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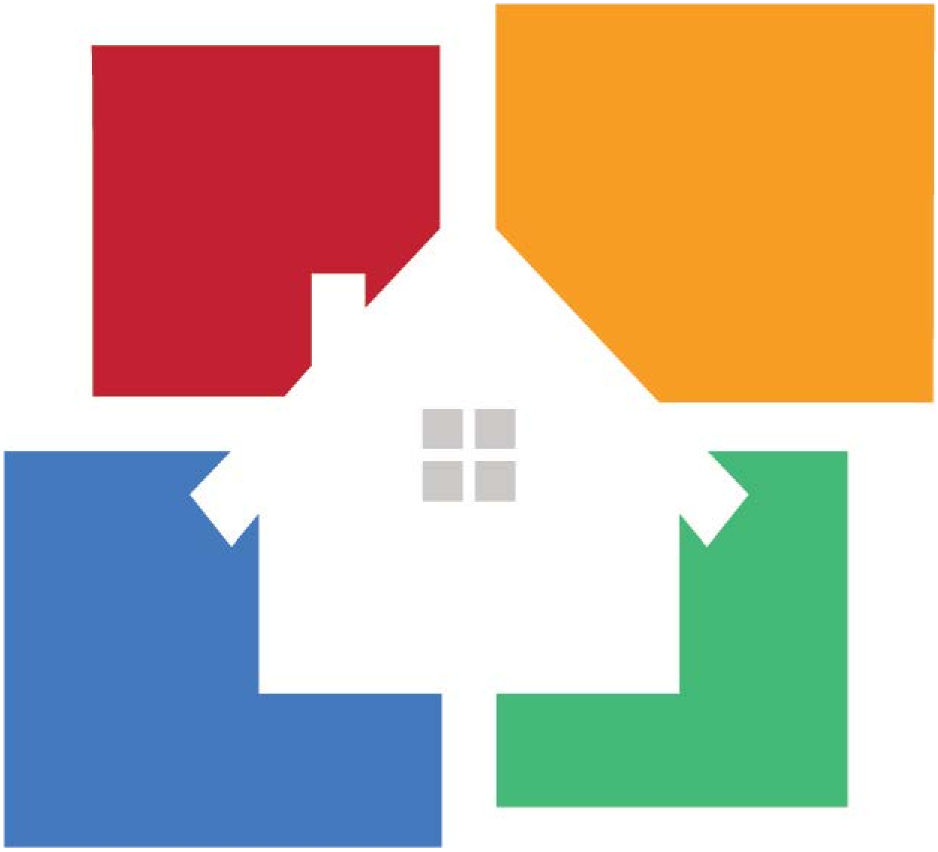

New Brunswick FASD Supportive Housing Framework

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New Brunswick FASD Supportive Housing **Framework**

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This document meets the following accessibility standards: PDF/UA-1 and WCAG 2.1 AA.
For a copy of this PDF, please contact us at FASDinfoTSAF@vitalitenb.ca.

This document is also available in French.

The framework is a living document and will continue to be reviewed, amended, and updated to reflect emerging evidence, best practices, and lessons learned through its implementation across the Province of New Brunswick.

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Acknowledgment

The development of this framework has been informed and enriched by the knowledge, experiences, and perspectives of individuals with Fetal Alcohol Spectrum Disorder (FASD), their families, and caregivers. Their lived experiences have provided critical insights that continue to guide service design, delivery, and evaluation across the province.

We also acknowledge the invaluable contributions of community partners, service providers, and organizational leaders who have shared their expertise and demonstrated a sustained commitment to collaboration. Their engagement has strengthened the collective capacity to respond effectively and respectfully to the diverse needs of individuals affected by FASD.

We honour the memory of individuals who experienced homelessness and systemic barriers and who passed away before receiving the supports they needed. Their experiences underscore the urgency and importance of continued efforts to provide equitable, timely, and culturally safe housing services.

This framework reflects the shared efforts of all those dedicated to advancing person- and family-centred, evidence-informed approaches to care and support.

Introduction

This framework was developed by the NB Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence at the request of relevant government departments and with support from various community organizations and parent partners.

Stable and supportive housing is a cornerstone of well-being, yet for many individuals with FASD in New Brunswick and across Canada, it remains out of reach. Too often, neurodevelopmental differences, gaps in services, and systemic barriers make it difficult to secure and sustain a safe home. Without accessible housing, people are more likely to experience homelessness, poor health, and involvement with the justice system. This framework is being developed to address those realities and chart a more sustainable path forward.

Supportive housing, when designed through an FASD-informed and strengths-based lens, offers the stability and scaffolding needed for individuals with FASD to thrive. This framework integrates the foundational principles, program priorities, and practice requirements essential for developing housing models that are both effective and sustainable.

