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2003 FASD Conference Sold Out!

Hon. Jim Rondeau, Minister of Healthy Living, addresses full capacity room

The 2003 Canada Northwest FASD Conference took place in Winnipeg from November 19-21. The conference was packed, with over 720 attendees registered from across Canada as well as Alaska and Australia. Combined with the speakers, total attendance exceeded 800.

A pre-conference day provided half-day and full-day workshops on focussed subjected areas by invited experts. The main conference focussed on enhancing skills, strengthening community networks, and learning about emerging information in the field. Overall, there were 32 sessions with 96 speakers.

The Honourable Jim Rondeau, Minister of Healthy Living and chair of the Healthy Child Committee of Cabinet, which brings together 7 ministries to work together in the interest of children, welcomed everyone to the 2003 Canada Northwest FASD conference.

"These are people who really care about the issue, are willing to spend time here, and who are willing to work hard to come to good solutions," said Minister Rondeau.

He added that the breadth and participation made the theme of this year's

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Ministers Create Research Network

A Canada Northwest FASD Partnership Ministers' Meeting was held on November 21, 2003, in conjunction with the conference.

The Honourable John Q. Nilson, Saskatchewan Minister of Health, chaired the meeting. Manitoba's representative was the Honourable Jim Rondeau, Minister of Healthy Living.

The Canada Northwest FASD Partnership is a collaboration of the Governments of Manitoba, Saskatchewan,

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Call for Action!

What do we want to see accomplished in our jurisdiction two years from now? This was the question posed at regional meetings held during the Canada Northwest FASD Conference.

Participants considered their response based on the conference themes of prevention, support to families, diagnostic issues, justice, education, community development and issues for First Nation/northern communities.

Winnipeg
Recommendations from this discussion included greater public

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Draft Guidelines for Diagnosis

Health Canada formed a subcommittee of its National Advisory Committee on FASD to address issues pertaining to screening, diagnosis, surveillance, and research.

The goals of the subcommittee are:

- to develop recommendations on national standardized guidelines for diagnosis;
- to develop screening/identification tools for prenatal alcohol exposure that can be validated;
- to lead the development of education and training programs for health care professionals;
- to facilitate the development of tools for surveillance of FAS/FAE in Canada; and
- to determine research priorities.

Data suggested that standardized guidelines for diagnosis would be helpful for clinicians to make accurate and objective diagnoses and referrals. By having diagnostic centres following the guidelines, data relating to diagnosis (incidence, prevalence, demographics) could be more easily compared on a national scale.

Highlights of the subcommittee's draft guidelines follow. Please note that the full version of the draft guidelines include a detailed description of the physical examination (growth, facial characteristics) and the brain/head.

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Top 10: Responding to Challenges

Dale Kendel, facilitator for the conference, closed with a "top 10" list to consider in responding to the challenges laid out during the various sessions.

10. We commit to change at least one thing in the lives of people living with FASD. Nothing is too small. All are important.
9. We dare to dream, deal with disappointment and delay, decide on where to go next. Celebrate success.
8. We expect that government at the Provincial/Territorial/Federal and municipal levels all have roles to play, but they are only a part of the solution. Communities and individuals have a role to play.

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FASD Community Mobilization Project

The Manitoba FASD Community Mobilization Project was developed in June 2002 by the Association for Community Living - Manitoba. The project has undertaken a number of initiatives to improve the health and well-being of adults with FASD, and to increase the understanding and support of adults affected by FASD.

"The most effective ways to reduce the disabling aspects of FASD lies within community development," explains Brenda Bennett, co-ordinator of the FASD Community Mobilization Project. "The numerous initiatives of the project have been integral to changing the ability of the community to understand and respond to the unique needs of persons affected by FASD."

In efforts to realize this goal, the project has had contact with more

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2003 FASD Conference cont'd...

conference—Our Communities, Our Strengths—particularly relevant and appropriate.

"As the new Minister of Healthy Living in Manitoba, I recognize that any strategy to improve the overall health and well-being of Manitobans must address the issue of fetal alcohol in a comprehensive way," said Rondeau. He noted he was looking forward to meeting with his federal and provincial colleagues at the Ministers' meeting, which took place during the conference.

"As you well know, FASD is a complex issue. There are no easy answers, but the Canada Northwest FASD Partnership believes strongly that the best answers will emerge from the sharing of information, research, experience and best practices."

Appropriately, the first full day of the conference coincided with National Child Day. Minister Rondeau noted that Manitoba has already demonstrated a commitment by establishing the Healthy Child Committee of Cabinet.

"I find it particularly interesting that we're one of the few jurisdictions that puts children first. Most governments have a treasury board that deals with money—we have a committee of cabinet that deals with children."

Minister Rondeau acknowledged his colleagues, The Honourable Oscar Lathlin (Minister of Aboriginal & Northern Affairs) and The Honourable Christine Melnick (Minister of Family Services & Housing), who also took time to attend the meetings at the conference.

Conference attendees came from as far away as Australia

"The next few days allow us an opportunity to learn from one another and move forward. It's a step in the right direction and I appreciate that you are taking that step along with us," said Rondeau. "Congratulations for coming and thank you for making a difference, day in and day out, in the lives of all our citizens."

The Canada Northwest FASD conferences now will be held every second year. The next conference will be held in 2005, likely in Saskatchewan. There will be an FASD partnership symposium in Yukon sometime in 2004/05 with emphasis on one topic. Also, on March 24-25, 2004, B.C. will host a conference dealing with the theme of adult services. In December 2004, SAFERA will hold the first French language alcohol symposium in Quebec City.

The Prairie Northern Pacific Fetal Alcohol Syndrome (FAS) Partnership was recently renamed the Canada Northwest Fetal Alcohol Spectrum Disorder (FASD) Partnership. It includes the governments of Alberta, British Columbia, Manitoba, Northwest Territories, Nunavut, Saskatchewan and Yukon.

Call for Action cont'd...

awareness and education through more effective marketing; funding to ensure support for high-risk mothers and people living with FASD, and the groups that support them; mandatory training and curriculum implementation throughout the province in all sectors; short- and long-term plans with identifiable markers to ensure evaluation and implementation; a centralized, multi-system, co-ordinated resource for the province; access to services (electronic or phone) with information that follows the client through a personal ID number; a web site for FASD resources and services; and the required political will to follow through.

Rural Manitoba
A separate summary for issues elsewhere in Manitoba included mandatory training for professional support workers; regional networking using TeleHealth; a simplified funding approach that takes geography into account; increased resources; rural diagnostic services for adults and youth using Telelink; and family-oriented treatment centres.

Saskatchewan
Our neighbour to the west would like to see peer support provided to at-risk women in their communities; more trained workers to support families; regional diagnostic clinics linked to services; different approaches explored for dealing with offenders in the justice system; opportunities for sharing information and best practices; a public awareness and media campaign; and government placing priority on a regional strategy for First Nations.

Alberta
The Alberta group focussed on a theme of communication and collaboration. They would like to see increased communication vertically and horizontally; funding and access for diagnosis; sustainable funding; communication that leads to collaboration; and a virtual forum for delegates.

British Columbia
The B.C. group described their vision based on the common values of respect, compassion and cultural sensitivity; comprehensiveness; collaboration, inclusion and capacity-building; balance of prevention and intervention; and evidence-based practice and policy. Their vision: all are aware of the cause and effects of FASD; pregnant women are supported in reducing alcohol use and achieving improved health; early identification and lifelong supports; and research supported in all areas. The BC strategic plan for FASD is available online at: **www.mcf.gov.bc.ca/fasd/**

Yukon
In the Yukon, they would like to see gaps in support services identified in all communities; creation of a co-ordinated interagency roadmap for services; support for frontline workers with opportunities to share problems and solutions; prevention education in schools; and diagnostic teams for children and adults.

Northwest Territories
The NWT group would like to break the silence around FASD; create a two-year action plan with input from all stakeholders; and to raise awareness of issues around women's use and abuse of alcohol.

Nunavut
The Nunavut group focussed on getting screening and diagnosis in place; prevention programs in school; open communication through interagency work in communities; environmental audits to remove barriers and build on strengths; and an FASD co-ordinator for the territory.

Ontario
In Ontario, they want to see province-wide K-12 mandatory curriculum; more diagnostic centres established; better linkages and communication between agencies; increased flexibility in funding; and making FASD a household word across the province.

Quebec
The speaker representing Quebec participants stressed how important the conference was for them as it opened their eyes and minds to an issue that is not well known in their province. The Quebec group wants to see the problem of FASD named and recognized; a mandate and support from their government to deal with FASD; and support for efforts to increase local awareness and assessment of FASD.

Nova Scotia
The Nova Scotia participants want to gain insight into the variety of resources and supports available across Canada; access ideas related to parenting tools and support systems; gain knowledge of support models in existence; and host a national FASD conference to share best practices.

Alaska
The representative from Alaska noted they share the same problems as rural and northern Canada, but use alternative approaches to provide medical and professional supports in rural areas. Specifically, they use a roundtable, inclusionary process to involve people from 14 villages. She added that we are a large village around the world with a common challenge.

Australia
The folks from Down Under would like to see diagnostic teams in place in all territories in Australia; consistent identification by health service providers of at-risk women of childbearing age; and greater collaboration between services. The representatives noted that Australians have a strong drinking culture, requiring that FASD be acknowledged and addressed.

FASD: a definition

Fetal Alcohol Syndrome (FAS) and related disorders, such as Fetal Alcohol Effects (FAE), are conditions now commonly referred to by the non-diagnostic umbrella term **Fetal Alcohol Spectrum Disorder** (FASD), where prenatal exposure to alcohol is an important factor in problems an individual exhibits throughout development.

"Top 10" list cont'd...

