Fetal Alcohol Spectrum Disorder: a Position Paper
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Abbreviations

ARBD: Alcohol-Related Birth Defects
ARND: Alcohol-Related Neurodevelopmental Disorder
CAPHC: Canadian Association of Paediatric Health Centres
CIHR: Canadian Institute of Health Research
CNS: Central Nervous System
DPN: Diagnostic Prevention Network
DSB: District School Board
EDU: Ministry of Education
FAS: Fetal Alcohol Syndrome
FASD: Fetal Alcohol Spectrum Disorder
IOM: Institute of Medicine (United States)
MCSCS: Ministry of Community Safety and Correctional Services
MCYS: Ministry of Children and Youth Services
MOH: Ministry of Health and Long-Term Care
OFIFC: Ontario Federation of Indian Friendship Centres
pFAS: Partial Fetal Alcohol Syndrome
PHAC: Public Health Agency of Canada
UNTS: Up North Training Services
Introduction - About Our Position

The knowledge that surrounds Fetal Alcohol Spectrum Disorder (FASD) is rife with misconceptions, including the notion that FASD is a product of modern Aboriginal culture with effects that are relegated primarily to Aboriginal lives. This erroneous characterization has not only negatively affected the mainstream understanding of Aboriginal health and community, but has also inhibited the progress of FASD research and strategy development. As stated by Pacey (2009),

“…a large proportion of Canadian research on [FASD] is focused on Aboriginal people and supports a commonly held belief that substance abuse during pregnancy occurs more frequently among Aboriginal women compared to their non-Aboriginal counterparts. However, the true extent of [FASD] in Aboriginal and non-Aboriginal populations is not known and thus no assessment of higher prevalence is possible.”

The Aboriginal focus of past Canadian FASD research has created an informational landscape that lacks comparative data to illustrate the prevalence of FASD in non-Aboriginal versus Aboriginal communities. Without this information, it is impossible to make any definitive statements regarding a cultural predisposition to the disorder. While Aboriginal communities are undeniably vulnerable to alcoholism, the proximate cause of FASD, the Mood Disorders Society of Canada (2009) found that the overall rate of alcohol consumption in Aboriginal populations is lower than that of non-Aboriginal populations, thus highlighting the need for a more accurate depiction of FASD distribution in Canada.

The Ontario Federation of Indian Friendship Centres (OFIFC) believes that FASD is not an issue of ethnicity or culture and recognizes the need for public education to address this common misconception. Aboriginal communities are often heavily affected by FASD not through cultural predisposition, but rather as a result of the disproportionate hardship that they experience in relation to the social determinants of health. The OFIFC asserts that the discrepancies in health outcomes that continue to plague urban Aboriginal communities are the reflection of a disconnection from Aboriginal culture, rather than the culture itself. Colonization and assimilation practices have resulted in high rates of mental illness, addiction, homelessness, poverty, unemployment, incarceration, poor physical health, and community and familial dysfunction in urban Aboriginal communities. Many individuals do not have access to the holistic services that would help them to cope with the social isolation and experiences of violence and abuse that can arise from these issues. Together, these consequences of a shared history of trauma embody the underlying, or ultimate, causes of FASD in Aboriginal communities, and must be addressed with culturally appropriate methods that foster cultural reintegration, personal and collective healing, and positive change. FASD is a

product of socioeconomic status rather than race or culture, and as long as a national or provincial strategy (in Ontario) does not exist, urban Aboriginal people affected by FASD will go without the culturally appropriate, wholistic, and self-determined supports and resources that they need to ensure positive health outcomes and an optimal quality of life.

About the Ontario Federation of Indian Friendship Centres (OFIFC)

The Ontario Federation of Indian Friendship Centres (OFIFC) is an urban Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres located in towns and cities throughout Ontario. Friendship Centres are not-for-profit corporations which are mandated to serve the needs of all Aboriginal people regardless of status. They are the primary service delivery agents for Aboriginal people living in urban areas, and the OFIFC is committed to assisting member Friendship Centres with program delivery and community development. The OFIFC’s vision is to improve the quality of life for Aboriginal people living in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian society and which respect Aboriginal cultural distinctiveness.

The OFIFC recognizes the unique needs of Aboriginal people when navigating a Westernized mental health and addictions system and has thus made the provision of associated services for urban Aboriginal communities a priority. Programming that has been specifically designed to address FASD is offered at some Friendship Centres, but a lack of government commitment has limited the possibility of expansion for these programs.