The intended audience for this framework includes government departments, housing service providers, community organizations, policy makers, as well as families preparing housing support for their children and individuals with FASD who wish to explore supportive options for themselves. Its application extends beyond service delivery to inform program design, funding decisions, evaluation strategies, and cross-sector collaboration. By grounding this work in the voices of families and those with lived experience, the framework encourages housing solutions that are not only practical and sustainable, but also hopeful, empowering, and life-enhancing for individuals and their support networks. Fundamentally, it recognizes the strengths of individuals with FASD and their families, ensuring that their perspectives remain at the heart of housing design and support. In doing so, the framework aims to foster environments where people can thrive, families feel supported, and communities work together toward innovative and sustainable housing solutions.

Safe, supportive housing is a basic human need. As a mother to someone with FASD and through my work in disability and health care settings, I've seen how lack of proper housing leads to real harm—homelessness, incarceration, and suicide.

I've watched young people run from group homes and lose their sense of worth when they feel unseen. But when someone with FASD has a space they feel safe in, everything changes.

They thrive with structure, routine, and compassion—especially when support is tailored to how FASD affects thinking, emotions, and sensory needs. Housing isn't just shelter—it's dignity, belonging, and a chance at a stable, meaningful life.

Alicia Munn, *parent of a young adult diagnosed with FASD*

Purpose

This framework was developed to guide the creation and delivery of supportive housing options for individuals with Fetal Alcohol Spectrum Disorder (FASD) in New Brunswick.

Unfortunately, many individuals who are unhoused or in unstable living situations within our province face multiple physical and mental health issues, including FASD, that often remain undiagnosed or misdiagnosed. By gaining a better understanding of FASD and the individuals who have this disability, relevant government departments and community agencies will be much better equipped to address the ever-pressing issue of homelessness within this population [1].

Although there are ongoing efforts to determine what is "best practice" for housing individuals with FASD, much research remains to be done. It is for this reason that the information contained in this framework includes a combination of information derived from existing literature as well as practice-based evidence and "real world" knowledge of individuals with FASD.

The NB FASD Centre of Excellence would like to acknowledge and thank Social Development for their review and contributions to this framework.

Background and Context

> *"FASD is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol.*
>
> *FASD is a lifelong disability. Individuals with FASD will experience some degree of challenges in their daily living, and will need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential.*
>
> *Each individual with FASD is unique and has areas of both strengths and challenges."* [2].

Children, youth and adults with FASD will require specific supports, services and accommodations in accordance with their specific needs profile, throughout their schooling and transition to adulthood. In their adult life, individuals may continue to require support with daily living in addition to employment, housing, mental and physical health services, as well as with being active members of their communities.

According to the Canada FASD Research Network (CanFASD), FASD is a leading cause of developmental disability in Canada and a major health and social issue, affecting 4% of the population or over 1.5 million Canadians. The prevalence of FASD is greater than Down Syndrome, Cerebral Palsy, Tourette's Syndrome and Autism **COMBINED** [3]. In New Brunswick, using the conservative prevalence of 4%, we estimate that 250 babies are born each year with FASD [4]. The prevalence of FASD is even higher among certain populations experiencing inequities related to social determinants of health, which contribute to increased risks of becoming unhoused, dropping out of school, or being involved with the criminal justice system, etc.

> *"FASD prevalence is inherently difficult to measure, due to challenges with recognition, screening, and diagnosis. The "invisibility" of FASD, as well as factors related to the social determinants of health that are often at play for individuals with FASD, confound our ability to establish accurate rates. Because symptoms of FASD are often complex and may not manifest fully until later in life, individuals with FASD may not come to the attention of service providers until the school years or beyond. As well, because of the stigma and shame attached to the disability, prenatal alcohol exposure (PAE) is likely underreported. Because of these issues, many individuals with FASD may be incorrectly diagnosed with another disability or missed altogether. Therefore, estimates across all studies are believed to be conservative."* [3].

Despite these overwhelming numbers, FASD remains largely unrecognized in individual programs and public policy, thereby leaving individuals in dire need of support even within the systems or programs that have been developed and implemented to help them. Developing any program for individuals with FASD, including housing programs, requires a very good understanding of FASD and of the individuals who are impacted.

Dr. Ann Streissguth, in her landmark longitudinal study at the University of Washington, highlighted the significance of providing informed and sustained support to individuals with Fetal Alcohol Spectrum Disorder (FASD). Her research identified a range of **adverse life outcomes** (referred to in her study as secondary disabilities) that are more likely to occur when individuals with FASD do not receive appropriate interventions, supports, and accommodations. These outcomes included:

- mental health challenges (experienced by more than 90% of participants)
- difficulties with school engagement or disrupted educational experiences (over 60%)
- involvement with the legal system (60%, including 14% of children)
- confinement in institutional settings such as psychiatric facilities, addiction treatment programs, or correctional institutions (impacting 50% of adolescents and adults)
- vulnerability to unsafe or socially inappropriate sexual behaviour (49%)
- challenges with substance use (35% of adolescents and adults) [5]

These findings underscore the critical need for early diagnosis, trauma-informed care, individualized supports, and systemic understanding to improve life outcomes for individuals with FASD and reduce the risk of these preventable adversities.