7. We all can do better, but we have to act with baby steps, a leap of faith... but steps forward.
6. We have gained an understanding of the courage of families to support their son or daughter who lives with FASD. We are inspired and encouraged as women reclaim their voices. May we stand beside you in support.
5. We recognize the gifts of each individual who lives with FASD, we understand the struggle, and share growth and joy.
4. We have created an expectation that communities—with their people, organizations, resources, energy, desire and money—can respond in amazing ways when partnerships are built. Power is shared and we act together.
3. We will continue to build connection, knowing every day that caring people all across Canada are doing their best to change the world of FASD and you are part of it.
2. We can learn the "lessons of the geese." It's about teamwork, discipline, co-operation, caring for an injured partner. Every time you see a goose in the sky, smile and think about today. [See page 11 for the Lessons of the Geese.]
1. Here's a test question. How do I know if my mission on earth is finished? Answer: If you're breathing, it isn't.

Advertising, Addictions & Targeting Women's Need for Connection

Dr. Jean Kilbourne is internationally recognized for her pioneering work on alcohol and tobacco advertising, and the image of women in advertising. She is the author most recently of *Can't Buy My Love: How Advertising Changes the Way We Think and Feel*.

"Just as it is difficult to be healthy in a toxic physical environment, so it is difficult to be healthy in a toxic cultural environment," says Dr. Kilbourne. "This environment surrounds us with unhealthy images and constantly sacrifices our health for the sake of corporate profit. One important aspect of this toxic cultural environment is advertising."

Advertisers, especially the advertisers of addictive products, target women by corrupting the meaning of relationship and connection in women's lives and exploiting that to hook them into using addictive products.

Dr. Kilbourne believes addiction is our number one health problem and yet it is often trivialized throughout popular culture and particularly in advertising.

"Addictions are extremely profitable. Every time an addict recovers, someone loses money. Whether it's the pusher on the corner or the pusher in the boardroom."

Dr. Jean Kilbourne

She notes the average North American is exposed to over 3,000 ads every single day, and will spend two years of his or her life watching television commercials.

While people insist they ignore ads and are not affected by them, Dr. Kilbourne disagrees. The simple truth is that advertising works. For example, Absolut Vodka sales soared after just one year of a new advertising campaign even though all expensive vodka is essentially the same. People will spend extra money to buy an image portrayed in an advertisement.

"You can't grow up in North America and not be influenced by advertising. It's quick, it's cumulative, and for the most part, it's unconscious."

Research has shown that the cumulative impact of these messages continues to be reworked in our minds unconsciously over time, which explains why the influence is so great and why we believe we are not influenced.

Addictions are extremely profitable. Each time an addict recovers, someone loses money.

"Advertising could be considered the propaganda of capitalism. It teaches us above all to be consumers, that happiness can be bought, and that products can fulfill us and meet our deepest human needs. This belief that something outside ourselves can fill us up and make us happy is at the root of most addictions. It creates an addictive mindset."

Ads imply that products will "transform our lives" and portray them as magical solutions to our problems.

"At the same time that advertising glamourizes products, it trivializes human relationships, especially marriage and sex. There are so many of these ads that they create a world in which products are more important than people, and in which people, including children, are trivialized. In the world of advertising, people are ever less important and things are ever more important. Advertising encourages us to have relationships with products rather than with people."

Kilbourne notes that addicts in particular feel they are in a relationship with their product or substance. Advertisers of addictive products understand this and use that knowledge in their ads. For example, they know that addicts feel isolated and lonely. Addicts feel the substance they are addicted to is their only real friend and source of comfort and the very thing that keeps them going, rather than the very thing that is killing them.

"The addict's powerful belief that the substance is her lover, her friend, is constantly reinforced in ads."

Women are more likely than men to use cigarettes, food, alcohol and other drugs to deal with stress, depression and negative feelings, such as anxiety, nervousness, and especially anger. Depressed women are also more likely than depressed men to eat, to smoke, and to blame themselves, whereas men are more likely to become aggressive, to isolate, or to engage in sexual behaviour.

"The advertisers of addictive products spend billions of dollars on psychological research studying addiction and use this information in their ads to hook people and keep them hooked. They understand that the addict is their best customer. No matter what you're selling, the heavy user is your best customer. But when the product is a drug or something that can be used like a drug, the heavy user is almost always an addict or certainly someone in desperate trouble."

Kilbourne notes that 10% of the drinking population consumes over 60% of the alcohol sold (Source: Center for Science in the Public Interest).

"If every adult in North America drank according to the generally accepted guidelines of what is low-risk drinking—which is no more than one drink a day for a women or two drinks for a man, and even if the 40% of those who don't drink started to drink according to those guidelines—alcohol industry sales would be cut by 80%. They would be destroyed. Huge powerful industries have a stake in encouraging addiction."

One of the purposes of advertising for addictive products, notes Kilbourne, is to normalize addiction and to create a climate of denial. This is for the benefit not only of the high-risk drinker, but for everyone around her so that problem drinking is not seen as a big deal.

"What can we do about all this? We need to understand that addiction is a public health issue and it affects all of us," says Dr. Kilbourne.

"We can make an enormous difference with our individual clients and in our communities. We can turn things around as we have done on the issue of tobacco in recent years."

For more information and an extensive resource list, see:

www.jeankilbourne.com.

Western Research Network cont'd...

Alberta, British Columbia, Northwest Territories, Yukon and Nunavut designed to maximize the use of existing expertise and resources in the development of joint strategies and initiatives to address Fetal Alcohol Spectrum Disorder (FASD). Saskatchewan is currently the lead jurisdiction for the Partnership.

At the meeting, Ministers discussed and agreed to pursue the development of a Western Provincial/Territorial FASD Research Network.

It is estimated that between one and three of every 1,000 infants born in Canada today are affected by prenatal exposure to alcohol, making the resulting permanent physical, intellectual and behavioural challenges the most common childhood disability in the country. However, the extent of FASD-related research activity in Canada is modest, despite the fact that the importance of comprehensive, evidence-based research is now widely recognized by all levels of government and by professionals working with FASD populations.

An inventory of FASD Research in Canada reveals that:

- ▲ A very small portion of national health research funding goes to FASD-related research. For example, in 1999-2002, only $1,381,382 was granted nationally for FASD-related research by the Canadian Institutes of Health Research (CIHR). The primary focus of this nationally funded research has been on the biology of FAS, with relatively little research on prevention or practice/service questions.
- ▲ The vast majority of nationally funded Principal Investigators are located outside northern/western Canada (i.e., in Ontario). For example, in 1999-2002, CIHR funded only $80,754 to northern/western Canada (projects in BC and Alberta).
- ▲ Overall, national funding for FASD-related research has been limited. Between 1998 and 2002, only 11 FASD-related projects were funded by national agencies across the country (four in the west and seven in Quebec and Ontario).
- ▲ There is a lack of co-ordination between the research, stakeholder and funding communities, particularly in the area of prioritizing research questions. No comprehensive, well-resourced FASD Research Network with regional or national scope currently exists in Canada.

Ministers have agreed to pursue the funding and development of a western provincial and territorial FASD research network. Networking enables groups of researchers from multiple disciplines to apply common methodologies and technologies (such as linked databases, clinical trials, health services research, health promotion research, and knowledge transfer strategies) to common applications.

Through networking, links are fostered amongst client populations, service providers and research communities, in order to facilitate shared costs, develop critical mass, enable joint priority setting, minimize duplication and make larger comparative and longitudinal analyses possible. Networks also further accountability by enhancing collective knowledge of cost effectiveness, outcome analysis, knowledge transfer, and quality assurance (evidence-based policy and program design).

With limited exceptions, a comprehensive networking approach is relatively new to the field of FASD. It presents a largely unexplored and potentially highly productive method to develop a comprehensive FASD research platform. Such a platform can initiate, develop and drive research to inform policy, practice and programs in the seven jurisdictions of this Partnership.

Northern Families Share Telelink Experiences

For families in northern and remote communities, the prospect of seeking a diagnosis can be overwhelming. Isolation and distance between diverse communities, weather conditions for travelling, limited services, and the need for follow-up services after diagnosis are a few of the challenges faced.

But the innovative use of telemedicine technology combined with partnerships between local community organizations and the Clinic for Alcohol and Drug Exposed Children (CADEC) at Children's Hospital in Winnipeg have shown it can work.

TeleHealth is described as the use of two-way information technologies to link care providers and patients over short or long distances. It reduces the hardship on families and the inconvenience of being away from work and home, is less disruptive for the child, and saves the family and healthcare system the time, money and risks associated with travel. Notably, the family can have their entire support system from the community, such as resource teachers or daycare workers, present.

Lionel Mason (left) and brother Mickey

TeleHealth links the Clinic for Alcohol and Drug Exposed Children (CADEC) in Winnipeg with hospitals in Thompson, The Pas, and Flin Flon. The technical potential exists to expand to 24 sites.

The Family Experience

Patrick and Kelly Jacobson live in Cranberry Portage. The couple foster three siblings whose birth mother had a history of alcohol and drug use during pregnancy.

"Having people around us who have been educated on FAS enabled us to get feedback and proper guidance in getting the children diagnosed."

Based on a referral from the Child/Family Resource Centre in Cranberry Portage, the Jacobsons completed the required forms.

"There was a lot of time spent on the telephone and fax, and a lot of extra help given by the Executive Director of the Child/Family Resource Centre, Wendy Trylinksi. She took a lot of the pressure off of us by doing all of that extra work."

During the actual telelink session, a support team for the family, including the children's social worker, the resource teacher from school, Wendy Trylinski, and Tim Spencer (TeleHealth site co-ordinator for The Pas and Flin Flon), joined the Winnipeg support team of Dr. Ab Chudley, Dr. Sally Longstaffe, and CADEC co-ordinator Mary Cox-Millar who were connected by telelink.

"The children called it the 'Magic TV' and it was the neatest thing that they and a few of us had seen. The children were comfortable and yet excited at the whole process, because they were around people who they felt safe and secure with."

