical Register of Birth Defects available at: www. Rejestrwad.pl/upload/file/wrodzone-wady-rozwojowe. Pdf), this group is much bigger. Children with partial defects account for an even greater number.

In 2014, the State Agency for the Prevention of Alcohol-Related Problems (PARPA) implemented a research programme called ALICJA¹ (Terlikowska et al., 2014). It shows that the number of children with full-blown FAS in Poland is not lower than four per 1000 live births and may be even higher. These statistics do not differ from other European countries. Despite such a high prevalence

1 ALICJA is a PARPA programme designed to study the epidemiology and functioning of children with FASD. Facilitated by Krzysztof Brzózka, Director of PARPA, the programme was implemented by the following researchers: Prof. A. Urbanik, Dr Krzysztof Liszcz, Dr Teresa Jadczak-Szumiło, Jolanta Terlikowska, Magdalena Borkowska, Dr Katarzyna Okulicz-Kozaryn and a group of diagnosticians from the St Louis Specialist Paediatric Hospital in Cracow.



of the problem in the population (there are more children with FASD than those with autism or Down syndrome), no systematic research is available in Poland that would explore the scale of FASD and its qualitative impact, as well as the functioning of children diagnosed with it. In consequence, these children do not receive the help they need, while health professionals have neither the knowledge nor the tools necessary to diagnose and treat children with FASD. The research conducted in Poland in 2013 (Liszcz, 2013) revealed that the knowledge of FASD among physicians is lower than among psychologists,

educators, nurses and social workers. This is a fundamental difference compared to the results reported by researchers from other countries.

Due to the lack of knowledge in regard to FASD and the stereotypes related to it, children with FASD in Poland are often diagnosed with other problems, such as hyperactivity disorder, Asperger syndrome, dyslexia, behavioural disorders, etc. The assistance provided to them and their families is inadequate; parents and care staff are often blamed for the child's behaviour, even though it is a consequence of the damage done to the central nervous system (Abel, 1996; Riley, 2011; Urbanik, 2013). Lack of access to adequate support results in other difficulties. As Streissguth (1997b) points out, without an early diagnosis children exposed to alcohol prenatally are at a higher risk of secondary disabilities, such as problems with graduation from school, sexual disorders, conflict with law.

# DIAGNOSING CHILDREN WITH FASD

Diagnosing children with FASD requires teamwork. The minimum diagnostic team should consist of a physician and a psychologist. This is a standard that PARPA has been trying to implement for many years and which is used in preparing diagnostic teams in different places in Poland<sup>2</sup>. In Poland we have adopted the so-called Canadian guidelines, which include the following procedures:

A diagnosis established by a team of a physician and a psychologist makes most sense, as the physician checks the patient for facial anomalies and other organ abnormalities, while the psychologist carries out neuropsychological tests to assess the functions and possible CNS impairments. Naturally, it is worth doing an EEG or MRI, if possible. However, as shown by the brain scans and tests carried out in children with FASD by Prof. A. Urbanik (2013), for a thorough picture of changes in the CNS it is necessary to use more advanced MRI techniques, such as DWI or HMRS.

Therefore, due to the specific nature of the diagnostic work, the following persons should be trained for the job. Firstly, a physician to assess facial anomalies and prepare a differential diagnosis and secondly, a psychologist for the purposes of a neuropsychological and differential diagnosis.

In children with FASD whose facial anomalies are obvious, the diagnosis is not particularly difficult provided that the diagnostician knows that such anomalies are related to cognitive skills (Astley, 2001). The problem is that a large percentage of children exposed to alcohol prenatally do not present symptoms characteristic of the full-blown FAS and seem to look and function normally. Therefore, proven diagnostic procedures are necessary that will allow the CNS impairment to be revealed, which prevents these

Table 1. Diagnostic criteria for Foetal Alcohol Syndrome (FAS), partial FAS (pFAS) and Alcohol-Related Neurodevelopmental Disorder (ARND).