Across Canada and within New Brunswick, individuals with FASD often face significant challenges in securing and maintaining stable housing. These challenges are shaped by a combination of neurodevelopmental differences, systemic barriers, and the limited availability of services tailored to their unique needs. When housing is not accessible or sustainable, individuals are at heightened risk of homelessness, involvement with the justice system, and poor health and social outcomes. Children with FASD grow up to be adults with FASD. People with FASD who remain unidentified and misunderstood often face homelessness [6, 7], unemployment [8, 9] and are at increased risk of substance use [1] and suicide [10].

Through our work across the province, we see firsthand the reality of homelessness among individuals with an FASD diagnosis, as well as many others who are likely undiagnosed. The Centre has identified 103 clients under 21 to date, including 25 children under 16 who are experiencing homelessness. Tragically, five of our clients have lost their battle with addictions over the past two years. These figures highlight both the seriousness and the urgency of this situation.

> As a parent, I have seen firsthand the difference between supported and unsupported housing for individuals with FASD. The difference is simple: connection over correction. Our children need safety, a home-like environment, meeting what their brain and body need, a place to anchor. Unsupported housing places an unspeakably heavy burden on families, a burden no parent should ever have to carry. Stability doesn't grow out of punishment or exclusion. It grows out of connection.
>
> **Tanya Walsh**, *parent of a child diagnosed with FASD*

As an Elder, I carry the responsibility to speak for those who may not always be heard. Our children, youth, and adults diagnosed with FASD walk a path that is not easy, but they do not walk it alone. They deserve homes where they are understood, supported, and treated with dignity. A Provincial FASD Supportive Housing Framework in New Brunswick must be rooted in cultural safety, community, and respect. This is how we honour the spirit of each person. This is how we begin to heal.

Elder Noel Milliea, *Mi' kmaq Elder from Elsipogtog First Nation Community, Guiding Elder with the NB FASD Centre of Excellence*

Supportive Housing Program Priorities and Requirements

Creating a successful supportive housing framework for individuals with Fetal Alcohol Spectrum Disorder (FASD) requires a foundation built on understanding, flexibility, and a commitment to meeting people where they are. Priorities have been categorized under the following headings:

- Foundational Planning and Service Structure
- Specialized Support and Program Development
- Developmental and Client-Centred Practices
- Community Integration and Wellness

When implemented together, the following priorities form the conditions for housing stability, safety, and well-being. While securing physical housing units and appropriate staffing are critical, it is important to recognize that many of the key elements for success do not rely on additional financial resources. What often proves most impactful is expanding our knowledge of FASD, shifting our expectations, and adapting our systems to better meet the unique cognitive, behavioural, and sensory needs of this population. With the right understanding and approach, supportive housing can be more than just a place to live, it can be a platform for stability, dignity, and inclusion.

Foundational Planning and Service Structure

When we build with care and intention, our structures become more than systems—they become pathways to growth and belonging.

Priority 1
Selecting an appropriate service provider

Perhaps the greatest priority in establishing a successful housing initiative for people with FASD is choosing the right service provider. An appropriate service provider is one who:

- Understands that housing people with FASD is more than just managing everyday behaviours. It requires an in-depth understanding of FASD and the brain-based nature of the disability [1, 11]. Recognizing that common interventions used to address common behaviours do not always carry over to someone who has a brain-based disability like FASD. Agencies charged with managing housing programs for individuals with FASD must recognize the need to make a paradigm shift and be open and willing to intervene differently to help manage challenging behaviours. Individuals with FASD may appear to be more skilled and able than they really are and therefore it is important to manage expectations accordingly [11].
- Is willing to modify their mandate, policies, and procedures if required, in order to help guide their work with individuals with FASD. Policies and procedures in many organizations are often structured in ways that hinder their ability to effectively address the needs of individuals with FASD. For example, depending on the type of housing service, strict zero-tolerance rules for missed appointments or substance use may not take into consideration the cognitive and behavioural challenges faced by individuals with FASD. Similarly, time-limited housing programs may not provide the long-term stability that many individuals with FASD require to succeed. Other common policies that can pose barriers include rigid expectations around independent living skills, visitation permissions and limiting transportation policies. Modifying such policies to allow for flexibility, support, and individualized approaches is key to creating accessible and successful housing environments for people with FASD.
- Is ready and willing to be the primary caregiver for individuals who may appear to function in line with their chronological age but are developmentally much younger [11] and therefore require more of a parenting role than strictly a supervisory one. This can be framed as a mentoring or coaching role for residents who may feel diminished by being “parented” yet the guidance and support commonly provided by a parent is what they require.
- Is willing to build a program that is focused on task management, teaching life skills (i.e., grocery shopping, cooking, proper hygiene, tidying up, making bed, sleep hygiene) and developing coping strategies that are specific to each individual based on their disability profile [11].
- Is willing to act as an advocate for the person with FASD and take on the roll of intermediary between services or agencies (police, justice, social development, community agencies, employment, school, etc.) and the individual with FASD.
- Is willing to create an environment that provides structure, supervision, consistency, predictability, and routine in all areas of their life.

