Hearing the voice of child welfare social workers: planning safe care for a child with or suspected of having fetal alcohol spectrum disorders (FASDs)

William Christopher Curran and Matthew C. Danbrook

Abstract

Purpose – *In the early 1970s, clinical evidence emerged documenting causal links between prenatal alcohol exposure (PAE) and children's behaviors as observed by child welfare social workers (CWSWs). Unfortunately, fetal alcohol spectrum disorders (FASD) remain on the margins of public health priorities. The purpose of this study was to elicit the views of child welfare social workers when responding to case of or suspected FASD.*

Design/methodology/approach – *A sample (*N *= 18) of CWSWs, allied health professionals and foster parents were interviewed.*

Findings – *Findings indicate that social workers struggle with their statutory duty to plan safe care for children with or suspected of having FASD. Emergent themes include struggling with advocacy, professional devaluation and lack of procedural guidance.*

Practical implications – *Social workers need a clear pathway and FASD knowledge to guide their interventions and enhance their capacity to advocate for affected children.*

Originality/value – *An abundance of research documents the direct effect of PAE on physical, cognitive and behavioral outcomes. However, few studies focus on the critical interface of children with an FASD entering public care and the social workers responsible for planning their safe care. This study sought to document social workers' response to this vulnerable cohort of children.*

Keywords *Social workers, Constructivist grounded theory, Statutory duty, Fetal alcohol spectrum disorders, Child welfare*

Paper type *Research paper*

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Listening to child welfare social workers: planning safe care for children with or suspected of fetal alcohol spectrum disorders

Currently, it is estimated 11.3 million individuals aged 18 or younger have a disability stemming from prenatal alcohol exposure (PAE), with only 1% having been formally diagnosed (Burd and Popova, 2019). Given this high prevalence rate and the large number of these children requiring care, researchers have noted that children with or suspected of having fetal alcohol spectrum disorder (FASD) are overrepresented in child welfare (Popova *et al.*, 2014). Furthermore, Popova *et al.* (2019) noted that children using state child welfare services constitute one of the five most vulnerable subpopulations with FASD at a rate 10–40 times higher than that of the general population. However, child welfare literature largely neglects the fact that children with or suspected of having FASD in care settings are under the standard legal protections of the law and therefore become the responsibility of child welfare social workers (CWSWs) charged with planning their safe care (Heady *et al.*, 2022).

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Many children who experience PAE have no abnormal physical manifestations (Brown *et al.*, 2016). By contrast, fetal alcohol syndrome (FAS) creates distinct dysmorphic features. Research has shown that between 70% and 90% of children suspected of having an FASD in child welfare have a hidden or "invisible" impairment (Chudley, 2008; Jones and Smith, 1973; Popova *et al.*, 2013), meaning they will present with no dysmorphic features of their impairment. Studies on prevalence rates in child welfare settings have found varying levels depending on cultural alcohol use. In Canada, Lang and colleagues found that 16.9 per every 1,000 children in care had an FASD. In the UK, Gregory *et al.* (2015) documented a rate of 27%, while in Australia, a social worker (Walker, 2014) noted a 34% rate of PAE and likely to be a suspected FASD rate in their child welfare setting.

We can deduce that child welfare has a significant issue with which to wrestle in responding to FASD. As Burd and Popova (2019) noted, the estimated global rate of FASD is considerable, suggesting that many affected children may experience a compromised level of care due to inadequate social work interventions and are likely subject to negative care trajectories as a result. It is reasonable to consider that children with PAE will grow up in environments characterized by alcohol abuse, where they are likely to suffer further trauma due to their condition (Price *et al.*, 2017). Furthermore, when unrecognized poor psychosocial outcomes become more pronounced, especially in the adolescent stage, where poor behaviors become more pronounced due to brain dysfunction and a poor fit with their environment (Malbin, 2004).

The obligation to plan safe care for children with FASD is a formal requirement under US child protection law as of the 2010 amendment of the Child Abuse Prevention and Treatment Act (CAPTA) formally recognizing FASD in child welfare (Lloyd *et al.*, 2019). CWSWs are mandated to plan the safe care of every child on their caseload, regardless of the antecedents that brought the children into state care services. CWSWs are skilled and knowledgeable in many other areas pertaining to satisfying children's needs, such as sexual and emotional neglect and physical harm, which also comprise their statutory obligations and are covered in undergraduate education recommended as preparation for the profession. However, Mukherjee *et al.* (2013) noted that CWSWs are woefully lacking knowledge and skills concerning diagnosing and treating FASD, which constrains their ability to make appropriate referrals to meet such children's needs. Unfortunately, there is scant literature indicating that CWSWs are equipped with sufficient knowledge to meet their obligations to children entering public care who have or are suspected of having an FASD. The lack of professional education and skills facilitates the fear of imparting stigma on children and their families and can be a major impediment to professional interventions. Families equally fear being stigmatized when uninformed professionals engage with mothers who have consumed alcohol during pregnancy (Bell *et al.*, 2015).

Research context

This study was conducted in the context of Irish state child welfare services delivered by the state agency Tusla. Currently, Tusla (2019, p. 16) cares for just over 6,267 children through its residential fostering service. The Irish child protection and welfare system aims for prevention and family preservation through early intervention and support (Buckley *et al.*, 2011; Devaney and Gregor, 2017). CWSWs perform initial assessment and screening to prevent children from entering the care system (Leslie *et al.*, 2005).