FASD DIAGNOSTIC CRITERIA	FAS	PFAS	ARND
Body weight and height	<ul> <li>At or below the 10th percentile;</li> <li>or</li> <li>Disproportionately low weight-to-height ratio</li> </ul>	May be within norm, so lack of anomalies in this domain is irrelevant to the diagnosis	May be within norm, so lack of anomalies in this domain is irrelevant to the diagnosis
Facial anomalies	Simultaneous presentation of all 3 facial anomalies	Simultaneous presentation of 2 of the facial anomalies	No facial anomalies
Central nervous system (CNS)	Impairment in 3 or more of the CNS domains (including brain structure, neurological impairment)	Impairment in 3 or more of the CNS domains (including brain structure, neurological impairment)	Impairment in 3 or more of the CNS domains (including brain structure, neurological impairment)
History of prenatal alcohol exposure	Confirmed or unconfirmed	Confirmed	Confirmed

Based on: T. Chudley et al. (2005).

<sup>2</sup> A list of places which have been trained by PARPA to diagnose children with FASD and which supervise their work is available at www.fasd.org.pl.

children from proper functioning, and will confirm that they need assistance and support.

Determining which diagnostic tools to use is not easy due to a wide range and a non-specific character of alcohol induced abnormalities in children exposed to alcohol prenatally (Riley, 2011). With such a broad spectrum of deficits, it is extremely difficult to develop uniform procedures that would apply to all children in this group. This may be explained by the very aetiology of FAS.

Alcohol is a teratogen which works in a particular way. It can either destroy the child's nerve cells causing selective damage to the CNS (ARND) or it can activate genes which should remain inactive, thus modulating specific damage in the form of FAS or pFAS (Abel, 1996; Astley, 2001; Riley, 2011).

The number and quality of the impairment may be different for every child, depending on the dose of alcohol consumed by the mother, the stage of pregnancy at the time when it was consumed, maternal predispositions and other medical factors, i.e. genetic material, lifestyle during pregnancy including a diet, use of other stimulants, etc. (www.cps. ca/documents/position/fetal-alcohol-syndrome).

As a consequence, no two children with FAS will ever be identical in terms of alcohol induced changes. The impairment may be different even in children from twin pregnancies (Abel, 1996). Due to the aetiology of the syndrome, every case will need to be assessed individually. Compared to other disorders, FASD is a more challenging task for health professionals. Researchers from different countries have studied the aetiology of FASD and functional problems of children with FASD for four decades (Jones, Smith, Ulleland, Streissguth, 1973; Streissguth, Kanter, 1997; O'Malley, 2007; Riley, Clarren, Weinberg, Jonsson, 2011; Mattson, Schoenfeld, 2011; Urbanik, Jadczak-Szumiło, 2013).

The results of multiple studies across various fields may help us better understand children with alcohol induced anomalies in terms of their diversification, functional problems and everyday difficulties.

# SUGGESTED THERAPIES FOR CHILDREN WITH FASD

Children with FASD should be diagnosed as early as possible. As pointed out by Prof. Ann Streissguth (1997), the earlier the diagnosis, the lower the risk of secondary disabilities. If the child is diagnosed early the respective therapies may be introduced to improve the child's functioning. As the functional problems of children with FASD are caused by brain damage, early intervention may be more effective, taking into account the CNS developmental capacity and brain

plasticity. There are cases in which children, despite early diagnosis, are refused further assistance because of good IQ test results. Unfortunately, this is a mistake which results from the misunderstanding of the very essence of problems related to FASD. In as many as 70 percent of children with FASD, the IQ scores are normal. This does not change the fact that they suffer from selective brain damage and, if left without support, they are at risk of secondary disabilities and multiple social problems.

Support provided to children with FASD must obviously depend on their age and the challenges they face. When working with them, one needs to remember that their deficits are specific to FASD and, as such, they will also require specific FASD-oriented therapies. The therapy model should be a response to the diagnosed damage and developmental deficits.

Below, I present a model which I have worked on through 20 years of experience in clinical work with this group of children. Many people in our team have contributed to developing these standards of work with children with FASD and their families<sup>3</sup>.

<sup>3</sup> Krzysztof Liszcz, Katarzyna Kałamajska-Liszcz, Michalina Jarosz, Urszula Mirosz, Jadwiga Zembek, Natalia Dorna, Edyta Gotkowska, Emil Szumiło, Bernadetta Wołoszyn, Monika Iskierka-Mreńca.