Organizations who are used to working with typically developing individuals may have a hard time making the shift from understanding that although behaviours may look the same, their origins are different and, as a result, will require a different type of intervention in many situations. For example, the motivation behind stealing for someone with FASD and for someone without the disability will be very different. An understanding of the brain-based deficits associated with this behaviour is crucial in order to intervene appropriately.

It may be in the best interest of the funder to undertake a Request for Proposal process to assist in choosing the most qualified and well-suited service provider. This framework can be used as a guide to develop and identify specific expectations to help in identifying the appropriate vendor as well as providing a means to evaluate program success throughout the length of the contract or agreement.

Priority 2
Reframing step-up, step-down and planning for long-term permanent housing

There is no cure for FASD and therefore individuals with FASD will require lifelong support to remain safe and successful [11]. This needs to be top of mind when exploring housing options for people with FASD.

Despite their lifelong need for support, it is important to remember that individuals with FASD can learn and make progress. However, it is more likely than not that individuals with FASD will continue to require some type of supportive housing throughout their lifespan. Creating opportunities for **interdependence** (a model that emphasizes autonomy within a sustainable framework of relational and structural supports) should be the goal and encouraged from the start [12].

The need to reframe the provincial stepped care model to accommodate individuals with FASD cannot be overstated. Individuals with FASD can indeed step up and step down; however, due to the primary disabilities caused by structural brain injury, this must be understood and considered within the context of their long-term living situation. The opportunity to step up and step down for this population could happen several times a week, a day, or an hour.

Research indicates that once support for a person with FASD is removed, they will often regress to their initial level of functioning or worse. Change is very difficult for individuals with FASD, and each subsequent placement can exacerbate the challenges they face in coping with their disability [13].

In rare situations where individuals with FASD can transition or step down to lower-intensity services, implementation of flexible housing approaches that can quickly adapt to their changing needs are essential. This would include conducting regular assessments and check-ins to ensure ongoing support and the ability to adjust services as needed [1].

Individuals with FASD deserve a permanent home that provides support and accommodations tailored to their unique needs [1]. It is essential to create an environment that fosters understanding, acceptance, and stability, ensuring they can thrive in a nurturing space. This may include providing access to case management, flexible housing rules, life skills coaching, and consistent, trauma-informed care. While this may challenge our current policies and practices, adapting is essential for success. The time for change is now! It is clear that our existing approaches, although costly, are not yielding the desired results. We must seek a new path forward—one that prioritizes individualized, long-term, and relationship-based housing solutions.

Priority 3
Housing location

The specific geographical location of the housing unit must not be overlooked. Setting up a residence in an area of the city with higher crime and/or substance use rates will likely sabotage the placement from the outset.

Individuals with FASD may struggle to avoid trouble due to challenges such as impulsive decision-making, a strong desire for social connections, and difficulties in grasping the consequences of their actions—all of which could ultimately lead to placement breakdown.

Ideally, the housing facility or unit should be located in an area that is close to amenities and community services, which will help individuals with FASD who may struggle with poor navigational skills, lack of transportation, poor memory, or poor time management skills, etc. [14].

Priority 4
Structural considerations

Although the most important factor in housing success for individuals with FASD is being supported by individuals with a good understanding of the disability [10], there are several structural elements worth considering when designing a new building or in the acquisition and subsequent renovation of an existing property. These considerations are mostly related to the sensory needs of individuals with FASD [14, 15]. To the extent possible, consideration should be given to ensuring an uncluttered, calming environment, where the individual with FASD can decompress should the need arise. This requirement can be fulfilled by identifying a specific place in the residence or a special space in the individual's bedroom. These spaces could be equipped with a variety of calming tools such as soft music and headphones, sunglasses, blindfolds, weighted blankets, fidget toys, white noise machines, etc. This will be highly dependant on the unique needs of the person requiring housing support.

In addition, the residence should accommodate the ability for each person to have their own room. This can prevent many challenges that could arise given the brain-and body-based disability profile of many individuals with FASD.

To the extent possible, once the home is set up, the layout should remain the same. Although redesigning spaces (i.e., moving furniture, painting, changing curtains or other decor elements) may be fun for some, even minimal changes to the environment can result in significant challenges for individuals with FASD. Choose carefully during set up to avoid difficulties down the road.

The Proof Alliance, a Minnesota-based nonprofit organization focused exclusively on prenatal alcohol exposure and FASD, conducted a research and design study entitled ***A Place to Call my Own – Housing Design for Young Adults with FASD*** [14]. This study identified key design features and supports (including several prototypes) that would best assist young adults with FASD in permanent supportive housing settings.

Priority 5
Staffing

Establishing appropriate staffing ratios in supportive housing for individuals with FASD is essential to ensuring both safety and therapeutic effectiveness.