The OFIFC has promoted the awareness of FASD and its effects on urban Aboriginal communities in Ontario for more than ten years through advocacy and service provision. For example, the Fetal Alcohol Spectrum Disorder program provides resources to urban Aboriginal people with FASD and utilizes both traditional and contemporary approaches. The Program is delivered at six sites throughout Ontario and provided 1,919 support services to 508 clients and families in 2011/2012. Akwe:go is a program that uses traditional cultural teachings and values to encourage healthy choices in at-risk children aged 7-12, including those with FASD and other disabilities. It is currently administered through 29 Friendship Centres and one other delivery site, with the High Risk version of the Program offered through three sites. In 2011/2012, 230 clients with FASD and other disabilities accessed behavioural and occupational therapy through Akwe:go. The Aboriginal Healthy Babies Healthy Children and Canadian Prenatal Nutrition programs each address FASD indirectly by providing support to at-risk mothers and children, through culturally-relevant education, nutritional supplementation, and counselling.

Importance of Friendship Centres in Addressing FASD

According to the 2006 Census, there are over one million Aboriginal people in Canada (1,172,790) with 242,495 (or twenty one per cent) of Aboriginal people living in Ontario,
making Ontario home to the largest Aboriginal population in the country. The 2010 Aboriginal Labour Force Analysis Series notes that between 1996 and 2006 the Aboriginal population grew by 45 per cent, almost six times the eight per cent growth rate of the general population. Aboriginal people represent the youngest, fastest growing demographic of Canadian society and this trend is expected to continue into 2017.

In Ontario, Aboriginal communities are increasingly urban. Of Ontario’s Aboriginal population, 80.4 per cent (194,980) live off-reserve with 62.1 per cent (150,570) located in towns, cities, and rural areas. More than half of the Aboriginal population in Ontario is under twenty seven and 35.7 per cent are under nineteen. Furthermore, forty nine per cent of off-reserve Aboriginal children under the age of six are growing up in low-income families (versus eighteen per cent of non-Aboriginal children).4

Friendship Centres are ideally situated to provide essential support to this large urban Aboriginal population and, for some communities, are the only available culturally-appropriate service providers. They play a critical role in addressing FASD, as they provide wholistic and self-determined supports for individuals and families, while collaborating with the non-Aboriginal community to increase the quality and amount of accessible services. These collaborative efforts have developed a strong sense of local involvement and ownership for urban Aboriginal people. Friendship Centres also serve an important function as advocates, at the community level, for the needs of individuals and families dealing with FASD. Given the combination of overwhelming population growth, the off-reserve residency of the majority of Ontario’s Aboriginal people, and the socioeconomic and political disadvantages faced by urban Aboriginal communities, the community-based support offered by Friendship Centres is an important factor in addressing issues like FASD.

Understanding the Aboriginal Historical and Cultural Context

Colonization, assimilation, and policies within the Indian Act have resulted in the unwilling loss of the rights, culture, language, and land of Aboriginal people in Canada throughout the past five centuries. The deleterious effects of this historical trauma are visible at the community and individual levels, with urban Aboriginal people experiencing an excess of social, economic, and political dysfunction. The Human Development Index (HDI) report released by the United Nations in 2010 measured life expectancy, education, and economic outlook as indicators of well-being for various populations, and concluded that Aboriginal people in Canada ranked far below the rest of the nation:

“...when the [HDI] is calculated for Aboriginal and non-Aboriginal people in Australia, Canada, New Zealand, and the United States, there is a consistent gap

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of [six to eighteen percent]. Indigenous people in these countries have lower life expectancy..."

Aboriginal worldviews place an emphasis on a holistic way of life, one that values the links between community, family, and self, and the process of forced colonization and assimilation have left many of our communities without a sense of belonging or place. The lingering scars of the residential school system are magnified and transmitted across generations, thereby continuing to affect the well-being of adults and youth long after the original abuse has ended. When these historic traumas are layered under the current issues of cultural isolation, systemic racism, and socioeconomic hardship, it becomes clear that Aboriginal communities are fighting an uphill battle towards cultural recovery.

Recovery and reconnection to traditional cultural practices is vital for the present and future well-being of Aboriginal communities. Our connection to culture allows us to maintain a relationship with our spirit, family, and community; our ancestors past, present, and future; and finally to our Indigenous ways of being, seeing, knowing, and doing. Encouraging and facilitating a cultural connection for Aboriginal people will initiate a process of therapeutic reorientation, which will allow culture to act as a compass to guide individual and collective healing, not only as a practice, but as a way of understanding our place in the world.