The Jacobsons note that the telelink diagnostic session helped to achieve their goal of doing what was best for the children. They were able to get instant feedback and meet the entire support team together in one room and have all questions answered at one time. The family saved travel time and money, and it was spared the children the negatives of travel, culture shock, and interference with routine. It eliminated time away from work and school, plus it opened new doors to other services and people with the same concern for the children.

"Since that telelink meeting in Flin Flon our children have had their psychological evaluations done. One of the children is currently seeing an excellent paediatrician. This has all taken place in less than seven months."

Lionel Mason's family also benefited from the telelink process. Mason, who now lives in Cranberry Portage, used to live in St. Theresa Point where there is no telesite. His brother Mickey is affected by prenatal exposure to alcohol.

"Mickey came to the family at age three. We suspected FASD, but nothing was officially diagnosed."

When Mickey was a teenager, he and the family decided to pursue a diagnosis.

"We figured it would be his best chance beyond high school," notes Mason. "Within six months we went from having nothing to having an assessment happen."

Mason says the relationships and comfort level were built before the telelink session. He notes that Marcie Johnson, the Flin Flon School Division Student Advocate Worker, helped them navigate the process.

The ability to connect through technology was a particular benefit for the Mason family as they had people from across the province who had to be pulled together.

"We found the process really flexible, with sites in different locations around the province," says Mason. "If we had had to do it in person, it would have taken years instead of six months."

This was important as the diagnosis was completed before Mickey turned 18 years of age. It allowed him to access services that otherwise would have been closed to him.

"Telelink worked only because of the relationships built before it was used," noted Mason. "The relationships humanize the technology. That is key."

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A letter to my son

My dear son Daniel,

Let me first begin by telling how precious you truly are and that I love you with all my heart and soul. I thank the Creator every day for having blessed me with such a wonderful son. You are a special gift from above and I am so proud of you and all that you do. We have been doing presentations in the past five and a half years, which has been both a healing process for myself and emotional at times. It is important that we share our stories with others in order to help them deal with FASD. I'm often not so sure that you fully understand that you are FAS even though we have been going to many doctors appointments and you have heard me talking to your teachers about this. However, as you are getting older I know and sense that you are only beginning to realize that you have this disability. You are beginning to feel different from all your peers, especially your classmates and cousins. Daniel, you know that I used to drink beer before, during, and after you were born. I had a problem and needed help. I still need help today, which is why I attend AA meetings regularly. I was weak and selfish before and while you were growing in my tummy. That is why you are the way you are today. Despite our challenges we love each other a lot and we are so lucky that God gave us each other. You inspire and motivate me every day to always be the best I can be.

love, from mom

Annette Cutknife is the single parent of Daniel, born October 31, 1988. Annette is employed with Samson Cree Nation in Alberta. She started advocating in the area of FASD and sharing her experience in 1998 as she began accepting her son's condition. She hopes to make a difference by sharing her story and experience regarding this sensitive issue.

Community Mobilization Project cont'd...

than 40 agencies and programs within the Winnipeg community.

The project has processed 89 intakes for service received from 21 community sources over the past year. Interim evaluation results demonstrate that the provision of direct services has surpassed client goals and the goals of those making the referrals. The evaluation also showed that the project has been successful in assisting participants in accessing resources and supports for which they had not previously been eligible or capable of accessing without advocacy or assistance.

Overall, the project is viewed as very effectively filling a gap existing in services and supports for a population known to be very vulnerable and at significant risk for problems involving health/ mental health; housing; unemployment; poverty; involvement in the criminal system; substance abuse; physical, emotional and sexual abuse; parenting/child custody; social isolation; and suicide.

The premier challenge remains the project's current limited term duration resulting from a lack of long-term or permanent funding support from government.

To contact the Manitoba FASD Community Mobilization Project, call Brenda Bennett at (204) 786-1607.

But Michael Makes Me Laugh!

There is nothing like a determined mother to get things done. Lori Stetina developed a disability awareness booklet for young children to help her son Ryan understand that he was affected by FASD.

"It's a tool to initiate discussion with a child on a level that is manageable for them," says Stetina. "Never underestimate a child's ability to understand his or her disability."

Lori Stetina

After reading the story to her son and securing his approval, she later read the story to his Grade 2 class. Her son turned the pages while she read.

"His classmates realized afterwards that Ryan has FASD. I was really impressed by their questions and understanding."

But Michael Makes Me Laugh can be purchased for $5.00 (plus $3.00 S&H) through the Interagency FAS Program. To order, call (204) 582-8658 in Winnipeg. Elsewhere in the province, call the FAS Information Manitoba helpline toll free at 1-866-877-0050. Fax: (204) 586-1874 / E-mail: interagency_fas@shaw.ca / Write to Unit 49-476 King St., Wpg, MB, R2W 3Z5.

Playing "the game"

Jeremy Baumbach, a clinical psychologist in the Yukon, explains that "the game" refers to a monopoly-like game that he has used as a valued intervention tool in a residential treatment program for youth with developmental disabilities, mostly FASD, and sexual offending behaviours. The game serves the primary purposes of teaching, developing cognitive skills, and practicing social skills.

He notes that while the game board can be purchased, the playing cards are developed by the worker using the tool and individualized to the participants, which could represent any type of population. Baumbach has also made a number of adaptations to the way his group plays the game.

The board is comprised mostly of squares of four different colours: red, green, yellow and blue. Each time a player lands on a coloured square he pulls a card of that colour and responds to the question or statement on the card. The cards for these coloured squares do not come with the game and are to be prepared specifically for the participants. For example, red cards are "Give and Take Cards" and describe a behaviour. If it is an appropriate behaviour, the player is paid $5. If it is an inappropriate behaviour, the player has to pay $5. The player can avoid paying and receive $5 by identifying the behaviour as inappropriate and giving a better response. The players can exchange the money they earn for various "reinforcers."

The game is based on "Social L.I.F.E.", which refers to Social **L**earning of **I**ndependence through **F**unctional **E**xperience. The game board (a plastic mat) and manual can be ordered for $30 (incl. S&H) from Behaviour Management Services, 13311 Yonge St., Suite 115, Richmond Hill, ON, L4E 3L6. Tel. (9905) 773-2362. Fax: (905) 773-8499 or e-mail: behaviour.mgmt@bellnet.ca.

Jeremy Baumbach

To contact Jeremy Baumbach, call (867) 633-6462.

"What works for me & my kids - most of the time"

When Sylvia Nagy started to suspect that her foster son's difficulties might be due to more than problems associated with a disrupted childhood and that he and his siblings (one foster, one adopted) might be affected by FASD, she began educating herself. At the 2001 FAS Conference in Saskatoon, she began to admit to herself that their adopted daughter was affected.

"We hoped that her environment was going to make a difference for her, and while it does make a difference, when you learn about FASD you realize that environment does not wipe out brain damage. When you realize things are never going to come together like you hoped, that's difficult to accept."

Nagy says she has learned through trial and error. But the more she has learned about FASD, the more she has been able to understand and therefore cope with her children's behaviour. She notes that some of the following strategies describe what works for both her *and* her kids most of the time, and some are the best practices of others.

Her disclaimer or 'fine print': There is no silver bullet. No one way will work for every individual and every family. Her advice: "If it is not dangerous, illegal, immoral or fattening, and it works for you - try it!"

Sylvia Nagy

A is for adjustment. Parents must be willing to adjust their lifestyle and provide a positive atmosphere. The onus is on the parents to make the adjustments because the child can't.

A is for anger. When a child's behaviour deviates from the parent's expectations, the parents feel anxiety (teachers, too), which is translated into frustration, impatience and anger.

A is for assumptions. Never assume anything and don't jump to conclusions.

A is for advocacy. Educate yourself and others. It's important to form partnerships with professionals.

B is for 'be there'. There is a need for constant supervision. Preventing messes is easier than trying to clean up afterwards.

C is for concrete language. Say what you mean and mean what you say. Say what you want, not what you don't want. Be exact and concrete in your language. For example, instead of telling a teenager to get his feet off the coffee table, simply say "feet on floor." Idioms, such as "tearing a strip off someone," are confusing for children affected by prenatal exposure to alcohol.

C is for circus. Sometimes it feels like you're running a three ring circus, juggling chores and doing a balancing act. You have to accept that life may not be the 'normal' that you had anticipated.

D is for diagnosis. Once the diagnosis is made, supports need to be put in place. Nagy's oldest son has a diagnosis, but the two younger ones do not. (They are under observation.) In this case, Nagy believes you treat the individual 'as if' there is a diagnosis and put the supports in place.

D is for diet. Cut out the junk food and sugar. Regular mealtimes and regulated portions are very important. These kids don't hear the inner clock that tells them they're hungry or full, says Nagy.

D is for trying differently. In a familiar quote from Diane Malbin, "Success takes place when we stop trying harder and start trying differently. If you've told a child not to do something a thousand times and the child still doesn't understand, it's not the child who is the slow learner."

D is for drug free. Nagy acknowledges this is controversial and there are arguments on both sides. At the moment, Nagy is on the drug free side.

E is for enjoy. Enjoy the good times you have today.

F is for forgiveness. Wipe the slate clean daily.

F is faith in God. "There is a God and you're not it."

G is for gratefulness. Celebrate the little victories and don't take success for granted. As Jan Lutke says, "Success has many definitions."

G is for grief. Acknowledge the grief felt for the losses. For many of our children, they have lost their birth family, and all the history, stories and family traditions, and have been transplanted into another family where they are genetic strangers.

H is for hope. Hope for the future.

H is for hearing. Theirs - make sure they've heard what you have said. Check for understanding. Yours - hear them out.

I is for 'identify' strengths, **'ignore'** some things since you can't fix everything, and **'interpret'** the world.

J is for join a support group**.**

K is for KISS. Keep it short and simple.