Lange *et al.* (2018) noted that Ireland has the world's third highest birth rate of FASD, at 47.5 per 1,000 births. In addition, one relatively recent study in the site of inquiry, placed alcohol use during pregnancy rate at 82% (O'Keeffe *et al.*, 2015). These statistics indicate that Ireland's CWSWs will likely intervene in cases involving FASD but due to hidden impairment will not aware of the disability. It is however, important to consider that content on disabilities within schools of social work curriculums, is regularly noted as poorly incorporated into social work education (Ogden *et al.*, 2017). So, it can be clearly understood why many social workers in current times are struggling to see and accept the disability of FASD in their case work.

Limitations in prevalence research make it difficult to ascertain the actual rate of FASD in any given culture. Lack of FASD diagnostic data and accurate alcohol use during pregnancy rates, where incidence of the latter is likely underreported due to stigma and fear of judgment, jointly contribute to confusion about actual rates of FASD. Equally, children may not be identified by professionals until adolescence stage of development, when the social and behavioral profile become more visible (Price *et al*., 2017)

Undiagnosed FASD is a problematic and challenging for CWSWs, given the empirical evidence that traditional interventions and assessments may not be effective for this vulnerable cohort of children (Pelech *et al*., 2013). This is primarily due to shallow understanding of the neurodevelopment and neurobehavioral and neurocognitive deficits associated with FASD coupled with the fact that these deficits may not respond to the traditional development concepts and behavioral strategies that underpin the mainstream response. Research has shown that without early diagnosis and intervention, affected children face poor trajectories. The development of poor psychosocial outcomes may result in affected children suffering mental health challenges, substance abuse and academic difficulties (Streissguth *et al*., 1996). It is therefore likely that many Irish and international CWSWs will continue to encounter children with undiagnosed FASD and proceed to use inappropriate traditional interventions given the lack of skills, knowledge and support to implement more effective alternatives.

Most literature concerning substance abuse and child welfare in Ireland has avoided the subject of PAE and its impact on state child welfare and protection services. In a previous study, the author found a level of palpable concern in allied health and a taboo subject for Irish society (Curran, 2007). This may be attributed to the evident potential for ethical and moral stigmatization of prenatal alcohol use. Butler (2009) noted that children's needs are not as clearly identified or as effectively managed as is desirable due to disjointed collaboration on the issue of parental alcohol (mis)use. Documented levels of alcohol use during pregnancy are in the range of 65%–80% (Barry *et al*., 2007; Mullally *et al*., 2011; O'Keeffe *et al*., 2015), signifying that CWSWs are encountering a substantial number of children who have experienced PAE without the benefit of FASD-informed interventions to meet those children's needs.

The role of child welfare social work in the FASD narrative

Generally, when children are either voluntarily or involuntarily removed from their biological parents, the state assumes the role of the "corporate parent," charged with the responsibility to care for and protect the child (Courtney, 2009). CWSWs in the employ of the "corporate parent" are directly responsible for performing the safeguarding duties comprising this parenting task.

Child welfare faces four significant difficulties in quantifying the FASD burden:

1. lack of universal screening for and documentation of alcohol use during pregnancy;
2. lack of clear clinical diagnostic procedures;
3. the fact that a large percentage of affected children carry no discernible markers of their condition; and
4. lack of formal acknowledgment by child welfare system facilitating an acceptance of not translating the good science on FASD and creating a knowledgably workforce.

Most cultures with this "corporate parenting" mandate in child welfare do not formally acknowledge the presence of FASD, except the USA, where the 2010 CAPTA amendment formally situated children with FASD under the child protection and welfare duty. In countries with other cultures, there is a legal obligation, by order of mainstream legislation, to generally protect and promote child welfare. Curran (2007) found a high level of "palpable concern" among allied health professionals in Ireland regarding substance misuse during pregnancy, indicating a strong need for guidance in the form of policy frameworks. A lack of approved clinical guidelines surrounding FASD (Brown *et al.*, 2017) may place CWSWs in a Catch-22 situation where they must plan safe care without a defined pathway regarding whether to seek diagnosis. As noted, the lack of clinical guidelines on diagnosis and the literature of Burd and Popova (2019) stating that many children in systems of care do not need a diagnosis but do need a few modest modifications, together may present confusion and stifle the actions of CWSW in care planning duties. The issue of knowledge translation of the empirical evidence remains a major gap within child welfare strategies.

The role of social work education

Research has identified a significant skills vacuum affecting CWSWs' ability to perform initial assessments to prevent and manage FASD in child welfare, with two social work academics advising that "Social work educators should intentionally build these skills" (Badry and Choate, 2015, p. 27) to facilitate assessment and care planning. Postsecondary education should prepare students in allied health service programs for their future casework with individuals who have or are suspected of having FASD via an appropriate curriculum that is both practical and culturally sensitive.