Firstly, and most importantly, it is necessary to regulate the basic functions of the child with FASD, i.e. their sleep-awake and hunger-satiety cycles.

The significance and levels of these states in terms of developmental standards are included in the Neonatal Behavioural Assessment Scale (NBAS), developed by T. Brazelton (2011). In children with FASD, these processes are usually disturbed, which can be observed in the first months of life. Unfortunately, children's health records hardly ever provide any information about it. Disruption of these cycles is typically related to improper foetal programming of the HPA axis (Kwon Kim et al., 1996). It is a process which can be affected by alcohol. Alterations in the HPA axis regulation have an impact on the child's cognitive and social functioning; therefore, it is critical to introduce a therapy aimed at its regulation as fast as possible. The next step is to stabilise the processes directly related to the CNS.

Research shows that patterns of reflex actions in children with FASD may be abnormal (Streissguth, 1997; Jadczak-Szumiło, 2008). However, these changes do not have to be pathological. In some cases, the pattern is correct, but it is preserved in its primitive form for too long or it is either too strong or too weak. Working on this has a good effect on the development of children with FASD (Masgutova, 2015; Goddard, 2015). Next, it is necessary to focus on the development of mental processes, such as reading, counting, thinking, writing, speaking. Their advancement is impossible in the absence of earlier stages of neurodevelopment. Cognitive functions constitute another step in the development of children with FASD. At this stage, alternative solutions need to be found if the brain damage makes it impossible to acquire skills in a simple way, normally available to healthy children. They will include global reading or learning mathematics by playing. Katarzyna Kałamajska-Liszcz has developed a number of good ideas to be used in practice (Liszcz, 2013). Children with FASD will specifically require a language training to improve their pragmatic language skills and verbal fluency, as well as learning how to count, read the time, use money, etc.

Our language training is based on T. Coggins's research and concept of language development in children with FASD (Coggins, 2007).

Below I present a model of providing support to children with FASD.

Table 2. Therapy plan for children with FASD.

# 1. REGULATION OF BASIC BRAIN PROCESSES

Stimulation exercises aimed at the regulation of processes in the following areas:

- HPA axis hyperactivity the basic process which blocks the development of children with FASD;
- Sleep disorders:
- Sensory disorders;
- Sensory-Based Motor Disorder (SBMD);
- Work on early childhood trauma;
- Regulation of emotions, including work on modifications associated with the altered regulation of emotions due to the style of attachment.



# 2. STIMULATION OF MOTOR PATTERNS AND REFLEX ACTIONS

- Motor patterns and reflex actions;
- Vision (eyesight) habits:
- Automation of fine and gross motor actions;
- Auditory processing basic neural development.



# 3. DEVELOPMENT OF MENTAL PROCESSES

- Speech and language therapy, including a language training (the training will be presented in a separate publication which is currently in preparation);
- Memoru exercises:
- Attention and concentration exercises;
- Looking for individualised, alternative ways of teaching reading and writing;
- Development of mathematical thinking;
- Auditory training;
- Environmental accommodations

Based on own research and therapeutic work4.

4 I would like to thank all my colleagues working on therapeutic camps for children with FASD, i.e. Katarzyna Kałamajska-Liszcz, Krzysztof Liszcz, Emil Szumiło, Bernadetta Wołoszyn, Jadwiga Zembek, Natalia Dorna, Urszula Mirosz, Michalina Jarosz, Edyta Gotkowska.

Therapy for children with FASD requires the knowledge of the disorder and the specific CNS processes related to it. The greater the preparation of the child's parents and therapists in this respect, the better are the effects of their work with the child. Early diagnosis is highly conducive to providing a better protection to children with FASD, while having a family constitutes a similarly protective role. These two factors ensure access to quick help and its implementation in practice. Frequently, children with FASD have neither of the above and are therefore at high risk of secondary disabilities, which are then wrongly attributed to all children with FASD. Children with FASD require a well-planned and well-organised therapy. Subsequent steps should result from the neurodevelopmental diagnosis and should help the child reach maturity in more advanced processes. This does not mean that any exercise from a randomly picked therapeutic model "will do". Taking into account the specificity of their development, children with FASD require a therapeutic intervention which will be consistent with their clinical diagnosis and current state of development.