K is for kinesthetic. Learning is enhanced and facilitated when the whole body is involved.

L is for 'less is more'. Less clutter equals less stress.

L is for limits. Limit television, computer and video games. Limit choices and free/unstructured time.

L is for love. Love covers a multitude of wrongs.

M is for modelling. Model appropriate behaviour.

N is for new view. Try to see the behaviour in light of the disability.

O is for observe. See how the child learns.

P is for predictability. Same time, same place, same station.

Q is for quiet. Quiet time is needed. Minimize distractions and stressors in the environment.

R is for repetition. Repetition, repetition, repetition.

R is for rewards. Learning is more likely to take place in a positive atmosphere where desired behaviour is rewarded.

R is for respite. Take a break.

S is for structure. Provide structure rather than control. Organize the environment for success. Have the same patterns every time you do something.

T is for teaching. Teach appropriate social skills and life skills.

T is for time. They will take more of your time, more of your attention, and more of your patience. They are high maintenance children.

T is for transitions. Make moving from one activity to another easier by giving plenty of warning, taking a transition object, and using a timer.

U is for understanding. We tend to see our children's behaviour as a direct reflection on our abilities as a parent.

V is for visual. Visual aids are more effective than verbal.

V is for value. Value your children as the creation of God. They have something to teach us.

W is for willingness. Willingness to adapt, change, try differently, and to challenge long held views on child rearing.

X is for expectations. Modify them and keep them realistic.

Y? Don't ask Y? They don't know Y.

Z is for zeal. You will need zeal to advocate for your child with teachers, friends, neighbours, relatives, lawyers, and judges. Never give up!

Sylvia Nagy is an adoptive mother, foster mother and teacher from Gordon's First Nation in Saskatchewan.

Stop FAS Program: Highlights & Successes

Stop FAS is a home visiting program that provides service to women who are pregnant or who recently gave birth and are using alcohol and/or drugs heavily. Mentors work with women for three years to help them access treatment, stay in recovery, work through the problems related to substance abuse, practice family planning, and move toward a healthy lifestyle.

Manitoba's Stop FAS sites include: Aboriginal Health and Wellness Centre FAS/E Prevention Program and Nor'west Mentor Program in Winnipeg, Grass Roots Mentoring FAS/FAE Prevention Program in Thompson, and The Pas Mentor Program.

Who is the typical Stop FAS client?
Based on the first three years of the program, the typical Stop FAS Client is approximately 26 years old, has had four children, has three children in care, and did not plan her pregnancies. She has completed Grade 8 and is in an abusive relationship. She began drinking early in youth and uses other substances in addition to alcohol. She was typically raised in a family with addiction issues, moves frequently or is homeless, has a history of trouble with the law, and is on social assistance.

Did Stop FAS make a difference?
After completing three years in Stop FAS:

- 84% of the women are no longer at risk of having a child with FAS; they have stopped using alcohol or drugs, or are using birth control
- 65% have completed an addictions treatment program
- 49% have stopped using alcohol; of those more than half have abstained for six months or more
- 49% use birth control
- 28% have completed an educational/training program
- 63% of the target children are living with their own families
- 100% of the target children are fully immunized

How women say the program has helped...
"I learned how to talk for myself with other agencies. My mentor would encourage me to call and speak for myself. She followed up and made me call her back."

"I am starting to say 'no' to things I would have said 'yes' to in the past, like friends wanting to go out drinking."

"I stand up for myself more now. I voice my opinions instead of hiding them."

"Instead of putting myself in bad situations, I check it out first."

"My mentor got me to look into FASD more and pay more attention to my son's needs."

"I am taking more responsibility for myself."

"My mentor said things like...'If you can't do it now, you can work on it and it will come.' "

For more information, contact Michelle Dubik at Healthy Child Manitoba at (204) 945-2215 or e-mail mdubik@gov.mb.ca.

Talking to Your Child About FASD

From the pre-conference day session on Family, here are a number of helpful hints for parents when talking to their child about FASD.

- Educate yourself about the disability.
- Work through your grief.
- Understand your own attitudes and beliefs about the use of substances during pregnancy.
- Prepare ahead for questions from the child about their challenges.
- Use questions from your child about the disability as opportunities to help them understand their strengths and challenges. This builds self-esteem and self-awareness.
- Use language and concepts that they will understand and that are appropriate for their developmental age.
- Remember that children with FASD are usually very literal. Think about how they will hear what you are telling them.
- Consult with others, but in the end do what is best for your own family.
- Be matter of fact.
- Be positive.
- Be respectful.
- Tell the truth simply.
- Sometimes social stories, pictures, books, and pamphlets are helpful tools.
- Remember this is not a one-time conversation. Talking to your child about their strengths and neurological challenges is a lifelong process.
- Normalize their challenges. "This is who you are and that's okay."
- Be honest and open about some of your own differences and challenges.
- Don't underestimate your child's ability to understand what you are trying to tell them.

Panel participants from the family pre-conference day session: (backrow, from left) Eileen Davidson, Ivan Miller, David Grouix, Graham Wyllie (front row, from left) Melissa Bright, Susan Opie, Paula Cook. Missing: Lori Stetina.

FASD Audit Project

The Action for Inclusion: FASD Audit Project is a two-year educational and training pilot project in B.C. designed to increase the capacity of communities to effectively accommodate people living with FASD. The project began in April 2003 and runs through March 2005. It is a project of the Cowichan Valley FAS Action Team Society, a diverse community group dedicated to promoting action that will prevent FASD and maximize the potential of people living with it.

An FASD audit is a tool designed to make community organizations more accessible to people with invisible disabilities. It involves learning about the physical, social and institutional factors that impact accessibility for people with FASD and developing practical strategies.

Organizations that participate in an audit benefit from new knowledge and skills to accommodate people with neurological disabilities, such as FASD.

Participation in an audit involves a brief questionnaire about FASD; on-site visits from project team members who live with FASD (supported by project staff) to assess accessibility factors of the organization; in-service workshops to provide knowledge and skills; written recommendations and follow-up contacts to support progress; and sharing information via a web site, reports, workshops and a manual.

Leila Wilson is a 31 year old living with FASD, who has been involved in FASD education for several years providing peer support as part of a mentorship program for young adults living with FASD. Wilson is one of the project team members and has assisted with audits of organizations. She shares her perspective on how to improve the environment to accommodate someone who lives with FASD and how to become more inclusive.

Outcomes of this pilot project will be shared with other parts of Canada through the distribution of a manual and their web site: **www.cfasd.org**.

Team members Leila Wilson (left) & Jennifer Kyffin

FAFAM Fundraiser

The Fetal Alcohol Family Association of Manitoba (FAFAM) held a special benefit concert and auction at the Manitoba Museum on November 20, 2003. The event, sponsored by the Canada Northwest FASD Partnership, raised $5,566 in total.

Entertainment was provided by The Wyrd Sisters, children from the Bridges Program at David Livingstone School, Karl Kohut (pianist from the River East Jazz Band), 'Prodigy' from Miles Macdonell Collegiate, Ma Mawi Wi Chi Itata Powwow Dancers, and the Winnipeg Celtic Pipe Band and Dancers. CBC Radio personality Al Rae kept the evening moving along as the master of ceremonies.

A big thank you from everyone associated with FAFAM to the volunteers, performers, sponsors, and supporters who attended the event. For more information on the Family Association, call (204) 786-1847 or e-mail fafam@mts.net..

Health Canada's Response to FASD

Co-ordination & Collaboration

"FASD: A Framework for Action" was produced from consultations with stakeholder organizations, nationally and within provinces and territories. It includes tools for communities and governments to plan and implement FASD policies and programs. The Framework can be viewed online at: **www.hc-sc.gc.ca/dca-dea/main_e.html**

A National Advisory Committee on FASD includes experts in the field who advise the Minister and department.

Public Awareness & Education

There has been a limited public awareness campaign that included posters and pamphlets with a common message for the general population, and one for First Nations and Inuit audiences. Articles have appeared in magazines for pregnant women, the Canadian Health Network web site, and News Canada. The "Pregnant? No Alcohol" message—developed with broad consensus across the country—has remained valid throughout the past four years.

Screening & Diagnosis

"FASD: Canadian Consensus on Guidelines for Diagnosis" was drafted by a subcommittee of the National Advisory Committee. The guidelines will be published in a peer reviewed medical journal and will represent the first step in incidence/prevalence data collection. It will require training and education of health care providers.

Professional Awareness, Education &Training

A national survey of health care providers will be published and posted on the web site. The objective of the survey was to obtain information from health professionals across Canada regarding current levels of knowledge and attitudes towards FASD.

A total of 5,478 Canadian health professionals were surveyed, including obstetricians/gynecologists, family physicians, paediatricians, psychiatrists, and midwives.

Survey results will form the basis for planning health care professional education and training programs, and the development of tools/resources for health care providers to use with patients. It will also form the baseline data for evaluation of effectiveness.

Community Capacity

The Strategic Project Fund allocates dollars to local projects that support parents, families and communities affected by FASD. The next call for proposals will take place in 2004-05.

Interdepartmental Focus

Across various departments, the Government of Canada is looking at:

- screening tools, training for awareness, supportive housing, and employment supports
- crime prevention, fitness to stand trial, and strategies to keep individuals affected by FASD out of the criminal justice system
- sentencing measures for individuals living with FASD, and programs and services for those in federal correctional facilities
- culturally appropriate norms, tools and interventions for individuals and communities living with FASD, both on- and off-reserve

First Nations On-Reserve & Inuit

Community Capacity Building Fund
Previously funded projects will continue, such as community training and the video "Before I was Born." There will be an added component of Community Assets Mapping, which will help communities identify their readiness for FASD programming.

Program Pilot Fund
There will be one or two programs per region. The focus will be on prevention and migrating from "one-off" to "sustainable" programming.