What is Fetal Alcohol Spectrum Disorder (FASD)?

Fetal alcohol spectrum disorders (FASDs) refer to a range of conditions that can affect an individual who was exposed to alcohol while still in the womb, including fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD). FASD is an umbrella term used to describe the spectrum of effects that alcohol can have on fetal development. Fetal alcohol exposure can alter brain metabolism, causing permanent brain damage, and is the primary cause of preventable developmental disability in Canada. Even though it is possible for individuals with FASD to possess an average intelligence quotient, disability often arises as a result of impaired cognitive functioning.

Alcohol has been identified as a teratogen, meaning that it can disturb the development of an embryo or fetus, and has been shown to cause this disturbance by hindering the central nervous system (CNS) cell growth that is necessary for normal fetal development. Primary disabilities resulting from FASD can, but do not always, include language comprehension deficits, impaired adaptive skills, poor impulse control and judgement, poor executive functioning, restricted physical growth, and characteristically

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Fetal Alcohol Spectrum Disorder

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dysmorphic facial features. Secondary disabilities associated with FASD usually arise later in life as a result of the prolonged discrepancy between societal expectations imposed upon an individual with FASD and their inability to meet these expectations without support. Secondary effects (commonly referred to as secondary disabilities, even if they are not medical in nature) most commonly include mental illness, substance abuse, and subsequent involvement with the law. The persistent link between FASD, mental illness, and substance abuse has been termed a “triple threat”; FASD often leads to mental illness which in turn increases the susceptibility of an individual to alcohol and drug abuse.⁷

Despite the number of possible weaknesses that FASD can cause, individuals should not be defined only by their disabilities. The individualized nature of the disorder often results in a variety of notable strengths, such as artistic talent or highly social and friendly personalities.⁸ An approach to FASD should emphasize strengths while finding creative solutions to support an individual’s unique needs.

**Understanding an “Invisible Disability”**

FASD is characterized as an invisible disability because many individuals with the disorder exhibit only subtle incarnations of its physically visible symptoms, if they exhibit any visible symptoms at all. Central nervous system damage does not always present itself by way of phenotypic abnormality or noticeably decreased intelligence even while it may manifest in other seriously deleterious, albeit invisible, ways. For example, ninety five per cent of those with FASD are diagnosed with ARND, which is characterized by brain damage equivalent to that seen with FAS, but without the accompanying growth defects or facial dysmorphism.⁹ This common lack of a visual signifier associated with FASD, combined with the overall scarcity of community knowledge about the disorder, has led many individuals to be dismissed as “lazy” or “willfully disobedient” by the uninformed observer.

**Diagnosis and Treatment**

The often invisible and highly personalized nature of FASD requires a complicated diagnostic process, leading to generations of non- or misdiagnosed individuals. Early and accurate diagnosis is a crucial component of well-being for an individual with FASD, and recent research has begun to reflect this urgency. Diagnostic criteria for FASD were first developed in the 1990s, including the standards created by the United States’ Institute of Medicine (IOM) and the Diagnostic Prevention Network (DPN), both of which framed the development of Canada’s diagnostic model. The Canadian Diagnostic Guidelines for FASD were created by Chudley et al (2005), almost ten years after the IOM published national guidelines in the United States that were endorsed by the Public

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Health Agency of Canada (PHAC) upon release. The goal of these Canadian guidelines was to standardize national FASD diagnosis in lieu of a national data collection method or FASD strategy, and they were developed by combining the terminology of the IOM (listed below) with the standards from the DPN (i.e.: the 4-Digit Diagnostic Code).

The guidelines of the IOM refer to five categories of FASD: Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), alcohol-related birth defects (ARBD), and alcohol-related neurodevelopmental disorder (ARND). FAS is defined by the presence of both facial and growth-related physical abnormalities as well as CNS neurodevelopment anomalies while pFAS involves only CNS neurodevelopment anomalies and either facial or growth-related physical abnormalities. Partial FAS should not be misconstrued to be less severe than FAS; it is only “partial” in that some, but not all, indicators are present. ARBD is the only variation under the FASD umbrella that does not involve neurodevelopment anomalies, but instead encompasses a range of physical abnormalities throughout the body. As mentioned in the preceding section, ARND is characterized by brain damage equivalent to that seen with FAS, but without the accompanying growth defects or facial dysmorphism. The key features that define the various types of FASD (growth abnormalities, phenotypic abnormalities, CNS impairment, and fetal alcohol exposure) were used as a basis to create the 4-Digit Diagnostic Code from the DPN, which provides a quantitative assessment of the severity of each feature. The individual variability of FASD is accounted for through the use of a Likert scale to rank the magnitude of each feature before combining the findings into a single 4-Digit Diagnostic Code.

