FASD-CAN
Fetal Alcohol Spectrum Disorder
Care Action Network

FASD, Mental Health and Suicide:

The Facts

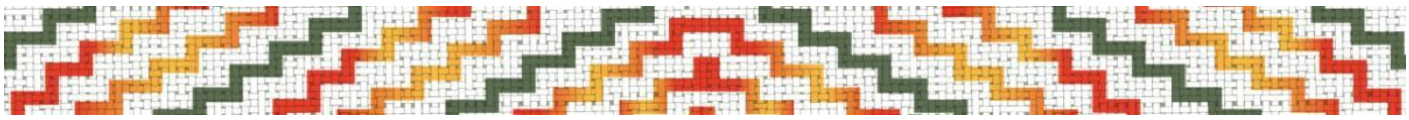
The Issues

It is estimated by Te Whatu Ora | Health New Zealand that 3-5% of babies born every year in Aotearoa New Zealand will have Fetal Alcohol Spectrum Disorder (FASD). There is an estimated 60,000 people under the age of 18 currently with FASD in this country.

These prevalence rates make FASD more common in our population than Autism, Down syndrome and cerebral palsy *combined*. However, only around 5% of those with FASD will ever receive a formal diagnosis due to our lack of affordable diagnostic capability. Lack of diagnosis leads to a lack of data, and a lack of research and funding. This is unacceptable when looking at the life outcomes associated with FASD and mental health: one international study established the life expectancy at birth for people with Fetal Alcohol Syndrome (a sub-type of FASD) as only 34 years, with the leading cause of death being suicide.[1]

There is no specific research in Aotearoa New Zealand on FASD and suicide. The following statistics come from Canadian and American research data, and highlight the unmet mental health needs of this large and
vulnerable population in our society.

- 90% of people with FASD have co-occurring mental health diagnoses, compared with 20% in the general population.[2]
- Depression (45%-50%) and anxiety (20%-40%) are the most common comorbid mental health challenges for people with FASD.[3]
- People with FASD use substances at rates 5 times higher than the general population.
- 35% will develop an alcohol or drug use disorder.
- One third of people with FASD will experience suicidal ideation.[4]
- Suicidal ideation among the FASD population is critically high compared to the general population: FASD 25.9% vs. general population 3 to 12%.[5]
- Suicidality ideation is also experienced at much younger ages among people with FASD than in the general population.[6]
- Adolescents with FASD required medical assistance at 5.5 times higher rates for suicide attempts than the general population.



- Substance use by people with FASD increased the incidence of suicidal ideation by 6.7 times, and by 1.9 higher for those with emotional control challenges.[7]
- Bullying by peers (very common among the FASD population) increases suicide risk.[8]
- People with FASD were more likely to have significantly higher Adverse Childhood Experience (ACE) scores than non-FASD people in a 2019 study of ACEs.[9]
- An increased number of ACEs showed increased rates of comorbid neurodevelopmental disorders in people with FASD, but not the non-FASD people in the ACEs study.[10]
- A person with FASD has an average of 3.4 ACEs, with almost half of them (46%) having experienced four or more ACEs; 13% had experienced 6 or more ACES. These numbers are notably higher compared with other disabilities or in the general population.[11]
- The rates of psychiatric disorders such as psychotic and personality disorders, conduct and oppositional defiance disorders, depression, anxiety and substance use are all higher in the FASD population in comparison to the general population.[12]
- Caregivers of children with FASD experience elevated levels of stress[8][13] which can adversely affect caregiver well-being and mental health, as well as family dynamics.
- Caregivers of people with FASD experience considerably higher levels of stress than even caregivers of people with Autism.[14]

What are we doing about it?

In September 2019, the Government made a commitment to address Aotearoa's high suicide rates when they released 'Every Life Matters' - The Suicide Prevention Strategy 2019–2029 and Action Plan 2019–2024 for Aotearoa New Zealand, and established the Suicide Prevention Office in Te Whatu Ora. There is also a Centre of Māori Suicide Prevention.

Due to the estimated prevalence of FASD in Aotearoa, and the greatly increased risk of suicide in this population, we believe FASD makes a significant contribution to our national suicide statistics. However, these current initiatives do not address the extremely poor mental health outcomes and high levels of suicidality found specifically among the FASD population, or the workforce capacity building required to improve the level of FASD knowledge and training required across the entire mental health workforce.

Research clearly shows the "critical need for comprehensive FASD-informed suicide prevention and intervention approaches to promote mental health and wellbeing of children and youth with FASD and their caregivers".[8] In the absence of FASD-informed service systems and supports, interventions will continue to fail to meet the unique needs of people with FASD and their families and whānau.

In the meantime, people with FASD continue to experience loss of self-esteem associated with social stigma and isolation, and significant mental health issues including anxiety, depression, drug

addiction and self-harm.