Immediate Next Steps

From the 1999 FASD funding, Health Canada will publish the Health Care Providers Survey, the National Framework for Action on FASD, and the National Diagnostic Guidelines. It will also be used to develop the next call for proposals for the Strategic Project Fund.

Canada's Drug Strategy (2004-2006) will focus on screening and diagnosis. This will include disseminating the National Diagnostic Guidelines; scaling-up models for health care provider education and training regarding the dangers of alcohol use during pregnancy and FASD; mining data from FASD diagnostic centres; and developing/validating/recommending screening tools.

Future plans include integrating and collaborating at the federal level; taking a lifespan approach; developing incidence, prevalence and cost benefit data; generating and exchanging knowledge on "what works"; and continuing to build the evidence base for decision making, support building community capacity, and strengthening public and professional awareness, knowledge and skills.

For more information in Manitoba, contact Lynne Foley at (204) 983-8028 or e-mail: Lynne_Foley@hc-sc.gc.ca

Canadian Consensus on Diagnostic Guidelines cont'd...

◀ Research is needed into developing culturally sensitive and effective screening tools that are adaptable to different age groups and to different contexts.

◀ Referral of individuals for a possible FAS diagnosis should be made in the following situations:

- evidence of heavy prenatal exposure
- presence of three characteristic facial features
- presence of one or more facial features with growth deficits
- presence of one or more facial features along with one or more central nervous system deficits
- presence of one or more facial features as well as growth deficits and one or more central nervous system deficits

◀ Individuals with learning and/or behavioural problems without physical or dysmorphic features and without a prenatal alcohol exposure history should not be referred to an FAS clinic. These referrals should be addressed by other professionals or specialty clinics.

◀ A multi-disciplinary team is essential for an accurate and comprehensive diagnosis and treatment recommendations.

◀ The community and the family must understand the reasons, benefits and potential harm of an alcohol-related diagnosis.

◀ The diagnostic assessment must include treatment recommendations for the family and the affected individual.

◀ The diagnostic team should follow-up outcomes of diagnostic assessments and treatment plans.

◀ Diagnosis should be linked to availability of resources and services that will improve outcome for affected individuals and their families. Where services are limited, an individual should not be denied an assessment for diagnosis and treatment.

◀ The post-diagnostic report should state the basis for the diagnosis by including the history of alcohol use, the physical criteria, and the psychological data that support the diagnosis.

◀ Funding for development, training, and maintenance of multi-disciplinary diagnostic teams is necessary.

◀ Prenatal alcohol exposure requires documentation of the alcohol consumption pattern of the mother during the index pregnancy. This can be based on reliable clinical observation, self-report, reports by a reliable informant, or medical records documenting positive blood alcohol record, alcohol treatment, other social, medical or legal problems relating to drinking during the pregnancy.

◀ Hearsay, lifestyle, other drug use, or history of alcohol exposure in previous pregnancies should not be informative of drinking patterns in the index pregnancy.

◀ The number and type(s) of alcohol beverages consumed (dose), the pattern of drinking, and the frequency of drinking should all be documented.

◀ The criteria for the diagnosis of ***Fetal Alcohol Syndrome***, after excluding other diagnoses, must include the following: growth impairment; documentation of all three facial characteristics; evidence of impairment in three domains of brain function; with or without confirmed prenatal alcohol exposure.

◀ The criteria for the diagnosis of ***partial Fetal Alcohol Syndrome***, after excluding other diagnoses, must include: one or more characteristic facial features; evidence of impairment in three domains of brain function; confirmed prenatal alcohol exposure.

◀ The criteria for the diagnosis of ***Alcohol Related Neurodevelopmental Disorder***, after excluding other diagnoses, must include: evidence of impairment in three domains of brain function and confirmed prenatal alcohol exposure.

The draft guidelines and recommendations were developed in parallel and shared with a similar United States committee.

"Our hope is that these will be used to facilitate training for health professionals and improve access to diagnostic services for all individuals and families," says Dr. Ab Chudley.

Dr. Chudley is a member of Health Canada's National Advisory Committee on FASD and the subcommittee that developed the draft guidelines. He is Head of the Section of Genetics and Metabolism at Children's Hospital in Winnipeg, and a member of the Clinic for Alcohol and Drug Exposed Children (CADEC), also at Children's Hospital. He is a Professor in the Department of Paediatrics and Child Health, Biochemistry and Medical Genetics, and Continuing Medical Education at the University of Manitoba.

Participants share ideas in the pre-conference session on community development

Developing Strategies & Proposals for FASD Research in Canada

In March 2002, a workshop was held in Saskatoon to develop strategies and proposals for FASD research in Canada.

The workshop was the first of its kind, bringing Canadian researchers together with government and non-government agencies, communities, and individuals interested in developing collaborative research proposals for FASD. The gathering also served to set research priorities, and to determine strategies for research and funding.

The four pillars on which the Canadian Institutes on Health Research (CIHR) concentrates its funding include clinical science, biomedical science; health systems and services; and social and cultural issues that affect population health.

Research priorities in each of these areas identified by interdisciplinary groups at the workshop are as follows.

Clinical Science

- a reliable screening tool that is sensitive and reliable as well as validated must be used
- physicians should be educated with respect to diagnosis and screening
- effective treatment should be determined
- impact of multiple home placements for affected children
- diagnosis (phenotype, functional MRI, behavioural profile)
- incidence/prevalence should be determined

Biomedical Science

- biomarkers should be developed to aid in diagnosis
- mechanisms mitigating prenatal effects of alcohol (e.g. antioxidants)
- effects of stress should be investigated
- brain phenotype
- co-morbidity
- animal models
- intergenerational effects
- dose/threshold effects
- treatment

Health Systems and Services

- best practices should be developed
- community-based and specific services (rural and urban)
- education is a priority with respect to screening tools, attitudes and appropriate means of communication
- measurement of effectiveness of intervention programs
- development and evaluation of treatment models (behaviour, parent training, early intervention)
- improve current approach to delivery of programs to First Nations and other communities/ individuals (develop an ideal model of delivery)
- media evaluation and education potential

Population/Community Health

- prenatal screening beginning with first prenatal visit
- networking among patients, community, and health service providers
- effective mechanisms to ensure at-risk women receive prenatal care
- breastfeeding
- capacity
- effective intervention across lifespan of mother/ caregiver and child
- psychological and social stressors
- harm reduction
- mental health support
- development of best practices
- practices and procedures should bridge Aboriginal and non-Aboriginal communities

Community representatives at the workshop identified the following research needs: screening and diagnosis; linking services with diagnosis; capacity development for research and training; assessment of adults and parents; prevention and treatment; and intervention programs for adults.

Some of the recommendations made to the Canadian Institutes on Health Research after the workshop included making the workshop an annual event, considering the Aboriginal community as a fifth pillar; extending the timeframe provided for submission of full research proposals after Request for Applications (RFA) announcements; and developing a national clearinghouse for FASD research-related information.

Using Functional MRI in FAS Diagnosis

Dr. Krisztina Malisza is a research officer at the National Research Council of Canada, Institute for Biodiagnostics (IBD), in Winnipeg. Her research interests include functional magnetic resonance imaging (fMRI) of neurological disorders, paediatric imaging, and functional MRI of the spinal cord.

Involved in the research on the use of functional magnetic resonance imaging (fMRI) of FASD are Dr. Malisza, Ms. A. Allman (IBD), Dr. D. Shiloff (IBD), Dr. A. Chudley (HSC), Dr. S. Longstaffe (HSC), and Dr. L. Jakobson (U of M, Psychology).

The objectives of the study were to determine FASD child/adult brain function in the areas of attention, spatial memory and working memory, and to develop fMRI-based techniques to aid in the diagnosis of FAS. The hypothesis is that FASD patients demonstrate decreased activity in the dorsolateral prefrontal cortex (the area of the brain involved in working memory rather than short-term memory) compared to control patients.

The researchers concluded that adults with FASD show impaired performance relative to age- and sex-matched controls on tasks tapping into executive function, sustained attention, and visual work memory. Both groups showed the same areas of activation, but it was less significant and extensive in those affected by FASD.

Similar fMRI results were found in children between the ages of 7 and 12. Significantly greater activation was observed in the dorsolateral prefrontal cortex of the brain, which is involved in working memory and executive function, in control children relative to children affected by FASD.

It was noted that not all exposed individuals showed deficits. Studying the unique, neuroanatomical and neuropsychological profile of affected individuals, is important for the design of assessment tools, and for the development of support and intervention programs for patients and their families. Functional MRI may prove helpful in this regard.

FASD Screening in Adult Offenders

Dr. Brian Grant, director of the Addictions Research Centre of Correctional Service Canada, and Dr. Ab Chudley, affiliated with the Clinic for Alcohol and Drug Exposed Children (CADEC), Children's Hospital (Winnipeg), and the University of Manitoba, are collaborating on a research study to estimate the incidence of FASD in a population of adult offenders, and to concurrently develop a screening tool to assess adults coming into the federal correctional system for FASD.

Patricia MacPherson is a research manager with the Addictions Research Centre and also teaches in the Psychology Department at the University of PEI. She is co-investigator on the project.

Patricia MacPherson

"The reality is that offenders come into the system without a diagnosis. Because of their special difficulties, they will not benefit from traditional programs. They have difficulty navigating the rules of the system and have trouble following the re-integration program."

Offenders who have been sentenced by the court with a new offence (age 30 and under) will be asked to participate in this study. The age cap of 30 was used because hospitals and doctors did not take note of women's drinking history during pregnancy prior to 1972-73. Maternal history is critical in making a diagnosis of FASD.

Participation is voluntary and offenders will be assured there are absolutely no consequences to them for not participating. The screening tool was developed jointly by Dr. Fred Boland, formerly of Queen's University, and Dr. Chudley. The tool will be completed by a minimum of four separate sources, including the offender, two parole officers who are familiar with the offender, and one community contact. Correctional Service Canada's current offender intake assessment process contains some indicators used in the screening tool, but is not currently being used to assess risk for FASD. The research will determine the best indicators for FASD screening and the most effective way to integrate screening into the intake assessment process.