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# A serious problem which is not reflected in the statistics

## DR KATARZYNA OKULICZ-KOZARYN

The State Agency for the Prevention of Alcohol-Related Problems (PARPA)

ANY DECISION, INCLUDING THAT PER-TAINING TO HEALTH POLICY, SHOULD ALWAYS BE BASED ON SPECIFIC AND **ACCURATE INFORMATION ON THE SCALE** OF THE PROBLEMS AND POSSIBLE SOLU-TIONS. OUR KNOWLEDGE ABOUT AL-COHOL CONSUMPTION BY PREGNANT WOMEN, WHICH MAY LEAD TO SEVERE **NEURODEVELOPMENTAL DISORDERS IN** CHILDREN. IS CURRENTLY INCOMPLETE. STUDIES SHOW THAT APPROX. 15 TO 40 PERCENT OF PREGNANT WOMEN DRINK ALCOHOL (OKULICZ-KOZARYN ET AL., IN PRINT). NATURALLY, EVEN 15 PERCENT IS A LOT, CONSIDERING THE IRREVERS-IBLE DAMAGE IT MAY CAUSE TO THE CHILD.

Little is also known of the prevalence of Foetal Alcohol Spectrum Disorders (FASD), i.e. a group of neurodevelopmental disorders resulting from the exposure of the developing foetus to alcohol consumed by the mother. According to the data of the National Health Fund (NFZ), in Poland in 2014, only 157 people suffered from Foetal Alcohol Syndrome (FAS), i.e. FASD with characteristic facial anomalies (Cook et al., 2016). This is indeed a very low figure given that epidemiological studies suggest that:



In Europe the prevalence of FAS is estimated at 8–12 per 1000 people, while that of FASD is at nearly 50 per 1000 people

(Roozen et al., 2016).

# PROJECT ALICJA<sup>1</sup>

Poland is the third member state of the European Union (next to Italy and Croatia) in which a study has been conducted to assess the prevalence of FASD in general population. It was implemented by the State Agency for the Prevention of Alcohol-Related Problems (PARPA) in four provinces in the South-East of Poland among children aged 7-9 years (Okulicz-Kozaryn et al., 2015). The study was conducted in the region of Cracow because, as revealed by ALICJA, all the children in need of further diagnosis and assistance were referred to the Centre for Comprehensive Diagnosis and Treatment of Children with FASD at the St Louis Specialist Paediatric Hospital in Cracow.

The prevalence of alcohol consumption by pregnant women differed significantly in the provinces selected for the study. In the Podkarpackie and Świętokrzyskie provinces it did not exceed 10 percent, while in the Małopolskie (Lesser Poland) and Śląskie (Silesia) provinces it was nearly twice as high (GIS, 2009).

# THE STUDY CONSISTED OF TWO STAGES:

STAGE 1: PRE-SCREENING TESTS. Carried out in schools by trained school counsellors/psychologists, nurses and social workers who collected the data on children's weight, height and head circumference, as well as behavioural disorders and/or educational deficits, as assessed by parents/guardians and teachers. Children with growth deficiency (i.e. with any of the growth parameters at or below the 10th percentile) or significant behavioural problems and educational deficits were enrolled for Stage 2 of the study. A similar-in-size control group was formed of randomly selected children in which the studied problems were not observed.

STAGE 2: SCREENING TESTS. The data about each child was collected independently by three trained persons. A physician/nurse assessed the child's general health and the presence of facial anomalies characteristic of FAS (primarily, short palpebral fissure length, thin upper lip, smooth philtrum). A counsellor/psychologist conducted an interview with the biological mother concerning pregnancy and her situation at that time and the child's exposure to various harmful agents (including alcohol). The task of a psychologist/neuropsychologist was to diagnose the function of the central nervous system in several domains (neu-

1 ALICJA - from Polish "ALkohol I Ciąża - JAk pomoc dziecku" (in English: "Alcohol and pregnancy – How to Help the Child"), a project implemented in cooperation with the World Health Organisation (WHO), approved by the Research Bioethics Board of the Institute of Psychiatry and Neurology in Warsaw. rological functions, intellectual functions, communication, school achievements, memory, abstract thinking, attention deficits/hyperactivity, adaptive behaviour, social skills).