In 2005, the Canadian Association of Paediatric Health Centres (CAPHC), with funding from the PHAC, took part in an initiative to create the National Screening Tool Kit for Children and Youth Identified and Potentially Affected by FASD. This tool kit was created to address the gap in valid and reliable screening tools, and was necessary because the capacity of diagnostic clinics did not, and still does not, match the prevalence of FASD. The tool kit is not meant to replace medical advice and health professionals are not bound to its guidelines. Over ninety national advisors were consulted during development of the tool kit, including five First Nation, one Inuit, and one Métis organization. The initiative evaluated the Neurobehavioural Screening Tool (for those aged six to eighteen), Meconium Fatty Acid Ethyl Esters [FAEE] Testing (for newborns), the Maternal History Guide (for at-risk women), the Medicine Wheel Student Index and the Medicine Wheel Developmental History tool (for those aged four to fourteen and at-risk mothers), and the FASD Screening and Referral Form for Youth Probation Officers. Each tool was tested for ease of use, accessibility, cost, expertise required for use, cultural appropriateness, and interpretability of results. The initiative found each tool to be valid and reliable. The CAPHC distributed the completed tool kit across Canada in 2010, provided nation-wide training on the tool kit in 2011, and tested each component of the tool kit through pilot sites across Canada (i.e.: Meconium FAEE

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in Prince Edward Island, the Neurobehavioural Screening Tool in Alberta and British Columbia, the FASD Screening and Referral Form for Youth Probation Officers in Manitoba, the Medicine Wheel Tools in various Aboriginal communities, and the Maternal Drinking Guide in Québec) to review its effectiveness during the timeframe from 2010-2012.\textsuperscript{12}

Other screening tools validated to assess a woman’s risk of alcohol use during pregnancy include TWEAK (Tolerance, Worried, Eye-Opener, Amnesia, K/Cut-Down), T-ACE (Tolerance, Annoyance, Cut-Down, Eye-Opener), and CAGE (Cut-Down, Annoyed, Guilt, Eye-Opener), which are brief question-based tests named after the key concepts in each question. CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) is similar to the above screening tools except that it broadens its scope to include alcohol and other drugs. AUDIT (Alcohol Use Disorders Identification Test) is a slightly longer question-based test that is highly accurate across ethnic and gender groups but is more complicated to administer and score. These tools are validated but are not part of the National Screening Tool Kit for Children and Youth Identified and Potentially Affected by FASD.

The multivariate nature of FASD disability has led the Canadian Diagnostic Guidelines to suggest that a multi-disciplinary team is required to oversee accurate diagnosis and to collaborate on the development of an appropriate treatment plan. This combination of efforts will help to ensure that the maximum quality of life is attained for the child. At a minimum, the Guidelines suggest that teams include a case manager, a physician, a psychologist, an occupational therapist, and a speech-language pathologist (all of whom are trained in FASD) so that treatments can be tailored specifically to the needs of each individual. The Guidelines also suggest that telemedicine technology and mobile teams be used to facilitate diagnoses in rural and remote areas where resources do not allow for the development of a permanent diagnostic team.\textsuperscript{13} Finally, the Guidelines advocate for the national screening of all women, regardless of whether or not they are pregnant or are planning a pregnancy, on a regular basis to improve maternal-child health outcomes and prevent the occurrence of FASD.\textsuperscript{14}

Moving forward, the Canadian Diagnostic Guidelines recommend the development of Canadian normative growth and anthropometric charts that are applicable across ages, genders, and cultural groups to properly assess phenotypic abnormalities and examine how they change over time. It is further recommended that culturally-appropriate screening tools for fetal alcohol exposure be developed and validated to facilitate accurate diagnoses; this is supported by the CAPHC (2012) and Badry and Bradshaw (2011). Timely and accurate diagnoses are critical to the mitigation of secondary


\textsuperscript{13} D. Badry and Bradshaw, C. (2011). Assessment and Diagnosis of FASD Among Adults – A National and International Systemic Review. (Ottawa, ON: Public Health Agency of Canada).

disabilities that can develop in association with FASD, and as such, the benchmark for receiving an FASD diagnosis should be placed no later than six years of age to encourage optimal development throughout the life cycle. Additionally, Badry and Bradshaw (2011) suggest that health professionals should be bound to standard national assessment tools in light of the continued debate around the most appropriate practices despite the development of the Canadian Diagnostic Guidelines.