Individuals with FASD may experience complex neurodevelopmental challenges, particularly when past interventions have been inconsistent or inadequate. It is strongly recommended that a minimum of two staff members be present on every shift, at all times, to provide the level of relational support, emotional regulation, and environmental consistency needed for success for a maximum of five clients.

Staffing models must be proactive rather than reactive. Individuals in early stages of housing stabilization, especially those navigating dysregulation, trauma, or unfamiliar routines, require heightened relational presence, predictable structure, and real-time support to manage transitions and build trust. These needs demand more than supervision; they require a staffing approach grounded in connection, consistency, and understanding of brain-based disability.

Over time, as individuals experience increased stability and self-awareness, a gradual shift in staffing intensity may be appropriate. However, this should never be framed as a pathway to full independence. Remember, the goal is to encourage **interdependence**. People with FASD thrive in environments where routines are reliable, change is introduced carefully, and support is embedded, not episodic. Staffing plans must be intentionally designed to reflect these needs, ensuring stability for both residents and staff.

Priority 6
Evaluation plan

Even the best-laid plans sometimes require tweaking. Developing a robust evaluation framework is essential to ensure that any housing program for individuals with FASD achieves its intended outcomes. This will also allow us to identify potential areas for improvement [10, 11]. A set of key performance indicators will be established to help guide this process. Contractual agreements between funder and service provider should clearly outline guidelines and specific criteria for service delivery that reflect the priorities set forth in this housing framework.

Specialized Support and Program Development

Specialized integrated supports and thoughtfully developed programs create housing environments where individuals with FASD can live safely, grow, and thrive.

Priority 7
Intensive targeted training and development of an FASD-informed service

Before the individual with FASD arrives, comprehensive training that supports the development and implementation of an FASD-informed service must be provided to those supporting individuals with FASD [1].

Unfortunately, a lack of FASD-informed practice across systems leads to individuals with FASD facing challenges with housing [7].

> *"We encourage community members to take an FASD-informed approach, one that is grounded in an understanding of the complexity of FASD and the experiences of being unhoused that emphasizes responsiveness to the physical, cognitive, and adaptive strengths and vulnerabilities of this population. An FASD-informed approach provides the context for a shared understanding of individuals with FASD, helping people to make sense of what they may see through an FASD-informed lens."* [10]

The NB FASD Centre of Excellence has developed a two-day in-person comprehensive FASD training package to help service providers adopt an FASD-informed approach. This two-day workshop is followed by three monthly check-ins to ensure the transfer and integration of knowledge. Trainers are also available to help troubleshoot as necessary. This training should be extended to frontline workers, management personnel of the chosen service provider as well as individuals representing the funder.

Given the high prevalence of FASD, it has been suggested by those working in the field that training in FASD should be mandatory within relevant government departments that serve at-risk populations. There is indeed a high likelihood that there will always be someone who has FASD in their program whether diagnosed or not. This training would only seek to strengthen a service provider's toolkit and the recommended interventions and supports would in no way be harmful to those who do not have FASD.

There is so much potential for success when everyone is on the same page!

Priority 8
Supporting the client's need to understand their disability

It is important to remember that FASD is a medical diagnosis with lifelong impacts. Every person has a right to know the status of their health in accordance with their developmental age and level of understanding. Everyone should have an opportunity to learn and understand their disability. People with FASD don't always recognize their individual limitations, which at times can make it more difficult for them to accept the support and accommodations that are being provided. The more an individual understands their disability, the more open they will be to accepting the support and accommodations that will help them to be successful.