The individual work of the three specialists was then summarised and analysed by a diagnostic team which formed a diagnosis for every child, following the Canadian diagnostic criteria (Chudley et al., 2005).

Approximately 2500 students of 155 classes 1–3 from 113 schools in the counties of Leżajsk, Żywiec, Kielce and Cracow were randomly selected for the study. Unfortunately, the parents of only 409 children consented to participation in the study. Of this group, 325 children were enrolled for Stage 2 of the study (163 with growth deficiency and/or behavioural disorders, and 162 as control). Finally, 280 children with parents/guardians took part in Stage 2. Here, boys accounted for 58 percent of the study group.

A very low percentage of families who agreed to take part in the study made it impossible to determine what is the actual prevalence of FASD in children aged 7-9 years. Assuming tentatively that all the children with neurodevelopmental disorders were "picked out" of the target group (n=2500), it is then possible to estimate the lower limits for the prevalence of FASD.

## RESULTS

The study allows us to conclude that Foetal Alcohol Spectrum Disorders (FASD) affect at least 20 per 1000 children aged 7–9 years. Full-blown Foetal Alcohol Syndrome (FAS) occurs in four per 1000 children. The prevalence of Partial Foetal Alcohol Syndrome (pFAS) and Alcohol-Related Neurodevelopmental Disorder (ARND) is estimated at eight cases per 1000 (see the table below).

DIAGNOSIS	NUMBER OF CASES (N)	PREVALENCE (N/2500)
FAS	10	4/1000
pFAS	20	8/1000
ARND	20	8/1000
TOTAL: FASD	50	20/1000 (2%)

It should be remembered that, for the diagnosis of pFAS or ARND, it is necessary to confirm maternal alcohol consumption during pregnancy. As drinking alcohol by pregnant women is generally disapproved, women are unwilling to admit to such behaviour. Thus, the study results may be significantly underestimated. In addition, a long time had passed between the pregnancy and the study, which also made it more difficult to estimate accurately the exposure of the foetus to alcohol.

The prevalence of FASD was the same in boys and girls and in the respective age groups (7-, 8- or 9-year-olds). The study also revealed neurodevelopmental disorders of unknown aetiology (foetal alcohol exposure not confirmed) in no fewer than 2.2 percent of children.

# SUMMARY AND CONCLUSIONS

Due to problems with subject recruitment and, in consequence, a low sample percentage, the prevalence of FASD in Poland cannot be accurately estimated based on this study. However, with a tentative assumption that the study managed to reveal 100 percent of children with CNS developmental disorders, while other children not included in the study were healthy, it may be concluded that:

The prevalence of FAS in the population is not lower than four per 1000 people, while that of FASD is not lower that 20 per 1000 people.

This means that FASD is more prevalent than for example Autism Spectrum Disorder (15 per 1000; Baio, 2014) or Down's syndrome (1 per 1000; Shin et al., 2009). However, the actual prevalence of FASD in Poland may be much higher.

The PARPA study clearly shows that the scale of FASD in Poland is significantly larger than indicated by the official data. Most cases remain undiagnosed, depriving patients and their families of proper support. It is urgently needed to develop national standards for the FASD diagnosis and appropriate therapies tailored to the individual needs of patients and their families. FASD cannot be cured and the only effective method of prevention is for women not to drink alcohol when they plan to get pregnant or when they are pregnant. Education and intervention actions need to be intensified among mothers-to-be by primary care physicians, qunaecologists, midwives and other health professionals.

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# Some good advice



**SYLWIA MELZER**Foster mother of 19-year-old Maria

WHEN MARYSIA [SHORT FOR "MARIA" IN POLISH] CAME TO US, HER FOSTER FAMILY, SHE WAS 7 YEARS OLD. AT THAT TIME NOBODY TALKED ABOUT FAS. WE DIAGNOSED HER OURSELVES BASED ON HER SYMPTOMS. We looked for the information in the Internet. In a genetics clinic in Gdańsk, where we met Dr Wierzba, we learned that Marysia's facial features could indicate that she had FAS. We went to the Medical Academy in Gdańsk, where Marysia was examined and diagnosed with Foetal Alcohol Syndrome. In regard to the above, we knew which direction to

go, but then a whole range of health problems presented itself; for example, with kidneys and epilepsy. We had to seek medical assistance in the Children's Memorial Health Institute in Warsaw.