A research liaison officer, a newly created position as part of this study, will approach the offender for assessment while at the intake unit at Stony Mountain Institution. They will ask the offender if they wish to continue to participate in the research and obtain consent a second time, after offenders have already been asked and gave consent to participate in the study while at the remand centre. The liaison officer will ask the offender questions on his medical history, family history of genetic disorder, and other issues, which will be used in combination with other information to make a diagnosis. A neuropsychological evaluation will be conducted at Stony Mountain by an institutional psychologist. Medical assessments also will be done at Stony Mountain Institution by Dr. Chudley and will include a 10 minute examination of facial features along with some questions.

Once incidence of FASD is determined, Correctional Service Canada can use that information to allocate resources to developing interventions targeted specifically towards FASD. While there are programs and services in place for offenders with diminished cognitive capacity, they are not designed for people with FASD.

Implementation of the research and data collection is planned to commence Spring 2004.

FASD Screening in Young Offenders

Dr. Patricia Blakley is with the Department of Paediatrics at the University of Saskatchewan in Saskatoon. She is medical director of the Kinsmen Children's Centre and director of the FAS diagnostic clinic at the Alvin Buckwold Child Development Program, Kinsmen Children's Centre. Dr. Blakley is involved in providing court ordered assessments. At the 2003 FASD conference, she described a project to develop a validated, specific and reliable screening tool for use with young offenders.

It is estimated that up to 75% of young offenders in Saskatchewan have FASD, but presently there is no universally accepted screen.

Of the court ordered assessments, 76% were youth and 24% were adults. The gender split was 86.5% males vs. 13.5% females.

Diagnoses resulting from these assessments were: FAS (2.1% affected); partial FAS (52.1%); Alcohol Related Neurodevelopmental Disorder or ARND (25.0%); prenatal alcohol exposure (2.1%); and no alcohol exposure (18.7%).

Regarding drug and alcohol use, 31.5% of those assessed used alcohol only; 38.6% used alcohol and marijuana; 5.7% used alcohol and other drugs; 2.8% used marijuana only; and 21.4% did not use alcohol or drugs.

Dr. Blakley noted that most of these offenders are not violent. Property related (39.6%) and system related (27.1%) were the most common offences (system related refers to breaches of court orders). Only 18.4% were violent offences and 14.9% were other (mainly assaults).

Why develop a screening tool? Early identification would allow for the implementation of appropriate interventions, recognition of etiology of behaviours, provide potential for use of alternative measures; and consideration for sentencing.

Dr. Blakley is involved in developing the FASD screen with Garry Prediger (Director, Kilburn Hall) and Garry Perry (Registered Psychologist, Coordinator of the Young Offenders Unit, Child and Youth Services).

The four sections of the screen include:

- **Family history of youth** - maternal use of alcohol during pregnancy (ideally provided by the birth mother), rate of consumption, use of other drugs during pregnancy, and any previous indications or diagnoses of FAS of the youth's siblings
- **Youth's history** - any previous indications or diagnosis of FAS, history of abusing substances, history of academic problems in school, history of behavioural problems at school, history of mental health problems, history of care/living arrangements
- **Youth's criminal history** - history of trouble with the justice system but no convictions, history of convictions, history of property offences, history of offences against the person, lack of continuity in criminal behaviour, and failure to abide by court ordered conditions
- **Observations of the youth** - early onset of attention problems, impulsivity/poor problem solving skills, easily led by others, presents developmental age-appropriate behaviours, lack of continuity in life (tends to live minute to minute), receptive language issues, expressive language issues, unusual responses to sensory stimuli, and unusual responses to environmental stimuli

The scoring system uses a four point Likert scale with clinical override. For example, a high score in maternal alcohol abuse would be an automatic override into high risk category even if the remainder of the score were low.

A low likelihood of FASD would be a score from 26 to 52. Moderate likelihood of FASD would be a score from 53 to 78. High likelihood of FASD would be a score from 79 to 104.

The outcome of a rating of a moderate likelihood of FASD would involve referral to a forensic psychologist for a generalized assessment. Those who are rated a high likelihood of FASD would be referred to a physician and neuropsychologist for specific exploration of FAS.

The study will be piloted initially in Kilburn Hall, a closed custody youth offender facility in Saskatoon.

For more details, contact Dr. Blakley at patricia.blakley@saskatoonhealthregion.ca

COALITION ON ALCOHOL AND PREGNANCY (CAP)

CAP represents over 160 organizations interested in FASD issues in Manitoba. Six focus areas include: Family Support, Education (including early years), Service Co-ordination/Development, Justice, Research, and Communication and Information Dissemination. Special task forces are formed around specific issues. CAP's members represent a diverse cross-section of individuals, groups and communities throughout Manitoba. We bring together the needs of parents (including birth, adoptive and foster) and professionals.

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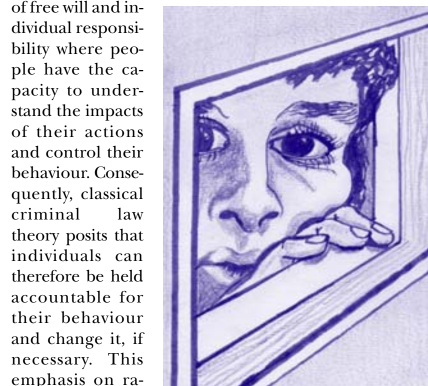
CAP receives funding support from Healthy Child Manitoba.

Overview of Criminal Justice Issues

Rod Garson is a prosecutor with the federal Department of Justice in Winnipeg. The following is excerpted from a paper he presented at the pre-conference workshop on justice at the Canada Northwest FASD conference in November 2003. The views expressed are those of the author and not necessarily the Department of Justice.

When individuals affected by FASD come into conflict with the law, their cognitive impairments give rise to interesting and significant challenges for the criminal justice system. These challenges arise throughout the criminal justice process, which, for the sake of convenience, can be divided into three phases: investigative, trial, and sentencing/corrections.

As a general proposition, individuals affected by FASD fall outside the criminal justice paradigm, which is based on theories of free will and individual responsibility where people have the capacity to understand the impacts of their actions and control their behaviour. Consequently, classical criminal law theory posits that individuals can therefore be held accountable for their behaviour and change it, if necessary. This emphasis on rational decision-making underpins not just the concept of criminal responsibility, but also much of criminal procedure, which affords the accused rights that may be exercised or waived.



The intellectual deficits of FASD affected individuals undermine these central features of the justice system. Yet, courts must strive to reconcile this "disconnect" with their ultimate responsibilities of ensuring accused persons are fairly tried and society protected.

Investigative and Trial Issues

Police work frequently requires officers to engage in the delicate (and difficult) balancing of the legitimate aims of law enforcement and the legal rights of citizens, particularly since the advent of the *Charter of Rights*. The law is often hard for lawyers and judges to understand, yet the police are called upon to make quick decisions in the field without the luxury of considered reflection.

This challenge is amplified when dealing with a suspect or accused who suffers from FASD. They have the same legal rights as all Canadians, but for those rights to be meaningful they have to be understood, because only then can they be exercised or waived. And therein lies the difficulty: their cognitive deficits impair their ability to understand their rights and consequently also hinder their ability to exercise or waive their rights. As a result, investigators must show tremendous care and sensitivity, from both voluntariness and *Charter* perspectives, if statements from an FASD affected accused are to be ruled admissible.

Sentencing/Corrections Issues

The crafting of an appropriate sentence for offenders afflicted by FASD engenders more than the usual difficulties for sentencing judges. The supervision and carrying out of the sentence pose equally large challenges for corrections workers.

The impaired cognitive functioning of the FASD offender makes it doubtful that penalties designed to specifically deter the offender will achieve any purpose. Unfortunately, even the prospects for rehabilitative sentences seem bleak given the panoply of difficulties experienced by the FASD offender.

Despite the limited effectiveness of the typical sentencing tools, it is nonetheless clear that public protection requires that something be done to ensure that FASD offenders adopt a lifestyle that reduces the risk of recidivism (repeat offences). To achieve this goal, the following points merit consideration:

- Deterrent penalties have a limited effect. For obvious reasons, the FASD offender is unlikely to "learn" from punishment as would a typical offender. However, retribution as a sentencing goal may nonetheless call for a punitive sanction. Where a jail sentence is appropriate, it is important to attempt to ascertain the availability in the institution of specialized programming for FASD offenders.
- Ordinary court orders are ineffective for FASD offenders. For probation orders or conditional sentences to be effective, they must be highly structured, intensive and designed with the special needs of the FASD offender in mind.
- Frequently, special programming will be required for the FASD offender. This will also often require a multi-disciplinary and interagency approach in order to adequately secure the appropriate professional resources.
- Community-based and supported dispositions can be very effective in the right cases. Professional resources are often seriously strained (if they are available at all), and in these cases, the ability to engage immediate and extended family, friends and community support can often provide the required structure and intensive supervision for the offender.

A Judge's Perspective: Manitoba Provincial Court Judge Giesbrecht

Judge Linda Giesbrecht was appointed to the Provincial Court of Manitoba in 1988. What follows is her response to questions posed in the pre-conference session on Justice at the 2003 Canada Northwest FASD conference.

In dealing with offenders who come before a judge and who appear to have a cognitive disorder, what might alert a judge to these cognitive differences?

Judge Giesbrecht noted that judges know nothing about offenders before they appear before them. Red flags could include: demeanour, lack of attention, confusion, appearing not to understand the proceedings or to be easily manipulated, showing exceptionally poor judgment, inappropriate behaviour in court, gaps in story when testifying, contradictory evidence (story keeps changing), or outright lying. The person may not appear to have any sense of victim empathy or isn't able to articulate it.