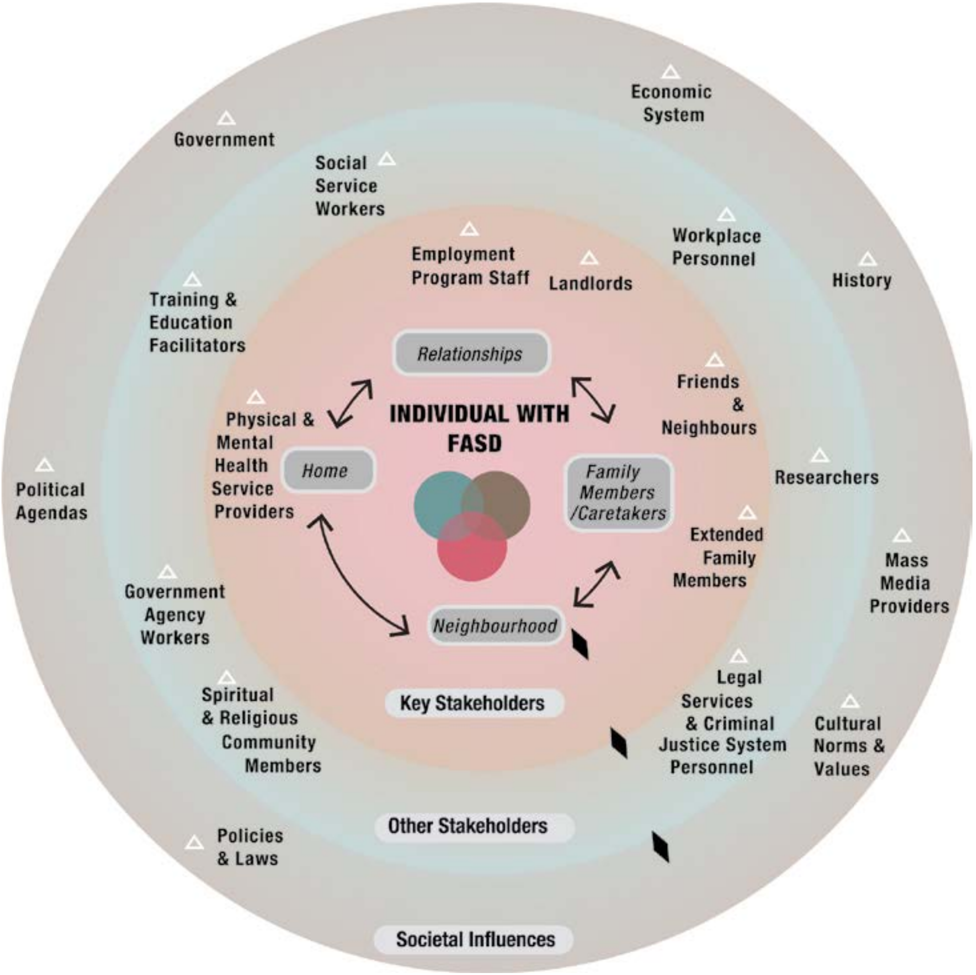
An approach that is often very helpful when discussing a diagnosis with someone who has FASD is to assure them that they are not broken, but that their brain simply works differently, just as all our brains do. It is important to help individuals with FASD understand that there are people who can guide them to understand their unique brain functions better and work with them to find effective solutions.

Priority 9
Access to an integrated system of care and implementation of a collaborative approach

Access to health services, including mental health and addiction services, vocational training and other supportive resources should be facilitated. The importance of interagency collaboration cannot be overstated. Securing and operating successful housing options for individuals with FASD cannot be tackled alone. There is no one person, one agency, or one community that can solve this issue on their own. The co-existence of poor mental health, substance use and trauma, among other factors, highlights the need for integrated approaches to address the complex needs of individuals with FASD [1, 12].

The **Person-Centred Stakeholder Map** *(see Figure 1)* provides a context for the development of a person-centred housing service that "instead of oversimplifying the problem or pointing fingers at a single group…sets the context for all people to situate themselves within so that they can define relationships with others and work collaboratively towards a sustainable solution." [1]

Figure 1
Person-Centred Stakeholder Map [1]



Case plans should support a collaborative approach and involve individuals with FASD, families, and professionals in decision-making to ensure continuity of care and alignment with developmentally appropriate personal goals and preferences [11].

Each person on the team should understand their respective roles and responsibilities while all moving together to reach the same goals.

The departments of Social Development and Health have been mandated by government to deliver comprehensive wraparound supports for individuals experiencing homelessness. Evidence from both formal assessments conducted through the NB FASD Centre of Excellence and extensive frontline experience indicates that many individuals within this population are impacted by Fetal Alcohol Spectrum Disorder (FASD), whether diagnosed or undiagnosed. This integrated approach emphasizes the importance of providing stable and supportive housing environments that foster personal growth and well-being through services tailored to the individual's unique neurodevelopmental profile.

Social Development recognizes that identifying housing needs through the lens of infrastructure, services, and workforce training is essential across the entire system, not only for those currently experiencing homelessness. Social Development has adopted a proactive approach that considers all complex cases (both children and adults) with the goal of co-designing purpose-built living environments that are safe, supportive, and tailored to meet diverse and individual needs ***(see Figure 2, and Appendix 1)***.

Given the high prevalence of individuals with FASD within the population experiencing homelessness, there is a valuable opportunity for stakeholder engagement and strategic collaboration with the NB FASD Centre of Excellence. This could include targeted, FASD-informed training for service providers and government staff, and involvement in pilot projects that explore innovative housing and support models aimed at improving long-term outcomes.

It is critical that we address the immediate needs of individuals who are currently unhoused or living in unstable conditions, while also investing in upstream, preventive solutions that reduce future system strain and promote lasting stability.

We are all working toward the same outcome: to better serve individuals with complex support needs. But we are doing so from within systems that were not designed to account for neurodiversity or the realities faced on the frontline. A Housing First approach, integrated with coordinated health and social supports and informed by collaboration with the NB FASD Centre of Excellence, offers a tangible path out of cycles of crisis, burnout, and system fatigue.

This is not about adding more to already full plates. It's about aligning our efforts, building capacity, and increasing the impact of the work we're already doing, so that both clients and providers can move toward stability, recovery, and hope.