Marysia attended a regular primary school, but she had a lot of extracurricular classes. She went to secondary school, but she never did her matriculation exams. Today, she works in gardening.

Raising a child with FAS means that you need to be constantly alert, always seeking help and controlling your child. It is not easy, but you should never give up and you have to fight for your child to achieve every little success. A child with FAS requires a lot of patience and understanding for their problems. Ideally, we should create a stable environment and define the rules which should never be changed – neither by parents/quardians nor by other members of the family. A proven idea is to arrange and write down a daily plan for the child and then to help them follow it, step by step. If the child has problems with remembering things, you can suggest that they should learn to automatically write them down on pieces of paper. To that end, you need to place post-it notes and pens all over the house to ensure quick access to them. This system worked in Marysia's case and made both her and our life much easier.



**BEATA PODLASEK**An educator, Manager of Residential Child Care Unit

THE KNOWLEDGE ABOUT FAS IS NATURALLY CRUCIAL, BOTH THAT ACQUIRED FROM BOOKS AND LECTURES, AS WELL AS THAT MOST VALUABLE ONE. I.E. OBTAINED FROM OTHER PARENTS. It is fundamental to understand what is happening to the child and to us. Fortunately, the education process of children with FAS is more frequently supported nowadays by a group of specialists. However, in my opinion, it is essential to find the right balance between using other people's help and guidance and following your own intuition. It is particularly important, albeit not easy, to constantly remember that your child's behaviour is a result of their difficulties, not of their malice. This does not mean though that you should be a lenient parent. You need to find the necessary resources in your child and always believe that you will succeed.

# In the light of the law...



CHIEF SUPERINTENDENT MICHAŁ RUSAK
Press Officer of the Municipal Police Headquarters
in Gdynia

OVER THE LAST FEW YEARS WE HAVE RECORDED FEWER THAN FIVE CASES OF WOMEN WHO GAVE BIRTH TO CHILDREN WHILE BEING UNDER THE INFLUENCE OF ALCOHOL. The last such dramatic case was reported in August 2015. In the PCK Hospital in Gdynia-Redłowo, an intoxicated woman delivered a baby girl at 36 weeks. The child weighed 2.5 kg, had almost 4 per mille of alcohol in blood and all the FAS symptoms.

Such cases always have one thing in common: the mother also drank alcohol during pregnancy. Although the Polish Criminal Code does not specify whether it is a foetus, a child or an adult, it clearly states that whoever puts in danger the life and health of a person dependent on them, they shall be subject to imprisonment for the period between three months to five years.

Unfortunately, the Polish law does not allow incapacitation of people who abuse alcohol or refer them to a compulsory treatment. It is thus impossible to work with a person who is addicted to alcohol, but does not consent to a therapy. During their interventions, police officers will meet pregnant women who are drunk. They know what to do in such situations; that is, they call for an ambulance and the woman is taken to hospital. Doctors then decide what to do next, i.e. whether to

save the foetus or order the mother's detoxification. Finally, the respective District Social Services Centre is informed about the incident.

The number of drastic cases may be low, but we are far from being pleased with these figures. On the contrary, we need to be concerned about every single case like this and be prepared for more to come. Hence the importance of such campaigns, such as the one organised by the Municipal Social Services Centre in Gdynia. It also makes us, police officers, open up to a whole new area and makes us feel that we can count upon other people's support. We need to know how to look, what to look for and how to talk to the people involved. Doubtlessly, it would be difficult to develop a procedure for FAS similar to that of "Blue Cards" used in case of domestic violence. Nevertheless, it is a good idea to create a group that will know how and when to react. When the police are called for a family which left a child home alone because they went out to drink alcohol, the police officers can observe the child for the signs of FAS. If we were to stop a drunken mother of a child that is a few months old, we would simply not be allowed to assume that she did not drink alcohol when she was pregnant.

I hope that such campaigns such as the one in Gdynia, with accompanying publications, lectures and videos, will make other cities and municipalities more aware of the problem of FAS. Once we achieve this level of awareness, we will be one step closer to adjusting current procedures to the scale of the problem. After all, it is a matter of the life and safety of both the person who consumes alcohol and that who is co-addicted from the very first seconds of their life.