Another important point and consideration is that caregivers, families and whānau suffer alongside them. FASD caregivers already experience elevated stress and anxiety in comparison to caregivers of other disabled people and the constant worry that their loved one might attempt to take their life materially affects their own mental health, well-being, and quality of life. [8]

Conclusion

Despite the stark inequities outlined above, there is strong reason for optimism. People with FASD demonstrate resilience, creativity, and a deep capacity to thrive when their environments are appropriately structured, understanding, and supportive. Evidence consistently shows that outcomes improve when systems shift from individual blame to neurodevelopmentally informed, relationship-based approaches that recognise strengths, reduce stigma, and provide consistent, lifelong support. By investing in FASD-informed mental health and suicide-prevention responses—alongside workforce development, early identification, and wrap-around support for families and whānau—we have a powerful opportunity to reduce distress, prevent loss of life, and enable people with FASD to experience belonging, purpose, and wellbeing. Addressing these needs is not only a matter of prevention, but of equity, dignity, and collective responsibility.

References and Resources

[1]. Thanh, N. X., & Jonsson, E. (2016). Life expectancy of people with fetal alcohol syndrome. *Journal of Population Therapeutics and Clinical Pharmacology, 23*(1), e53–e59.

[2]. Lebel, C. A., Gibbard, W. B., Tortorelli, C., Pei, J., Beaulieu, C., Bagshawe, M., & McMorris, C. A. (2021). Prenatal exposure and child brain and mental health (PEACH) study: Protocol for a cohort study of children and youth with prenatal alcohol exposure. *BMJ Open, 11*(5), e051660. https://doi.org/10.1136/bmjopen-2021-051660

[3]. Famy, C., Streissguth, A. P., & Unis, A. S. (1998). Mental illness in adults with fetal alcohol syndrome or fetal alcohol effects. *American Journal of Psychiatry, 155*(4), 552–554. https://doi.org/10.1176/ajp.155.4.552

[4]. Flannigan, K., McMorris, C., Ewasiuk, A., Badry, D., Mela, M., Gibbard, W. B., Unsworth, K., Cook, J., & Harding, K. D. (2022). Suicidality and associated factors among individuals assessed for fetal alcohol spectrum disorder across the lifespan in Canada. *Canadian Journal of Psychiatry, 67*(5), 361–370. https://doi.org/10.1177/07067437211053288

[5]. Ibid.

[6]. Ibid.

[7]. Ibid.

[8]. Harding, K. D., Turner, K., Howe, S. J., Bagshawe, M. J., Flannigan, K., Mela, M., McMorris, C. A., & Badry, D. (2022). *Caregivers' experiences and perceptions of suicidality among their children and youth with fetal alcohol spectrum disorder*. **Frontiers in Psychiatry, 13**, Article 931528. https://doi.org/10.3389/fpsyt.2022.931528

[9]. Kambeitz, C., Klug, M. G., Greenmyer, J., Popova, S., & Burd, L. (2019). Association of adverse childhood experiences and neurodevelopmental disorders in people with fetal alcohol spectrum disorders (FASD) and non-FASD controls. *BMC Pediatrics, 19*(1), Article 498. https://doi.org/10.1186/s12887-019-1878-8

[10]. Ibid.

[11]. Ibid.

[12]. Tait, C. L., Mela, M., Boothman, G., & Stoops, M. A. (2017). The lived experience of paroled offenders with fetal alcohol spectrum disorder and comorbid psychiatric disorder. *Transcultural Psychiatry, 54*(1), 107–124. https://doi.org/10.1177/1363461516689216

Brown, J., Long-McGie, J., et al. (2014). *[Details cited within Tait et al., 2017]*.

Fast, D. K., & Conry, J. (2011). *[Details cited within Tait et al., 2017]*.

Jonsson, E., et al. (2009). *[Details cited within Tait et al., 2017]*.

[13]. Kautz, C., Parr, J., & Petrenko, C. L. M. (2020). Self-care in caregivers of children with fetal alcohol spectrum disorder: How do caregivers care for themselves, and what are the benefits and obstacles for doing so? *Research in Developmental Disabilities, 99*, 103578. https://doi.org/10.1016/j.ridd.2020.103578

[14]. Watson, S. L., Coons, K. D., & Hayes, C. S. A. (2013). Autism spectrum disorder and fetal alcohol spectrum disorder. Part I: A comparison of parenting stress. *Journal of Intellectual & Developmental Disability*, *38*(2), 95–104. https://doi.org/10.3109/13668250.2013.788136

Other Research:

Rangmar, J., Dahlgren Sandberg, A., Aronson, M., & Fahlke, C. (2017). Self-reported health, use of alcohol and illicit drugs, and criminality among adults with foetal alcohol syndrome. *Nordic Studies on Alcohol and Drugs, 34*(3), 255–266. https://doi.org/10.1177/1455072517707887