Research and Bias

The first academic literature about FASD was written by French researcher Paul Lemoine in 1968 and used the term “alcoholic fetopathies” to describe what is now known as Fetal Alcohol Syndrome (FAS). The term FAS came into use after North American dysmorphology studies revealed associations between phenotypic abnormalities and fetal alcohol exposure in 1973. In the 1980’s, research began to focus on the varying effects of FASD across the life cycle, the supports necessary at each stage, and the difficulties in diagnosing FASD in adulthood due to the physical changes that occur during puberty. These changes can mask physical indicators of FASD such as inhibited growth or dysmorphic facial features. This later research pointed to the realization that although phenotypic abnormalities can “self-correct” over time, CNS impairments are permanent.

The bias toward Aboriginal populations in FASD research has perpetuated the widely-held belief that FASD is an Aboriginal issue. Pacey (2009) notes that there is a “paradox related to FASD” in that there is the recognition that FASD represents a significant issue in Aboriginal populations, but research has not been conducted to determine how this compares to its impact on other populations. As mentioned previously, this lack of data means that comparisons cannot be made between FASD prevalence in Aboriginal populations and non-Aboriginal populations. Even comparisons amongst Aboriginal populations are problematic because many FASD research projects tend to study single, extremely low-population communities with unique cultural and socioeconomic factors, making it difficult, if not impossible, to generalize the findings across all Aboriginal populations.

For example, consider the 1987 study by Robinson et al concerning a British Columbia reserve with a population of 350. Out of the 116 children that participated in the study, fifty four were found to have been subject to fetal alcohol exposure and twenty two (from fourteen different mothers) were diagnosed with FASD, resulting in prevalence rates of 190 per 1000 live births. This seems shockingly high when compared to the national prevalence rate of one per one hundred live births (or ten per 1000). Due to the small sample size and unique nature of the population, the findings of the study can not be effectively applied to other populations without drastically over-representing the prevalence of FASD. The abundance of overly specific studies has resulted in a fragmented knowledge of the reality of FASD with an excessive focus on culture or ethnicity rather than socioeconomic environment.

Current Political Climate

Currently, the federal government is not prioritizing FASD and has done little to advance a national strategy to address the issue, despite the development of an action plan and national Diagnostic Guidelines for FASD in 2005. Ontario is the only province without an action plan to address FASD and this deficiency has necessitated the development of multiple coalitions and support groups to provide a basic level of support and resources to families in lieu of government support. Overall, the federal and provincial governments have failed Ontario’s FASD-affected families through their reluctance to prioritize the issue.

In 1999, Health Canada’s FASD Initiative was introduced as a joint project between the PHAC and the First Nations and Inuit Health Branch. This initiative recognized the need for an increase in knowledge, tools, and resources to address FASD in Canada and for culturally-appropriate tools to be developed for use in Aboriginal populations. The FASD National Strategic Projects Fund is a component of this initiative and has the goal of enhancing pre-existing FASD activities and creating new capacity. An evaluation report by the PHAC (2009) on the initiative recommended that, although it faced some administrative barriers, the initiative achieved many of its outcomes and should stay active considering that FASD was still a national public health concern with more work required. This initiative gave approximately $26,760,000 to FASD programming between 2004 and 2008.

In 2002, Health Canada and the US Department of Health and Human Services signed a memorandum of understanding in order to address FASD in Aboriginal populations across North America. Health Canada (2012) stated that this partnership was active between 2007 and 2012 and helped to build and share research knowledge and develop stronger relationships between both the government and Aboriginal people and Canada and the US.

In 2004, the FASD portfolio was transferred from Health Canada to the PHAC. In 2005, the PHAC released FASD: A Framework for Action to pave the way for the future directives of preventing and addressing FASD across Canada at the community-level. In 2006, the Standing Committee on Health (“the Committee”) released Even One is
Too Many: A Call for A Comprehensive Action Plan for Fetal Alcohol Spectrum Disorder after consultations between the Committee, Health Canada, the PHAC, and the Canadian Institutes of Health Research (CIHR), suggested that FASD should be made a national priority. To ensure that leadership and priority were given to the FASD portfolio, the Committee (2006) recommended that Health Canada regain control of the portfolio from the PHAC, that a national strategy be developed to address and prevent FASD with dedicated funding, and that a national database be developed to track the prevalence of FASD. These recommendations have not been implemented.