## MAŁGORZATA GOEBEL

Regional Prosecutor in Gdynia

UNDER POLISH LAW, BEHAVIOUR RESULTING IN A BODILY HARM, RISK OF A BODILY HARM OR THE DEATH OF A PERSON IS PENALISED. LEGAL PROVISIONS DO NOT ENVISAGE PENALISATION OF A MOTHER FOR CAUSING AN INJURY TO A FOETUS – which is what a child is considered to be until the beginning of labour. Labour starts with the first contractions which lead to a child being born. A certain inconsistency arises here, one that is understandable because a compromise was necessary when the parliamentary Act on Family Planning and Protection of Unborn Life came into force. It provides for a certain degree of immunity from prosecution for mothers in case of a foetal injury.

I remember a case in which we managed to prove that a woman was still drinking alcohol after labour started. The woman was charged and convicted because we could already speak of a person that she was putting at risk of a loss of life or a serious injury with her drinking. The woman was intoxicated and already in labour when she was taken from the bar by an ambulance in which she gave birth to the child. Later, by the decision of the Court, the child was taken away from her.

On the other hand, there was a situation in which we were forced by the law to discontinue the proceedings against a woman who gave birth at home, preterm, in the summer of 2015. The woman stated that she had a beer because she did not expect for the labour to start so suddenly. No legal ground existed for anybody to be charged, as from the legal point of view and based on the jurisprudence of the Supreme Court, it was not yet a person that was put in danger. According to the Criminal Code, the non-penalisation clause applies until the labour starts.

This is an issue on the borderline of ethics, law and medicine. I realise that it might be difficult for an average person to understand, being that so much is said about the protection of life.

Any change to the existing provisions could be initiated by the Sejm and Senate, i.e. the legislative bodies in Poland, in response to the respective signals from the public. The question is whether the public is ready for a change and if so, what kind of change is expected?

Naturally, whenever people hear of a woman drinking alcohol during pregnancy, their most common reaction is: "She deserves to be punished". The criminal law is said to be the law of limits, as it sets the limits which should not be crossed and makes sure that whoever crosses them has to face the consequences. Punishment is the last resort and must always be preceded

by prevention, education and detection of disturbing cases. Campaigns are needed which will penetrate the environment of such people. Nonetheless, should social services perhaps be more alert, have more power and be able to feel that the state is on their side?

Some will say that prosecutors do nothing – children are born ill and no charges are filed. Others will ask: How can you prosecute a woman who has a problem? We must remember that somewhere in the middle of all this there is a child, so we need to look for solutions which would be most effective, without necessarily resorting to a more severe penalisation. After all, our intention is not to take children from their parents, but to prevent situations in which children get hurt.

\*\*\*

to 5 years.

Art. 160, Para. 1 of the Criminal Code: Whoever puts a person in the immediate danger of a loss of life or a grievous bodily harm, shall be subject to the penalty of deprivation of liberty for up to 3 years.

Art. 160, Para. 2 of the Criminal Code: If the perpetrator is obliged to take care of the person put in danger, they shall be subject to the penalty of deprivation of liberty for the period from 3 months

**Art. 156, Para. 1 of the Criminal Code** – a grievous bodily harm – from one year to 10 years.

Art. 156, Para. 3 of the Criminal Code – if such act results in death of a person – from 2 to 12 years.

Art. 157, Para. 1 of the Criminal Code – other bodily harm (lighter than in Art. 156, Para. 1 of the Criminal Code), impairing the function of bodily organs for more than 7 days – from 3 months to 5 years.

Art. 157, Para. 2 of the Criminal Code – a bodily harm impairing the function of bodily organs for less than 7 days – a fine, the penalty of restriction of liberty or deprivation of liberty for up to 2 years.

Non-penalisation clause – Art. 157a, Para. 3 of the Criminal Code – A mother of a conceived child who commits an act referred to in Para. 1 of Art. 157a, i.e. causing a bodily harm to a conceived child or a life-threatening health impairment, shall not be subject to penalisation.

MUM EVEN ONE GLASS IS TOO MUCH FOR ME





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