The literature on FASD highlights that CWSWs are in a prime position to facilitate and lead multidisciplinary care planning in medical and social agency settings with attention to FASD-informed practices. Durkin (2016) noted that CWSWs "who are more aware of children/youth with FASD, their unique service needs, and available strategies to help them can improve their outcomes" (p. 85). It follows that undergraduate and postgraduate social work education should incorporate a related component to aid future CWSWs in their likely encounters with children with FASD, so that they may use appropriate knowledge and resources that are both practical and culturally sensitive. Also, calls for ongoing CPD education have been voiced (Badry and Choate, 2015) to ensure social workers in practice are sufficiently upskilled in identification and management of FASD

Although social work's critical role in the FASD narrative is regularly acknowledged, a gap exists in terms of pragmatic understanding of affected children's needs and wants; that is, there is a paucity of literature depicting the pragmatic side of CWSWs' FASD interventions and assessments, apart from Durkin (2016) who conducted a quantitative study to examine how CWSWs engaged in FASD-related practice and training and found that FASD training is needed to enhance CWSWs' skillsets, which should include assessment, referral to partner agencies within a multidisciplinary framework, and the provision of helpful services to children with FASD. The responsibility for children with FASD and a supporting framework to facilitate this need to be formally mandated in statute in Ireland, as in the USA with CAPTA. Other countries are likely to eventually follow with some form of legal mandate to manage FASD. Doing so will require a significant investment in FASD knowledge for undergraduate and postgraduate social work students. Currently, there are significant gaps in the social work literature in the following three key areas:

1. substantive professional education to facilitate safe care planning;
2. identifying the causes and consequences of marginalization and disenfranchisement in individuals and their caregivers with or suspected of FASD; and
3. developing evidence-based, community-relevant interventions for individuals with or suspected of having FASD throughout the lifespan.

To address these gaps, this study, based on constructive grounded theory, sought to hear directly from CWSWs to understand affected individuals' needs as well as the pragmatic application of support resources to enable and empower CWSWs to be effective in planning safe care for children with or suspected of having FASD.

Badry and Choate (2015, p. 29) warned that the FASD community is in "urgent need of what social work can offer" and suggested that any child welfare policy should engage CWSWs, which would require a *paradigm shift* away from the current focus on "epidemiological, diagnostic, and behavioral containment." By addressing the prevention and management of FASD, social workers can be agents of change in public health.

To realize this role, CWSWs need to become informed about FASD. There is an equally urgent need for senior child welfare executives to proactively engage with mounting concerns regarding the socioeconomic impacts of FASD. Disengagement could hinder CWSWs' capacity to honor their statutory obligation to keep children safe.

Methodology

This study sought to explore CWSWs' role in screening and assessing FASD in fulfillment of their statutory duty to plan safe care for children. As CWSWs are an integral part of children's care network, researchers focused on their lived experience helping children with FASD to document the scope of the problem, which this study adopted as its overarching goal. Specifically, using a constructivist grounded theory (Charmaz, 2014, 2017), approach, this qualitative study aimed to explore how CWSWs in Ireland respond to children with or suspected of having FASD. The constructivist grounded theory-based methodology encompasses several methods to yield theoretical findings and meet key study objectives.

Procedure

The researchers conducted individual semistructured 45–65-min interviews with the study sample ($N = 18$). Questions followed an interview guide, but question sequencing varied for each participant, allowing for an open discussion about FASD and a more natural exploration of participants' views, experiences and perceptions. Questions such as:

Q1. Can you tell me a little bit about your experiences of intervening for a child with or suspected of having an FASD?

Q2. How do experiences of responding to FASD impact on your professional role?

Initial sampling entailed meeting with social workers on the frontline of state child welfare interventions. As Charmaz stated, "Initial sampling gets you started, while theoretical sampling guides you [to] where you are going" (2014, p. 197). In this study, initial sampling established the research criteria by going directly to the participants that could best articulate the complex issue of FASD in child welfare. In the second stage, researchers sought two groups of key informants for theoretical sampling: foster parents who provide care to children with FASD and allied health professionals. This stage aimed for further theoretical depth in the categories identified during phase one of the data analysis.

Ethical approvals

The study received two ethical approvals each from Tusla Ethics Committee (Ireland) and two approvals from Concordia University Human Research Ethics Committee to cover both initial and second stage data collection. All consent requirements were detailed with ethical approvals and each participant was given their personal copy of a signed consent form (Table 1).

Eighteen CWSWs, allied health professionals and foster carers participated in the interviews. Researchers recruited participants by area from child welfare services and the International Foster Care Association. The two latter groups provided data to support the theoretical

Table 1 Demographics of the sample

Demographic	N	*(%)*
Gender		
Male	4	22.2
Female	14	77.8
Professional role		
Social worker	11	61.1
Foster parent	3	16.7
Psychologist	1	5.5
Midwife	1	5.5
Occupational therapist	1	5.5
CWS staff development officer	1	5.5

sampling of the initial data. All participating social workers held a master's degree and had been employed at the state agency for a minimum of two years. Table 1 provides participants' demographic details. The study applies pseudonym identities throughout.

This qualitative study applied constructivist grounded theory to understand the context, explore different perspectives and generate and extend related theory (Charmaz, 2014, 2017; Creswell, 1998; Kegler *et al.*, 2018). In Ireland, understanding and awareness of FASD remain inadequate, underpinning CWSWs' challenges in fully responding to the needs of this vulnerable cohort of children. This study identifies systemic needs to support CWSWs' interventions.

Analytic approach

The researchers analyzed the data using Dedoose (7.3, 2016). Identification codes and pseudonyms protected participant confidentiality. Initial coding tagged the data, highlighting the significance of dialogue that might otherwise have escaped the researchers' attention (Charmaz, 2006, 2014). Coding exposes "implicit processes, [allowing researchers] to make connections between codes and to keep their analyses active and emergent" (Charmaz, 2008, p. 164).