Figure 2
Provided by Social Development

(Housing Type)___________________________for _______________________ (specific population)

In this context, low barrier means:____

<table>
<tr><td>Housing Characteristics</td><td colspan="2">Housing & Unit Requirements
(e.g., features, standards, max. number of people, specialized spaces)</td><td colspan="2">Location & Infrastructure Considerations</td><td>Best Practice / Design Standards</td></tr>
<tr><td>Human Factors</td><td>Care / Treatment Requirements</td><td>Team Credentials / Qualifications</td><td>Team Training</td><td>Social Supports, Skills Devel-opment, Employment, etc.
(Residents)</td><td>Financial Support / Opportunities</td></tr>
<tr><td>Other Considerations</td><td colspan="4">What Else?
(What else is needed in the environment / care ecosystem to increase chance of success)</td><td>Who Else Should be Engaged?</td></tr>
</table>

Priority 10
Consideration for resident variability

Given the common profile shared by many individuals with FASD, integrating residents with a wide range of disabilities or mental health challenges would not be advisable. Greater success is achieved when environments are designed to meet individuals where they are developmentally. In settings where most residents share similar levels of developmental functioning, it becomes easier to apply consistent, supportive strategies and reduce social friction, particularly for those with significant dysmaturity.

The needs of individuals with FASD are often distinct [1] even when their behaviours resemble those associated with other neurodevelopmental or mental health conditions. What is less widely understood is that effective interventions must be tailored to the unique brain-based differences seen in FASD, rather than relying on generalized behaviour management strategies. This can be confusing for many, including the individuals themselves, especially when support approaches do not align with their cognitive or developmental needs.

When housed together, individuals with FASD can help each other understand their disability, seek support from one another when appropriate, and form new positive friendships.

Due to challenges with judgment, understanding consequences and emotional regulation, placing individuals with FASD in co-ed housing is generally not advisable.

Developmental and Client-Centred Practices

Supporting individuals with FASD is most effective when it is developmentally informed, client-centred, strength-based, and tailored to each person's unique needs—promoting growth, autonomy, and inclusion.

Priority 11
Staggered admissions

If the housing program intends to support more than one individual living with FASD, it would be helpful to stagger admissions. Allowing for a period of stabilization, where positive relationships can be built between residents and staff is important—staff will become familiar with the needs of each person prior to the introduction of a new resident who may have similar but unique needs. There have been instances where an original resident, following their period of stabilization has taken on the role of mentor for new arrivals—a very positive and empowering role. This has served as a continued source of empowerment and pride for this individual, where none had existed before.

Priority 12
Think developmental age

Dysmaturity is the term used to describe when someone's developmental age is younger than their physical or chronological age, causing them to think and act in ways that are less mature than expected ***(see Figure 3)***. Given the areas of the brain that are commonly affected by prenatal alcohol exposure, it is not uncommon for individuals with FASD to demonstrate a mismatch between their chronological age and their developmental age. The following chart shows what is meant by dysmaturity and how it can present in an individual with FASD.

Most of us expect children to develop and grow according to an accepted chronological schedule and for physical, cognitive, and psychological development to occur at about the same rate. Unfortunately for individuals with prenatal alcohol exposure, these assumptions about development create a poor fit between abilities and the expectations placed upon individuals. Providing developmentally appropriate care also means the need to change treatment goals and interventions over time [11].

Reflecting on *Figure 3*, we must ask ourselves whether an individual who is chronologically 19 years old but has the living skills of an 11-year-old and the social skills of a 7-year-old could be expected to live independently without supervision, accommodations, and support?

Figure 3
Source: Trying Differently Rather Than Harder (2002), Diane Malbin

Priority 13
Encourage autonomy where possible and according to developmental age

Although individuals with FASD often require a high level of support and supervision, they also express, as we all do, the desire to make their own decisions. To the extent possible, and remaining cognizant of their developmental age, individuals with FASD should be permitted to exercise agency over their own lives [11]. In this context, encouraging autonomy should not be misinterpreted to mean encouraging independence. Remember – **interdependence** is the goal [12].

There is little doubt that you will get greater buy-in (and it will indeed feel more like their forever home) if the individual feels as though they have had a say in creating their surroundings [12, 14]. This is also an opportunity to reinforce learning and skill development while fostering positive, supportive relationships with those around them.

Individuals with FASD can learn and their decision-making skills can improve. In some cases, and depending on the task at hand, this may take longer than it would for neurotypical individuals. Instead of mastering a task in a day or two it may take someone with FASD several days, months or years to achieve. For others, individual skills may be there one day and gone the next. Ongoing and consistent practice can go a long way in helping individuals with FASD develop skills and make decisions that meet their needs and keep them safe.