Judge Linda Giesbrecht

"The nature of the offence is another red flag," notes Judge Giesbrecht. Examples include offences that involve exceptional anger and very aggressive offences that seem inexplicable or out of the blue. The person may appear particularly unsophisticated or as an inept criminal who was bound to be caught.

Judge Giesbrecht cautions that most of these attributes also can apply to non-affected individuals.

Other red flags in the background of the offender if the judge hears about it in a pre-sentence report prepared by Probation Services or in submissions from defence counsel could include: family history of alcohol use; history of breaking court orders; history of problems in school; or history of legal issues, i.e. "doesn't seem to learn."

If counsel doesn't say the client is affected, at what point should the judge raise it?

"You don't want to label someone, but you have to raise the possibility in a diplomatic way. You may want to ask counsel if he or she has any concerns about the cognitive abilities of the client. Or the judge may want to ask for an assessment."

Judge Giesbrecht noted it would be helpful for someone to develop a "cheat sheet" with general information about FASD for the court. This will be less important as education of judges increases on the issue of FASD.

How important is assessment and diagnosis?

"It is important to get input from professionals on the level of functioning of that particular individual. We need to know how great the impairments are for that specific person. The court then has the specific information necessary to develop an appropriate plan."

The next important item a judge would look for is a viable community plan. This plan should answer questions such as: Where will this person live and with whom? Who will ensure that any court order is complied with? What type of programming and counselling does this particular person require and how will that be provided? Who will supervise this person?

"Ordinary probation is not appropriate. Usually it is up to the offender to report in so how will this be facilitated for someone with FASD? The plan needs to address this."

Judge Giesbrecht recognizes that jail is not the best place for most offenders with FASD, but sometimes it is the only option given that one of the primary purposes of the sentencing process is to protect the public.

In this case, she notes that the judge can make recommendations on how the offender should be dealt with in the correctional system. These recommendations, however, are not binding.

What special considerations are there in sentencing an offender with FASD?

"Our system is adversarial and does not lend itself to addressing individuals with FASD. People with cognitive impairments do not fit easily into the system. It requires everyone, including judges, to shift in attitudes and strategies."

Another consideration is the need for some sort of assessment.

"Whether it needs to be a full blown medical diagnosis or if some other assessment tool would satisfy the needs of the court to deal with this person appropriately is something that needs to be determined."

How can courts ensure programs are provided that meets the needs of a specific individual to avoid, as much as possible, any future criminal behaviour?

"There are different types of supervision, programming, and probation arrangements needed. The usual group counselling or treatment resources in the community are not really going to work for these people so something else has to be developed. More one-on-one is needed."

Judge Giesbrecht perceives that these offenders need someone to hold their hand and lead them from one place to the next. Accordingly, the plan needs to deal with every aspect of the offender's life 24 hours a day for a considerable period of time.

In a guilty plea, the judge has to be particularly certain that the individual understands what they are charged with doing, even when they have a lawyer.

"Judges also need to use clear, plain, concrete terms and language. This is a good idea with everyone since most people don't understand the terms that lawyers and court officials use."

That said, there are certain things that must be covered from a legal standpoint. In giving a decision, Judge Giesbrecht thinks the judge could give a more formal explanation to the lawyer, public, and the Manitoba Court of Appeal, and a second version for the offender that is put in much simpler terms.

Sentencing Principles

Judge Giesbrecht explained there are a number of sentencing principles that the court has to keep in mind and these principles also apply to offenders with FASD. However, in dealing with these offenders there may need to be a shift in paradigms or a shift in thinking.

"For example, a sentence imposed should generally act as a deterrent to others. The judge has to look at the individual's criminal responsibility in that regard in determining how much emphasis you wish to place on that."

Similar sentences are to be imposed for similar offences. But an individual who is affected by FASD is not similar to someone who is non-affected. Also, a sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender.

"This is a particularly important principle from the judge's point of view as you can look at the degree of responsibility. I think this is where the diminished cognitive abilities can be taken into account."

"The whole idea of a moral culpability, moral blameworthiness, is where a judge can say that this person with FASD must be assessed in light of their cognitive impairment and their moral culpability should not be judged against that of an ordinary person."

Clearly, our courtrooms are not set up for people with cognitive impairments.

Judge Giesbrecht also thinks there is a different role the judge can play after sentencing offenders with FASD. For example, there could be some benefit from further appearances before the judge for ongoing progress reports.

"This allows courts to see changes and hopefully avoid problems before they occur. It always keeps the issue in the forefront for the agencies involved."

Judge Giesbrecht noted that consistency is important in all aspects. It would be best to have the same courtroom, same judge, and same time.

Clearly, our courtrooms are not set up for people with cognitive impairments. They are busy, frenzied places. If possible, Judge Giesbrecht says it would be helpful to deal with people affected by FASD at a separate time when not so many people are present. The ideal, she adds, would be a separate courtroom and a separate system. Some jurisdictions in Canada have a separate court for individuals with records of mental impairments. However, she cautions this is not likely to happen any time soon in Manitoba.

What are the issues in getting assessments done: If an assessment has not been done in the past, how will the court get it done and who will pay for it?

"In Youth Court, there's a greater flexibility as they have jurisdiction to order at any time a report that deals with medical, psychological, psychiatric issues in order to deal with issues of bail and sentencing. Also, they have the ability to hold conferences and get these multi-disciplinary teams together to give advice to the court about an appropriate plan."

Adult courts are more difficult as it is up to counsel to order reports. The judge can only order fitness reports and reports related to criminal responsibility, which are fairly narrow issues. When ordered, these reports are done by a psychiatrist through the provincial office, which is a different focus from an assessment for FASD.

"We need to find a way of ordering these assessments. It is easier in serious crimes like murder. But we really need not to wait until someone kills someone. We need to get involved earlier, in some of these minor offences. The problem is the question of funding."

Resources, she notes, are the greatest issue. People require 24 hour supervision for a long time yet three years is the maximum that a court can order. The next issue is accommodation for these offenders and what happens if they do not like it there. Judge Giesbrecht believes we need to put resources into creating a facility for individuals affected by FASD where they would not be vulnerable to other offenders as happens in jails.

In closing, Judge Giesbrecht noted that, "We need a multi-disciplinary approach—from health, social services, corrections, probation, justice system, mental health services—with many people working together so it doesn't just end up on the shoulders of corrections."

She emphasized that parents and guardians should be included. They have things to contribute and know more about the offender than anyone.

"Ultimately, the judge's role increasingly relies on the co-ordinated efforts of all agencies," says Judge Giesbrecht. "The justice system is the last resort to deal with these offenders and ultimate protection of society really rests on the ability of these various agencies to work together."

Community Development: Mind Mapping & Lessons of the Geese

Nancy Poole, Marlene Thio-Watts and Christine Leischner provided a large group community development exercise at the FASD conference.

Nancy Poole works as a provincial research consultant on Women and Substance Use Issues with the Aurora centre, a provincial women's alcohol and drug treatment program based at B.C. Women's Hospital in Vancouver. Marlene Thio-Watts is past director of programs at the Northern Family Health Society in Prince George, B.C. Chris Leischner is community development and research co-ordinator with Northern Family Health Society, working on prevention of FASD.

From left: **Nancy Poole, Chris Leischner, and Marlene Thio-Watts**

Nancy Poole pointed out that we need to better understand women's substance use in order to work effectively at the community level to prevent FASD. She described three levels of prevention that address the range of people to be reached through complex, mutually reinforcing prevention efforts, that are grounded in both evidence and compassion.

Thio-Watts led the entire conference audience through a mind mapping exercise, a tool that can be used for strategic planning in a community.

To start, the audience responded to an initial question: **What does a woman need for a healthy pregnancy?** Suggestions included general categories such as supports, education, recreation, safe environment, basic needs, spiritual, self worth, choices, and services, which were each broken down further.

Thio-Watts then posed the question: **What if this woman is at risk (i.e. low or fixed income, isolated)?** As ideas came forward from the audience and were recorded on the board, additional scenarios were presented, such as: **What if the woman has an addiction? What if the addicted woman is also affected by FASD?** The final layer identified the needs for a child with FASD. Responses for each scenario were marked on the board in a different colour.

In this way, noted Thio-Watts, a group can keep breaking down any issue to produce a good understanding of the solutions needed, even to the level of detail that would produce individual work plans.

"You can do overall mind mapping to a question or do it by sector, such as health, education, etc.," she explained. "The good thing is that it's solution-focussed. It keeps you from getting dragged down in identifying the problems. It keeps everyone hopeful and focussed on the future."

Also, because the mind map is not linear, it shows the big picture and does not paint one aspect of an issue as more important than another.

"It develops a framework your community can work on for years and refer back to as an evaluation tool," explained Thio-Watts. "The learning is collective."

Chris Leischner spoke from the larger perspective of the need for community development.

"We are becoming more and more disconnected and dislocated from our families, our roots, our histories, and our supports," says Leischner.

"As we built the mind map around what was needed (for a woman to have a healthy pregnancy), you saw the interconnectedness of everything in the diagram. The only power we have against this disconnection is to build strong communities."

Community development implies a democratic process of equal voice and equal participation to produce a healthy and empowered community.

Leischner noted that community development is community driven not just community focussed. This means those who are affected by FASD and the people who live with them are the ones who write the agenda.

Community development is also sustainable. It builds knowledge created by the community for the community. It leads to action, which in turn leads to change that will be authentic, viable and strong.

Here are the seven elements needed to guide a community development process, whether a group chooses to use mind mapping or another approach.

1. Shared vision is an agreed upon common vision or picture of your community that details what you want it to look and be like.

2. Meaningful participation and shared ownership means the active involvement of the hearts, minds, and spirits of the community members where individuals feel included in the process, feel the process is equitably shared, feel they are valued and have a purpose in being there.