In vivo codes were derived directly from the language the CWSWs used to meaningfully extenuate, describe and emphasize the problems they experienced (Charmaz, 2006). These codes provided theoretical insight into the direct experience of social workers engaging with the phenomenon under inquiry, without the need for further abstraction (Strauss, 1987).

Comparative analysis of preliminary data transcripts and audio recordings as well as the use of Dedoose facilitated the early emergence of conceptual categories (Charmaz, 2006, 2008, 2014), which reduced the large amount of collected data into general descriptors of responses, facilitating comparison between different data features.

Results

Results indicated professional tension on all levels of CWSWs' social work practice: other medical professionals (micro), agency policy (mezzo) and Irish culture/society (macro). Spanning several data categories, the main themes drawn from the interviews reflected these tensions. The findings of the study offer a grounded theory of advocating against the tide, supported be four subcategories of: professional positioning; intellectual haze; broaching difficult conversations; and disabling the enabler. A brief synopsis of the grounded theory and the four categories are detailed as follows:

Advocating against the tide

The study found that a lack of open communication and fragmented information flow due to silo structures affected CWSWs' responses to FASD cases. Given their mandated duty to plan safe care for affected children, CWSWs experienced the phenomenon of advocating against the tide (see Figure 1) while responding to cases of FASD. Data suggest that professional devaluation, intellectual haze, broaching difficult conversations and disabling the enabler all describe CWSWs' struggles to effectively respond to children living with or suspected of having FASD. Ireland's prevalent pro-alcohol culture further constrains CWSWs' ability to fulfill their duty to protect children's best interests. Figure 1 depicts the four categories, with two subcategories, and shows how CWSWs advocate against the tide in FASD cases.

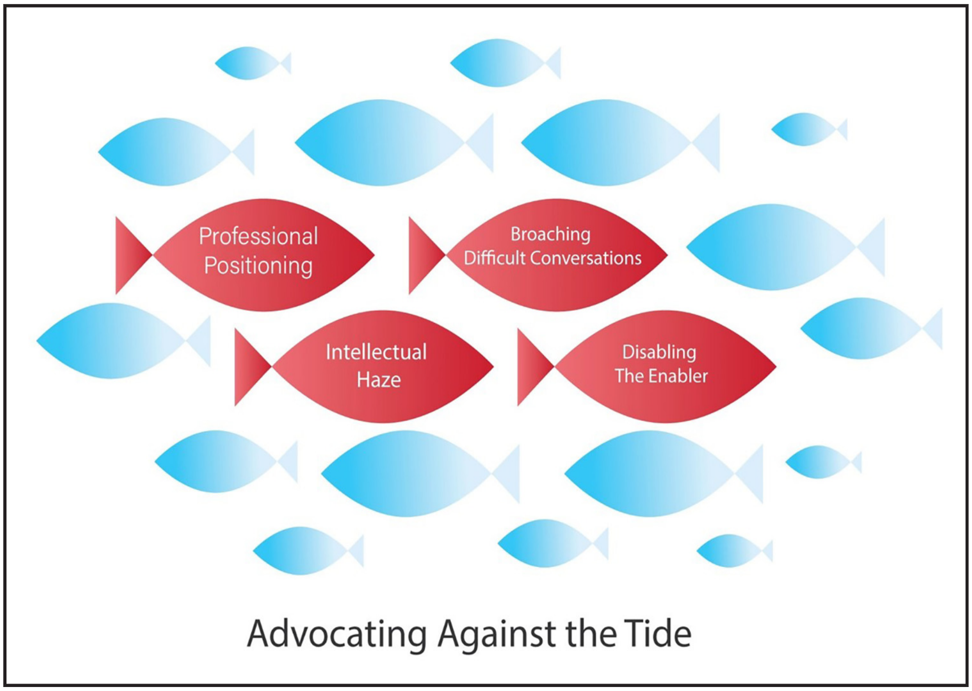
Professional devaluation

CWSWs described being unwilling participants in a "merry dance" in which they have little input and being led in many different directions when seeking to offer services in the interest of children with an FASD. Regarding professional devaluation, CWSWs reported that other professionals who consider themselves to be of superior rank exert their power and influence in the dialogue about meeting FASD children's needs, which entails a range of professionals engaging in a turf war, creating exclusion zones around necessary services.

Feeling devalued

The motif of feeling devalued recurred throughout the interview data. It was found that non-social work professionals with a higher status devalued CWSWs' advocacy. Participating CWSWs articulated that the hierarchical care system often devalues or dismisses their interventions. For instance, John said, "Just speaking the word 'FASD' can make you wonder, 'Oh my God, what's going to happen?' Fear of speaking up majorly devalues CWSWs' responses." Similarly, Mary discussed her experience of the devaluation of her work: "What I hear is 'I'm the doctor' or 'I'm the psychologist' and 'You are only a social worker, so you can't question me.'" Mary's self-deprecation revealed the sense of

Figure 1 Categories and subcategories. Blue fish represent CWSWs planning safe care for affected children, while red fish represent the dominant tidal forces impeding their statutory response to FASD



powerlessness CWSWs often feel regarding their ability to design and implement safe care plans for children with FASD. Other interviewees expressed similar sentiments, as follows:

> You might have had a conversation, a difficult conversation, with a parent or a foster carer about the fact that this is something you're concerned about, and you're going to raise it. And then it damages your relationship further because, like, a doctor says, "No–no, it's too early to consider that." You end up just [feeling] deflated. (Carol)
>
> I am working on a specific caseload, and my responsibility is to those children on my caseload. And I must learn whatever I can to ensure that all their needs are met, and there's that constant questioning of yourself that you have when you're a social worker (laugh) and that thing of "Why didn't I do psychology?" Maybe then they would listen to me. You also think, "Oh my God, I have all these great ideas, but somebody who has more power says, 'You know, you're wrong. We are not looking at that until next year.'" (Rosin)

Notably, Carol mentioned that having potentially controversial conversations concerning FASD damages CWSWs' relationships with caregivers. Of equal importance, Rosin pointed out the educational/professional barriers CWSWs face when trying to advocate for their charges. As CWSWs, both Carol and Rosin have a statutory obligation to uphold children's rights. However, as the interview data demonstrate, their struggle to be heard impedes their fulfillment of those obligations.