Working alongside members of the unhoused community challenged many of the assumptions we didn't even realize we carried. When we asked about their experiences of homelessness and their hopes for housing, several people paused, puzzled. They told us they were not homeless—though they did not have houses. They showed us the spaces they cared for, the belongings they valued, and the communities they were part of. In that moment, we began to see more clearly: a house and a home are not the same thing. Providing shelter alone is not enough; without the relationships, routines, design choices, and sense of belonging that create a home, housing can feel empty. Sustainable solutions start with listening—learning what makes a home for each individual. Being housed does not guarantee being homed, and if in our efforts to house people we strip away the homes they have built, then our solutions are ours alone, not theirs. To truly support lasting change, we must set aside our assumptions and work with communities to create housing that is also home.

Ultimately, houses and homes are not the same. Being housed is not the same as being homed. True solutions come from listening—understanding what and who makes a home for each person. Without this, we risk building roofs, not roots.

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Community Integration and Wellness

Promoting community integration and wellness for individuals with FASD involves fostering meaningful connections, encouraging participation in community life, and supporting access to inclusive environments that enhance belonging, well-being, and long-term stability.

Priority 14
Support community engagement and encourage opportunities for building healthy relationships

Many individuals with FASD have grown up with limited healthy friendships or relationships. This needs to be taken into consideration when developing policies and procedures for the housing service. To the extent possible and ensuring the safety of all involved, residents should be allowed to have visitors. In saying this, individuals with FASD are particularly vulnerable to peer influence, for better or for worse, and can find themselves in situations that do not serve their best interests. With the supervision and support of frontline staff, this can be largely minimized and opportunities to model appropriate behaviour that nurtures healthy relationships can be helpful. In addition, watching for teaching moments when a resident is not being treated appropriately or being victimized in any way would be beneficial.

Sadly, many have also become estranged from family and friends. Being in a stable housing situation may provide opportunities to repair relationships that are meaningful to the person with FASD. This should not be coerced and only encouraged if there is sufficient evidence to demonstrate that the person may be a positive influence in the life of the resident. Ultimately however, this should be the decision of each individual.

Opportunities for community integration and involvement, helping individuals build social connections and a sense of belonging should be facilitated and encouraged in accordance with the person's skills and interests [11].

Priority 15
Formally celebrate successes and special events

Many individuals with FASD have lived lives where success was rarely acknowledged and celebrated. These may be individuals who were never invited to birthday parties or family holiday celebrations during childhood, either because family members were unaware of the child's disability or due to difficulties in managing behaviours associated with the disability. The focus is not on compensating for lost time but on establishing these opportunities as a normal part of residential life.

In addition, celebrating success raises self-esteem and provides individuals with FASD the opportunity to feel proud, confident, and hopeful.

When celebrating successes, it is crucial to keep in mind the sensory issues commonly experienced by individuals with FASD. Celebrations do not need to involve a lot of people or be loud, etc. Depending on the individuals in the housing unit, quiet celebrations that minimize disruption to the regular routine are also meaningful [15].

> Having my own place is essential to maintaining my independence. It may not always be perfectly organized, but it's thoughtfully arranged to suit my needs and comfort. What I cherish most about having my own home is the sense of freedom—it allows me to live without feeling like a burden or inconvenience to anyone else. My house is more than just a space; it's a sanctuary where I feel safe, grounded, and truly myself
>
> **Joseph Munn,** *young adult diagnosed with FASD*

Conclusion

Young people and adults with Fetal Alcohol Spectrum Disorder (FASD) often face some of the most persistent barriers to stable housing, especially when they have not received a formal diagnosis or were only identified in adulthood, missing key supports during early development. Since FASD is a largely hidden disability, individuals are frequently misunderstood, and their support needs may go unrecognized or unmet.

Despite these challenges, individuals with FASD can thrive when provided with housing environments that are safe, predictable, and tailored to their unique neurodevelopmental needs. When housing models are designed through an FASD-informed lens, prioritizing relationship-based support, structured routines, and responsive services, individuals can experience stability, purpose, and a meaningful sense of belonging.

By adopting this supportive housing framework, we have the opportunity to build systems that are not only more effective, but also more compassionate and inclusive. This is a chance to move beyond crisis management and toward long-term success, for both individuals with FASD and the people who support them.

The time to act is NOW!

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Appendix 1

Figure 2
Provided by Social Development

(Housing Type)______________________________for ________________________ (specific population)

In this context, low barrier means: ____

<table>
<tr><td>Housing Characteristics</td><td colspan="2">Housing & Unit Requirements
(e.g., features, standards, max. number of people, specialized spaces)</td><td colspan="2">Location & Infrastructure Considerations</td><td>Best Practice / Design Standards</td></tr>
<tr><td>Human Factors</td><td>Care / Treatment Requirements</td><td>Team Credentials / Qualifications</td><td>Team Training</td><td>Social Supports, Skills Development, Employment, etc. (Residents)</td><td>Financial Support / Opportunities</td></tr>
<tr><td>Other Considerations</td><td colspan="4">What Else?
(What else is needed in the environment / care ecosystem to increase chance of success)</td><td>Who Else Should be Engaged?</td></tr>
</table>

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