Provincially, the Ministry of Children and Youth Services (MCYS) has funded the Aboriginal Fetal Alcohol Spectrum Disorder and Child Nutrition Program, which are delivered through eighteen provincial Aboriginal organizations on- and off-reserve. The MCYS also funds the Special Services at Home and the Assistance for Children with Severe Disabilities programs to help with the costs associated with addressing the needs of children with developmental and physical disabilities. However, these programs have strict guidelines that do not adequately recognize the unique needs of individuals with FASD, causing most families to pay out of pocket for things like respite care and transportation.20 The Ministry of Health and Long-Term Care (MOH) funds the Aboriginal Fetal Alcohol Syndrome/Effects program (in combination with the Aboriginal Child Nutrition Program) to provide Aboriginal families with information and support for FASD through nineteen Aboriginal organizations on- and off-reserve. The MOH’s Primary Health Care Transition Fund project funded the FASD: A Rural Strategy for Diagnosis and Case Management project through the Lake of the Woods District Hospital in Kenora to increase access to diagnostic and case management services using multidisciplinary teams for children aged zero to twelve.

The Ministry of Education (EDU) funds special education programming in schools but it is left to the discretion of each District School Board (DSB) to decide which type of programming it will offer based on community need. While this funding can include services to address FASD, most DSBs are hesitant to take advantage of it despite parental advocacy in support of FASD services in schools.21 An exception is the Keewatin Patricia District School Board, which undertook a two year FASD research and support project called Eliminating Barriers and Building Bridges. The goal of the project was to increase the capacity of caregivers and teachers to support children with FASD by enhancing understanding of FASD and providing access to project workers and support groups.

The Ministry of Community and Social Services funds supports for individuals with a developmental disability as per the definition within the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008. The Act requires that individuals have mental impairment that is associated with maladaptive behaviour and which occurs in their developmental years. This is not suitable for adults

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with FASD who have been un- or misdiagnosed as they will likely require services beyond their developmental years.

The Ministry of Community Safety and Correctional Services (MCSCS) does not fund FASD-specific programming in its adult correctional facilities but has provided FASD training to correctional officers and has incorporated it into staff training for new hires. This is a small but important step towards the introduction of a paradigm shift in the approach taken by correctional facilities to address FASD. Further work needs to be done to ensure that the proper supports are offered to those with FASD, particularly while they are going through the judicial process. Individuals with FASD in the justice system require the respect and advocacy of lawyers and judges to ensure that appropriate expectations of them are created based on an understanding of the effects of FASD.

A variety of ministries\textsuperscript{22} sit alongside caregivers and service providers on the \textit{FASD Intergovernmental Action Network}. This network works with the PHAC to advance the \textit{FASD National Framework for Action} and to further the FASD knowledge and resource landscape in Ontario. The work of this network is significantly hampered by a lack of funding and commitment to FASD strategies.

\textbf{Advancing a Culture-Based Approach to Address FASD}

\textbf{Approach to Promotion and Prevention}

\textit{Education and Training}

Caregivers, medical professionals, and individuals suffering from FASD need to have access to high-quality information regarding the disorder and its myriad effects. Not only is knowledge beneficial to the positive growth and development of FASD sufferers, but it will also tear through stigma and encourage acceptance. Greater knowledge can be easily gained on a public level through awareness campaigns and community outreach initiatives. Of particular necessity, however, is that service providers, educators, and health professionals possess a wealth of knowledge encompassing all aspects of FASD so that they can easily and efficiently identify potential cases, arrange referrals for assessment, or perform the assessment themselves. Duquette and Orders (2010) found that educators often know less about FASD than parents because it is not mandated as part of their professional development training, and a national study by the PHAC (2005) found that critical gaps in knowledge exist across Canada between health professionals. The study observed that health professionals often do not feel educated or trained enough to address cases of potential FASD, to screen for FASD, or to question pregnant women about their alcohol use. The study identified the need for more education and training to adequately prepare medical professionals to address FASD with confidence, and suggested that this training be added to the Canadian healthcare curriculum as a set of standardized guidelines.