Professional subordination

The professional subordination of social work personnel to medical personnel is evident. Carol laughed during her interview, which may signify hopelessness regarding her capacity to advocate for the children on her caseload. She reported feeling as though she should "stop asking" since medical doctors are routinely dismissive of her role as a CWSW. This report offers further evidence that CWSWs are advocating against the tide. In a subsequent comment, Carol crystallized CWSWs' ambiguous role in the context of interventions for children with FASD:

> Because there is a real disrespect, you know, from our court system, and you wouldn't go in[to] [court] and disagree with the doctor because you'd end up regretting it. And it's hard, even within the organization, if you disagree with [professionals in] other disciplines. (Carol)

Carol's comment clearly demonstrates the devaluation of CWSW advocacy. Although Carol attempted to advocate for her charge within a multidisciplinary arena, she was overruled by senior personnel within her organization and by ostensibly superior professionals outside of it. The devaluation of CWSWs' FASD advocacy is a serious matter that the state system needs to address. Another interviewee reported a similar experience:

> Well, doctors or medical people tend to – do you know the term "to be ridden roughshod over – you know, not exactly ignored, but just, you're not important maybe, you know? We do think we're important because we're the parent, you know. (John)

As indicated in the above comment, contesting a medical decision is a major challenge for CWSWs, who are often "ridden roughshod" while trying to play the corporate parent role in relation to children with FASD in need of welfare services. John acknowledged CWSWs' responsibility to assume this parental role when he stated that "We are the parent," suggesting that CWSWs typically experience conflict between forces of devaluation and their desire to "parent" their charges. The development of strategies that will allow CWSWs to uphold their statutory duty to plan their charges' safe care in the face of systemic devaluation is problematic.

Intellectual haze

The second theme that emerged from the data is intellectual haze, which refers to CWSWs' discomfort while managing and responding to FASD. This category derived from the following codes: fear of speaking up, wanting to get it right, emerging knowledge and lack of a procedural pathway. Intellectual haze denotes a deluge of misinformation concerning FASD. The theme featured heavily throughout the study and was particularly evident in data on collaborative work.

Working amidst an intellectual haze places CWSWs in a precarious position regarding their capacity to ensure the welfare of children with FASD. Dialoguing about PAE and FASD is culturally challenging in Ireland. CWSWs and allied health professionals' resultant fear of discussing FASD significantly hinders cultural understanding and acceptance of the condition.

Fear of speaking up

The fear of speaking up refers to the onset of insecurity and doubt while addressing the needs of a child with FASD. Discussing the sensitive issue of PAE can render the most secure CWSW helpless and fearful of discussing maternal rights versus the rights of the child. This task is likely to weigh heavily on the CWSW's shoulders as they attempt to safeguard their charge's welfare and respond to their needs, as evidenced in the following remark:

> I think there's also definitely a fear there that, I mean, we're Irish, and there is a huge amount of drinking, obviously, in our culture. We do not like to think about the effects of alcohol on children or that it harms children. So, I think there's a protective thing there for us, as well in saying that it's not to do with alcohol, or sure, lots of people drink, or, you know, sure, one or two won't do any harm. (Jane)

Jane notes the task of addressing FASD within the culture is fraught with complexity. CWSWs' descriptions of their attempts to fulfill their professional duty as a "lonely road," an "absolute nightmare," a "merry-go-round" of assessments and feeling apprehensive or "not going there" reveal their fearfulness regarding carrying out their interventions.

Wanting to get it right

An overwhelming theme that pervaded the data was that CWSWs want to do their absolute best for children and families impacted by FASD. However, they lamented encountering many barriers, including the following examples:

> I got from the early intervention team that they didn't want to look at it, and then with the CAMHs, we couldn't because there was a waiting list for CAMHs. It wasn't that they wouldn't take it on, but I think the waiting list was, was it two years, I think. Yeah, it was a long time anyway. (Jane)

> It may give the agency a better overview for learning about working with these children to see what the best ways we can help these children are. It may give them a better understanding of how much alcohol needs to be consumed to cause these conditions. (Mary)

FASD present as an extremely complex set of neurobehavioral, cognitive, and sensory profiles with which CWSWs must grapple when performing assessments. A crucial professional function of the CWSW is to assess need to inform the development of a safe care plan. As Carol mentioned, when discussing a child with an FASD, inadequate knowledge of the condition impedes the task of seeking a customized intervention to meet the child's needs.

Broaching difficult conversations

Undoubtedly, broaching the subject of prenatal alcohol use as the possible cause of a child's difficulties is a sensitive and emotional topic for a CWSW to undertake. However, CWSWs are required to do exactly that to carry out their mandated duty. The lack of a protocol, adequate information and relevant guiding knowledge could result in children being mislabeled, incorrectly medicated and directed toward the wrong services.