Leischner noted that involving those most affected (families and individuals) requires that they feel their presence is meaningful and not token.

"For them to be part of the process, it is important that we pace ourselves differently, structure ourselves differently, and use all the skills that we are coming to know to be the tools for working with those who need differential treatment."

Mind mapping diagram created by audience members at the FASD conference

3. Leadership development requires leaders, formal and informal, who are willing to mentor others around the circle to be leaders as well.

4. Resource mobilization means using the skills, knowledge, human talents and gifts available in addition to the tangible financial resources.

5. Relationship building is essential to developing a cohesive sense of community.

6. Reflection and action occur in synchronicity. Thoughtful reflection leads to greater self-awareness and community understanding.

7. Renewed energy and revitalization occurs by continually involving new members and giving renewed hope and concrete results. This sustains old members, fosters hope, and gives meaning.

These guiding principles along with a number of tools (including an assessment check, mind mapping, a method for meaningful evaluation, questions to ponder, etc.) are available on the Northern Family Health Society web site:

www.nfhs-pg.org

Lessons of the Geese

Fact #1: As each goose flaps its wing, it creates an uplift for the birds that follow. By flying in a V formation, the whole flock creates 71% greater flying range than if each bird flew alone.

Lesson #1: People who share a common direction and vision and sense of community can get where they're going quicker and easier because they're travelling on the thrust of one another.

Fact #2: When a goose falls out of formation, it suddenly feels the drag and resistance of flying alone. It quickly moves back into formation and takes advantage of the lifting power of the bird in front of it.

Lesson #2: If we have as much sense as a goose, we will stay in formation with those headed where we want to go. We're willing to accept their help and give our help to others. This keeps us in formation.

Fact #3: When the lead goose tires, it rotates back into formation and another goose rises to the point position.

Lesson #3: It pays to take turns doing the hard tasks and sharing leadership. As with geese, people are interdependent on each other's skills, capabilities and unique arrangements of gifts, talents and resources.

Fact #4: Geese flying in formation honk to encourage those at the front to keep up their speed.

Lesson #4: We need to make sure that our honking is encouraging not deprecating of each other. In groups where there is encouragement, production is much greater. The power of encouragement, which is to stand by one's heart or core values and encourage the core values of others, is actually the quality of the honking that we should all be seeking.

Fact #5: When a goose gets sick, wounded or shot down, two geese drop out of formation and follow down to help protect it. They stay with it until it dies or is able to fly again. Then they launch out with another formation or catch up with the flock.

Lesson #5: If we have as much sense as the geese, we will stand by each other in difficult times as well as when we are strong.

TRAINING

Building Circles of Support for Children with FASD

Parents, caregivers, and other family members who support children recently seen or diagnosed at the Clinic for Alcohol and Drug Exposed Children are invited to a Fetal Alcohol Spectrum Disorder (FASD) and Alcohol Related Neurodevelopmental Disorder (ARND) information series.

Topics include:

- What does it mean that my child has FASD or ARND?
- How will FASD/ARND affect my child?
- How will FASD/ARND affect their behaviour, school performance, and social interactions?
- What can I do to help my child?
- How can I help others understand my child's disability?
- How can I help my child understand his/her disability?

When:	**Spring 2004**
Time:	**6:30 to 8:30 p.m.**
Where:	**Mount Carmel Clinic 886 Main St., Winnipeg**
Contact:	**Dorothy (787-1836) or Shirley (787-1828)**

Please advise in advance if child care is needed. Refreshments will be served.

Applied Studies in FAS/E Certificate Program

Acquire the knowledge, skills and attitude to work from a strength-based perspective to provide the complex care and structured support required for children, youth, adults, and families affected by FASD. Key study areas include attitudes and values, understanding and managing behaviour, teaching and learning strategies, family issues, health, and advocacy and learning. The program consists of 431 hours of theory and 172 hours practicum.

For more information, contact **continuinged@rrc.mb.ca** or call **(204) 694-1789 or 1-866-242-7073**.

RRC is interested in partnering with other educational institutions to offer the program jointly, to pass on expertise they have developed, and to share their experiences and commitment to the program. For more information regarding partnership opportunities, contact Norma Kerr at (204) 632-2145.

FASWorld is an international alliance of parents and professionals who do not want to see any more children, teenagers and adults struggle with birth defects caused when their mothers drank alcohol in pregnancy. For more information, visit **www.fasworld.com**.

To join the FASDay list, subscribe to FASDAY-subscribe@egroups.com.

FASD RESOURCES

AFM Library

The William Potoroka Memorial Library at AFM (1031 Portage Ave, Tel: 944-6233) contains a large collection of FASD materials. Membership is free and resources can be shipped anywhere in the province.

To receive a bibliography listing the wide range of print and video titles available through AFM Library on:

- Fetal Alcohol Spectrum Disorder - Parenting, Caregiving and Educational Strategies
- Prevention of Substance Abuse During Pregnancy

Contact the Library at 944-6279 or library@afm.mb.ca.

Recent publications now available:

FETAL ALCOHOL SPECTRUM DISORDER - VIDEO

Motivating Pregnant Women to Stop Drinking (2003)

Drs. Reid Hester and Nancy Handmaker have taken histories from real-life patients and re-enacted their interviews to demonstrate the basic elements of a counselling approach that has proved to be effective in motivating women to stop drinking. The interview segments are meant to teach prenatal health care practitioners how to help their pregnant patients stop drinking.

Can be viewed only in the Library.

Call #: SVTR/RG 629.F45/M6/2003

FETAL ALCOHOL SPECTRUM DISORDER–DIRECTORIES

Directory of FAS/FAE information and support services in Canada (2003)

Corp. Author: Canadian Centre on Substance Abuse

Call #: RG 629/.F45/D57/2003

PARENTING A CHILD WITH DEVELOPMENTAL NEEDS: AN INTERACTIVE CD-ROM

This CD was developed by professionals from the Glenrose Rehabilitation Hospital in Edmonton, Alberta, who work extensively with children with special developmental needs and their families. It provides an invaluable resource for parents with questions about their child's development or for those looking for ways of working with their child to enhance development.

Price per CD is $58.50 CAD including S&H. Send payment and contact information to Glenrose Rehabilitation Hospital, Education Services, 0601, 10230 - 111 Avenue, Edmonton, AB, T5G 0B7. For information call toll free: 1-877-877-8714.

MOTHER AND CHILD REUNION: PREVENTING FETAL ALCOHOL SPECTRUM DISORDER BY PROMOTING WOMEN'S HEALTH

Prepared by Nancy Poole (June 2003), BC Centre of Excellence for Women's Health, BC Policy Series. This document is available online at **www.bccewh.bc.ca**. Non-profit organizations may make copies for educational purposes.

LIVING IN LIMBO: FAMILIES JOURNEYING TOWARD UNDERSTANDING

Mavis Olesen, PhD, and Dallas Williams (www.geocities.com/adoption_dallas_mavis).

This book is meant to ease the burden of people who have lived with, loved, parented and married transracial adoptive children during their journey toward adulthood, including the adoptees and those who are still struggling with some of the issues of the adoptees.

Price per copy is $19.95 CAD plus $5.00 shipping and handling. ISBN #0-9733168-0-2. Send contact information and money order to: M. Olesen, 127 Quincy Drive, Regina, SK, S4S 6L9.

VIEWPOINTS ON FASD

Dorothy Badry, Dr. Heidi Schroter, and Shirley Wormsbecker

This booklet helps the reader to understand the complexity we are faced with in dealing with FASD. The booklet gives the individual family, caregiver and professional a voice and helps clarify varying viewpoints from which one can look at FASD from a compassionate yet realistic point of view.

Price per copy is $6.00 including postage. Send contact information and cheque payable to Fetal Alcohol Syndrome Diagnostic Clinic, Alberta Children's Hospital, 1820 Richmond Road SW, Calgary, AB, T2T 5C7. For further information, call (403) 943-7281.

FACES of FASD
three years later...

Putting a personal face on Fetal Alcohol Spectrum Disorder

FACES of FASD is a collection of real stories about real people and their real life situations. By reading these stories, it is hoped that others in our community will be able to share in the wisdom, strength and insight that the families have offered.

Copies of FACES of FASD are $5.00 each. To order, call ACL-Manitoba at (204) 786-1607.

Drinking alcohol while you are pregnant can harm your baby.

Call the Alcohol and Substance Use in Pregnancy
HELPLINE

MOTHERISK
1(877) FAS-INFO
Toll-free 1-877-327-4636
HSC The Hospital for Sick Children

CONFERENCES

Reclaiming Our Voices 5
A Gathering of Women Who Have Been Affected Alcohol and Drugs

Hosted by the West Region Child & Family Services, Reclaiming Our Voices 5 will feature speakers Cecilia Firethunder and Marie Lands. Marie will talk about her journey from foster child to university instructor.

When women come together and talk, they bring their strength and wisdom. Reclaiming Our Voices 5 invites you to join with us in making the first step towards building a community of support towards a healthier and safer home and community for ourselves and our children.

This year's theme is 'Taking Care of Ourselves'. In addition to the guest speakers, events include workshops (story stick teaching and teepee teaching), traditional teachings (sweats, healing circles, teachings) and support (counsellors, prayer circles, friends).

West Region Child & Family Services

Reclaiming Our Voices 5

May 12-14, 2004

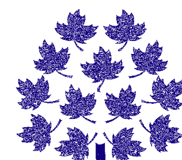
Russell, Manitoba

For more information, contact:

Sarah (Rolling River)
(204) 636-6100

Kathy (Winnipeg)
(204) 985-4050

For information on FAS call:
Fetal Alcohol Syndrome Information Manitoba
1-866-877-0050



canadian-health-network.ca
reseau-canadien-sante.ca

The Canadian Health Network is a national, bilingual, Internet-based health information service. FASD information can be found under the topic area of Substance Use/Addictions.