\textsuperscript{22} MCYS, EDU, MCSCS, MOH, and Ministry of Health Promotion and Sport
Education and training in FASD that incorporates cultural competency and historical understanding is particularly important for caregivers and service providers that deal with Aboriginal clients. The OFIFC’s *FASD Toolkit for Aboriginal Families* (2008) uses a Medicine Wheel to guide front-line community workers through the process of understanding, supporting, and advocating for individuals with FASD and their families. The worker begins in the East, the Vision section of the wheel, to establish an awareness of FASD based on the issues that exist in the community. The worker then moves to the Relationship section of the wheel, in the South, and begins to build relationships with individuals affected by FASD and the people who support them. The West and North sections of the wheel represent Reason and Movement respectively, where the worker uses existing knowledge to build strategies for addressing FASD and then moves to mobilize community-wide involvement through advocacy and activism. The process illustrated by the Community FASD wheel can be used by anyone caring for or supporting an individual with FASD, and is not limited to use by front-line community workers. The movement through the four directions of the wheel promotes a wholistic approach to FASD that encompasses the worker, the individual with FASD, the family, and the community.

Education at the public and professional levels is necessary to ensure that FASD is properly understood, identified, assessed, diagnosed, and quantified. This depth of knowledge will serve to increase the likelihood that children and youth with FASD will receive the necessary educational supports and appropriate treatment plans, and by extension, avoid the development of secondary disabilities that may arise through non- and misdiagnosis. Communities that have a comprehensive knowledge of the disorder and its wide-ranging effects will also be better prepared to support adults with FASD. In a broader sense, public and professional education will go a long way toward reducing the prevalence and impact of FASD. According to the PHAC (2005), the implementation of a national standard of practice for addressing FASD will help to prevent new cases while improving the outlook for current ones.

**Alcohol Use and FASD**

Using the AUDIT self-assessment tool, the 2004 *Canadian Addiction Survey* found that almost nine per cent of Canadian women scored as high-risk drinkers. Approximately fourteen per cent of women drink during pregnancy in Canada, with the population most at risk profiled as women who are over thirty five, educated, of high socioeconomic standing, social and/or binge drinkers, smokers, experiencing an unplanned pregnancy, and/or have a history of violence and abuse. While these findings suggest that fetal alcohol exposure is relatively common, the lack of a national database to track the prevalence of FASD or analyze existing research data has led to a dearth of information. The national prevalence of FASD is unknown, with only very conservative estimates available from existing research.

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One per cent of Canadians, or approximately 300,000 individuals, suffer from FASD, while the worldwide incidence of Fetal Alcohol Syndrome, the most serious form of FASD, has been estimated to be 0.97 per 1000 live births.\textsuperscript{25,26} The annual cost of FASD in Canada is estimated to be $21,642 per individual or $5.3-billion in total (for individuals aged zero to fifty three), with a direct personal cost of $1.5-million over an individual’s lifetime, excluding lost productivity.\textsuperscript{27,28} The burden of personal cost depends on the severity of disability and age of the individual, with costs highest for children and youth aged six to fifteen, and these costs stem primarily from physician visits, hospitalizations, prescription use, and special education costs.\textsuperscript{29} Pacey (2009) estimated that, for the Aboriginal child population in Canada (aged zero to nineteen), annual national costs associated with FAS and ARND total $18,056,000.

According to the Native Women’s Association of Canada (2002), more than 50 percent of Aboriginal people consider alcohol abuse to be a significant social problem in their communities. Since FASD is completely avoidable, the most important factor towards preventing future cases lies in community awareness of the risks of alcohol consumption during pregnancy and treatment of existing alcohol abuse issues in women and communities. FASD can be a sensitive issue in Aboriginal communities, so the \textit{FASD Toolkit for Aboriginal Families} (2008) recommends that conversations about FASD should be gradually introduced and framed in a way that emphasizes the community-wide nature of the issue. Culturally-competent and wholistic substance abuse treatment methods that take into account the historic roots of alcohol abuse in Aboriginal communities should be promoted as effective preventative measures for FASD.