Ethical dilemmas/moral judgments

Social work entails collaboration across a range of social services and broader health settings to achieve social justice. CWSWs promote fundamental human rights and are integral to social justice (Stuckler and Basu, 2013). Interventions to prevent and manage FASD involve multifaceted ethical issues with specific characteristics depending on the cultural setting (Bell *et al.*, 2015). The social work literature does not address how CWSWs manage such ethical challenges while fulfilling their statutory duties in cases involving FASD. It is purported that CWSWs may be placed in a vulnerable position when intervening in the interest of a child with or suspected of having FASD, as evidenced in the following comment:

> I've been in situations where you're working with professionals, and you might be out, and people will be drinking during their pregnancy, and it makes me enormously uncomfortable that people feel quite judged and get quite defensive if an opinion is expressed about alcohol use during pregnancy. (Jane)

The risk of damaging relationships with parents figured highly in interviewees' remarks. CWSWs need special skills and vocabulary to approach the subject of alcohol use during pregnancy as a child welfare concern, particularly when seeking to ascertain whether a parent is using alcohol during pregnancy to facilitate accurate assessment of such children's current and future needs. One interviewee pointed out that such a vocabulary has been developed for CWSWs' use concerning the sexual, physical or neglectful abuse of children:

> It is very difficult, isn't it? We can talk about them burning the child with a cigarette, and we can talk about them sexually abusing the children – why can't we talk about them drinking when they are pregnant? We seem more comfortable discussing the other two problems. (Rachel)

Since broaching the subject of FASD is difficult, the controversial nature of this responsibility impedes allied health professionals' collaborative contribution to meeting the needs of children living with an FASD. Evidence has continually shown that effective intervention in such children's lives is a shared responsibility that requires demolishing silos in the care planning process to facilitate cross-organizational collaboration.

Blaming mothers

Balancing moral, ethical and professional duties requires that CWSWs walk a tightrope when intervening in cases of suspected FASD. Their statutory child welfare obligation coupled with their inclination to support parents creates a Catch-22 that Carol described as follows:

> Sometimes, there's almost this thing of, you know, are you trying to, are you worried that people perceive it as, look, you know, are you trying to blame the parent for everything and being overly harsh on the parent? (Carol)

Another burden weighing on CWSWs concerns the stigmatization of birth mothers of children with an FASD. Broaching difficult conversations loaded with ethical and moral minefields requires professional guidance. Because the majority of CWSWs lack such knowledge, they are vulnerable during their interventions, as Patrick pointed out:

> I think certainly the first point is that they (social workers) don't want to damage the relationship (with the parents), or they don't want to go there. I think whether we like it or not, we live in a blame-free culture. So, the idea that someone is being blamed for causing something or as a causative factor is almost too terrible to comprehend. (Patrick)

Responding to FASD is loaded with complex ethical challenges that can damage relationships, a risk that is often paralyzing to the point of societal inaction. The fear of stigmatizing the birth mothers of children with an FASD weighs heavily on CWSWs' response formulation. Social media misinformation about prenatal alcohol use and FASD is a compounding factor that intensifies the challenge.

Disabling the enabler

Disabling the enabler refers to the professional gap between expectations of CWSWs and their ability to deliver. CWSWs' roles as enablers who support, protect and promote children's healthy development are core attributes of the profession. Alongside struggling to access services and challenging authoritative medical professionals, disabling the enabler is another aspect of CWSWs' uphill battle during their advocacy for children with FASD. Their ability to enable plans of safe care for the child with or suspected FASD are curtailed due to cultural and organizational lack of acknowledgment on the critical role offered by CWSW when children present in initial assessment on entry to services.

Struggling to access services

Marie described her struggle to advocate given the nonrecognition of FASD within the service structure:

> I am talking like a year and a half of trying to get this child into services, not a week or two. I have written many, many letters to the child development team and CAMHS, and still, we're waiting to hear back from the child development team; we need to know where this child will be placed. They need to be more cognizant of efficiency and time. (Marie)

Marie also highlighted the challenges involved in multidisciplinary advocacy to seek services for a child with a suspected FASD. Long delays such as 1.5 years to access the services a child needs is not in the child's best interest. It can therefore be said that CWSWs, as children's enablers, have been disabled in terms of their capacity to access services for their charges.

Marie also noted that failure to collaborate strains her work and the agency at large. Nevertheless, the most concerning aspect of her remark is the prolonged period children wait for assessment and service access. We are once again confronted with CWSWs' statutory obligation to respond to children's needs and provide them with helpful and appropriate services, but it is obvious that the study participants' efforts in several cases were rebuffed by the actions or inaction of allied health colleagues. Hence, the codes returned for this category included struggling to access services, challenging diagnostic labels, searching for interventions and working in service provision silos. Marie also mentioned the lack of services for children with FASD:

> Oh, I don't think we have the services to deal with it. But that's not to say that I don't feel it should happen. I mean, I know that we don't have the services to deal with the mandatory reporting that's going to come in, but I still think it should happen. I don't believe that just because we don't have the provisions in place to deal with something means that we shouldn't try and move forward with it because I think in those instances, services should be made available. (Mary)

Another challenge to CWSWs' advocacy is the lack of a social model for neuro-disability, particularly for children with an FASD. Rachel described the "fight" in which CWSWs must engage to advocate for these children:

> We do because I suppose we have come down to resources and sanctioning and money, and if the medical model does not even recognize it, well, what are we doing? So that probably disempowers people, so they don't fight. (Rachel)

Challenging diagnostic labels

Many participants mentioned the confusion surrounding children's diagnostic needs and related services. Participants were very mindful of the high degree of stress that a diagnosis and concomitant labeling impose on children. They were also aware of the ethical issues and the potential stigmatization of parents because of a child's diagnosis. These concerns among the study participants echo those in the literature.

> There is definitely the potential for misdiagnosis. I don't think that there's, I don't think people are particularly looking to diagnose FAS or FASD. I think maybe it's because it doesn't benefit the young person. With ADHD, you automatically qualify for school support. There's an understanding among teachers about what ADHD is. There seems to be a lot more awareness around ADHD and autism than there is around FAS. (Marie)

Marie's remark offers further insight into the challenges CWSWs face in the Irish cultural context regarding the failure to incorporate FASD into the medical model and issues involving caregivers. Many forces can render CWSWs "caught between a rock and a hard place" while seeking to provide services for a child with an FASD. Among such children's critical needs are a secure and stable home life and the receipt of appropriate interventions and services through their CWSW. However, despite good intentions, CWSWs encounter organizational barriers that may limit, frustrate and potentially entirely obstruct their interventions.

The nonprovision of services mindset that asserts that welfare services should be obtained from private providers isolates children in need within the service structure. This mindset also reduces the efficiency of child welfare and can negatively affect CWSWs' morale and ultimately their interventions. Indeed, a large body of research has shown that caregivers feel isolated and rejected when seeking services for children with an FASD (Mukherjee *et al.*, 2013; Salmon, 2008). This further accentuates the conflict CWSWs experience during FASD response. CWSWs' "rock and a hard place" experiences constitute a recurring phenomenon that weakens their professional collaboration with caregivers. The following extended remark from Carol sums up all aspects of CWSWs' advocacy against the tide:

> I've been down that road, you know, with another part of the agency, maybe where there's a multidisciplinary team that wants one thing, and you're being asked to sign off on this care plan because the other person is in charge, and in the whole of my being, I know that it's the wrong plan, and I'm saying, "No, I'm not doing it" and that I disagree with it. And then, you get a phone call to say, "Well, you're going to have to agree with it because we're going into court," and you can't go into court and say that you disagree with somebody else who is in Tusla. (Carol)

The data offered by Carlo clearly articulates the enormous challenges encounter by CWSW is seeking to offer a care plan for a child. It encapsulates the conceptual category of professional positioning in that the professional opinions of Carol are counterproductive to meeting a child's needs. The most common area of conflict surrounds to issue of diagnosis, where competing narratives between the medical and social models of care.

Discussion

This study explored experiences of CWSW and offers a finding that CWSW are *Advocating against the Tide* when seeking to intervene and plan safe care for a child with or suspected of having FASD. CWSWs talked of their struggle to advocate and pursue the best interests of the child. Seeing and responding to the best interest of a child with an FASD is a fundamental requirement of a CWSWs intervention practice, as their role mandated in law to keep all children safe. The results align with previous research focusing on social work and child welfare, such as that by Badry and Choate (2015) and Gibbs (2018) who note that valuable role of CWSW but acknowledge a lack of formal education.

It was in the early 1970s, when we were first alerted to the direct link of fetal alcohol exposure to the child welfare services. In the research of Jones and Smith (1973) that eight children of the washing child welfare services were diagnosed with FAS. Since this time, a plethora of studies has evidenced both the prevalence rates of FASD in child welfare services (Lange *et al.*, 2014; Popova *et al.*, 2014; Selwyn and Wijedesa, 2011; Walker, 2014), and a significant body of research documenting the needs of social work in responding to FASD (Badry and Choate, 2015; Caley *et al.*, 2008; Durkin, 2016; Gibbs, 2018). Internationally, we have seen poor application or even acknowledgment of this research, leading to what one researcher to conclude that FASD still suffers from a “degree of arrogance” within society leaving many to accept their ‘blind spot’ professionally (Mukherjee *et al.*, 2015).

The “Tide” which is impeding the professional responses of CWSW is a significant barrier to corporate responsibility in meeting children’s needs, a point noted by Coveney (2018) within the cultural site of inquiry. If this struggle could be viewed within a microculture on the front line of child welfare, there is a macro culture that further impedes and restricts the CWSWs in carrying out the duties toward both a child with an FASD and the child’s caregivers. Rooted within the macro culture are four of the key components which give evidence to *Advocating against the Tide. Professional positioning* is a major impediment to the statutory obligation of CWSW. It derives for a belief that FASD is a medical issue and therefore its ownership is firmly encapsulated with the medical model of child development. It is perhaps this strongly held belief that FASD is purely a medical issue that is facilitating the disabling of “social” in social work in its activities. As noted, *Disabling the Enabler* is fundamentally a weakness in the overall requirements of state systems of care and protection. These findings are significant in that professional practice of CWSWs regarding FASD because, while professional knowledge of and services for FASD remain inconsistent or inexistent, CWSW still have a central requirement to uphold the welfare of the as paramount. This evidence concurs with literature showing that social and community workers have noted a number of barriers when working with persons having FASD including a lack of understanding (Bagley, 2018; Petrenko *et al.*, 2014).

Operating with an *Intellectual Haze* while working a mandated role is a recipe for failure in the systems response to FASD. The absence of professional knowledge translation likely leaves CWSW relying on social media for professional development. Such education is not conducive to professional ethics and values of CWSW. Equally social media has been shown by both Mukherjee *et al.* (2015) and Chasnoff *et al.* (2015) as a nonsafe dialogue hub for FASD professional understanding . Furthermore, it has been offered by Aspler *et al.* (2019) that social media negatively affects the public health needs of FASDs by promoting stigmatization, exaggeration and contradiction. It follows for the work of Holland *et al.* (2015) in New Zealand who found the social media was gravely misrepresenting the professional messages of alcohol in pregnancy, a factor that was leading to confusion on messages of abstinence in pregnancy.

The data speaks to a complete lack of multidisciplinary approaches to addressing FASD in the services. It is firmly encapsulated within the good science of FASD, that multidisciplinary approaches are optimal for best outcome targets (Hoyme *et al.*, 2016; Lange *et al.*, 2017). The inclusion of social work in such approaches is pivotal to the broader psychosocial needs impacting the child and their caregivers. A multidisciplinary approach ensures that professionals from a variety of services can provide education to their professions. Streissguth (1997, p. 254) noted in that “professional training was best accomplished by trainers from the same profession as those being trained.” This is a particularly relevant consideration to be applied to CWSWs, giving the complexity of their role and their mandatory responsibility to provide a Plan of Safe Care to children living with an FASD. The data clearly points to CWSWs seeking the collaboration of allied health colleagues. However, as the data demonstrates significant obstacles exist which is curtailing and, in some instances, completely inhibiting the CWSW from carrying out their objectives of planning safe care.

Conclusion

This study's main objectives were to illuminate FASD and deepen understanding of their impact on state child welfare services in Ireland. It further aimed to give voice to the narratives of the CWSWs that serve this vulnerable cohort of children and their families through their interventions. The study also listened to allied health professionals and foster parents, who have direct relationships with CWSWs in the context of FASD assessments and child placement. The enormity and complexity of the challenges child welfare faces in terms of delivering services and establishing policy to address FASD cannot be underestimated. However, incontrovertible evidence suggests that child welfare services are struggling to acknowledge the suffering of children who have experienced PAE and go on to develop FASD. Data clearly offers that CWSWs have a strong desire to deliver safe care, but their efforts are thwarted by several forces with little regard for CWSWs' statutory obligation to establish safe care for children in need.

Although a half a century of fetal alcohol research has occurred, this study data suggests that intervening in FASD cases places CWSWs with uncertainty and systemic barriers in effective care planning. Children and young adults living with FASD have a complex matrix of needs requiring continuous care involving services from a range of professionals. To enable CWSWs to effectively fulfill their legal duty in FASD cases, a fresh conceptual approach that empowers these professionals across disciplines, that is, an all-agencies collaborative approach, needs to be implemented. Only changes in the leadership of child welfare services can empower CWSWs to perform their mandated role to ensure children's best interest.

Ireland is in its formative stage in terms of addressing FASD and, as such, the nation may be able to extract lessons from the vast body research to avoid embodying the factors associated with failure to prevent and manage the disorders. Further research that neglects to offer substantive solutions for the children and families affected by FASD would merely add to the already overflowing library of scholarly publications related to FAS, reinforce the stigmatization of mothers and continue to deliver contradictory prevention advice. Culturally sensitive strategies that empower women to make safe choices through nonjudgmental dialogue are urgently needed.

CWSW who advocate against the tide for vulnerable children with FASD have described the phenomenon as an "absolute nightmare." Removing such defeatist language from CWSWs' vocabulary will require serious strategic action within our allied health systems and in the senior ranks of state child welfare services. Although the data highlighted a strong desire among CWSWs to plan safe care for children with FASD, their narratives revealed that these professionals often feel thwarted and severely constrained in their efforts to fulfill their duty. FASD exerts a significant demand on child welfare services and the CWSWs seeking to meet their statutory obligation to vulnerable children. We have reached a critical juncture in child welfare regarding addressing FASD – a point where we are in urgent need of pragmatic and workable solutions that empower and support CWSWs in their interventions. Currently, as noted by Bagley and Badry (2019) professional, including CWSW "lack appropriate advice and support" (p. 5) to be effective in professional judgments concerning FASD. Children and youth are a vulnerable cohort of services users in key sectors including child welfare, justice and mental health, yet FASD continues to be an under-recognized disability globally with major gaps existing within service structures. This study has focused on one such "gap" by speaking directly to CWSWs to elicit their views. Again, this needs to acknowledge the legal/mandated role of CWSWs verses other professionals within the allied health field. CWSW need specific professional education to fulfill obligations of their role.

New solutions are needed to broaden the narratives on early intervention beyond just diagnosis as a singular response. As Badry and Choate (2015) note, "Social work can begin to change the conversation by shifting it towards what is possible for clients and bringing in tools that have been shown create a difference where disability is a concern for a client" (p. 29). Youth with likely or confirmed impairments due to PAE would benefit greatly from early recognition and intervention to offset the more severe effects of secondary disabilities (Streissguth *et al.*, 1996). Further investigation is needed to identify the current professional barriers impacting CWSWs in their mandated duties concerning FASD. Equipping, educating and supporting CWSWs to make early and accurate assessments followed by a timely and clearly delineated referral pathway can significantly ameliorate the cost and social implications of FASD in all societies where alcohol is a common commodity.

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