\textit{Child Welfare and FASD}

The behavioural and learning difficulties experienced by children with FASD means that they tend to enter care earlier, stay in care longer, and become Crown Wards faster than children who do not have FASD.\textsuperscript{30} As many as 3.3 to fifty percent of Canadian children with FASD live in care, depending on location. For example, sixty percent of the clients at the Lakeland Centre for FASD in Alberta have children, forty percent of

\textsuperscript{29} D. Fuchs \textit{et al.} (2009). \textit{The Economic Impact of Children in Care with FASD and Parental Alcohol Issues Phase II: Costs and Service Utilization of Health Care, Special Education, and Child Care}. (Ottawa, ON: Centre for Excellence on Child Welfare).
\textsuperscript{30} L.B. Whyte (2010). \textit{Towards a Provincial Strategy: Advancing Effective Respite Services in Fetal Alcohol Spectrum Disorder}. Prepared for FASD ONE.
whom are living in care. In Manitoba, 34.3 percent of all children in care had been diagnosed with FASD as of 2005, and an additional seventeen percent were suspected of having FASD. While it is true that many of these children are Aboriginal, this does not point to a cultural predisposition to FASD. The overrepresentation of Aboriginal children with FASD in care can be attributed to the disproportionate number of Aboriginal children that are in the child welfare system as a result of the colonial legacy of residential schools and the 60s scoop. In Manitoba, as of 2006, eighty one percent of the entire child population in care were First Nation and of the remainder, nine percent were Métis and four percent were non-status.

Regarding the economic impact of FASD in the Canadian child welfare system, Fuchs et al (2009) found that services for individuals with FASD cost more in total than services for other groups, even though these individuals comprise a smaller portion of the child welfare population. This is supported by Whyte (2010), who found that the average cost of supporting a child without FASD in care is thirty five dollars per day, while the cost for a child with FASD is sixty five dollars per day.

A focus on community-based programs that support physical, mental, and emotional development will increase the capacity of urban Aboriginal communities to assist FASD-affected children without removing them from the family or community. Children with FASD who are already in care must be given the appropriate supports, including early diagnosis, treatment, and understanding of their unique needs. Aboriginal children should have access to traditional cultural practices and teachings through elders and healers, so that they may remain connected to their culture even if they are placed in a mainstream facility. The child welfare system is a difficult place for any child to navigate, so a strategy to address FASD must aim to improve the capacity of the child welfare system to deal with complex requirements. An accepting, understanding, and safe environment with a meaningful connection to culture during childhood will help to prevent the onset of secondary disabilities such as mental illness and substance abuse.

**Approach to Access to Services**

**Service Coordination**

Efficient and standardized collaboration between caregivers, educators, service providers, and health professionals is essential to ensuring the positive growth and development of individuals with FASD. Seamless coordination will ensure that caregivers are not a child’s only advocates and that the individual is fully supported at home, at school, and within the community. Communication between services will also aide in the creation and implementation of effective and appropriate treatment plans that are able to respond and adapt to changes throughout the lifecycle and which

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incorporate wrap-around approaches to care. Sharing of information between Aboriginal and mainstream organizations and services is of particular importance to guarantee unity and congruence between each facet of care, be it Western or traditional, particularly in areas where service provider options are limited.33

Diagnostic Clinics

The scarcity of diagnostic clinics in Ontario, insufficient provincial and federal funding for services, and a shortage of trained health professionals represent significant barriers to early diagnosis of FASD. Early diagnosis is one of the most important protective factors in the prevention of secondary disabilities that can develop due to ineffective or altogether lacking support of an individual with FASD. Early diagnosis not only improves the outcome for the child by allowing caregivers, educators, and service providers to understand the strengths and limitations associated with FASD, but can also identify problematic substance use within the family unit and prevent the consumption of alcohol during subsequent pregnancies.

There are currently only 12 FASD diagnostic clinics in Ontario, meaning that many individuals and families must travel long distances to access each appointment throughout the often lengthy diagnostic process.34 This problem of access can be partially remedied through the use of diagnostic tools by non-specialists, but the complex, subjective, and often vague assessment criteria for FASD do not lend well to use by individuals who are not specifically trained in the diagnosis of FASD, and can lead to non- and misdiagnosis.35 It is therefore vital that all communities in Ontario have access to comprehensive and culturally-competent FASD diagnostic clinics that are capable of handling high case loads and a diverse client base.

Aboriginal-specific or culturally-based diagnostic clinics, like the one run by Anishnawbe Health Toronto, incorporate Elders, Medicine People, and Traditional Healers into a family-based, wholistic process that links cultural supports with mainstream diagnostic aspects. The use of culture in the diagnostic process helps to lessen anxiety and create a supportive environment for the individual and family, while providing a culture-based understanding of the disorder and its future implications and treatment. Culture-based diagnostic clinics are currently rare in Ontario, but the model must be recognized as a vital component of any strategy to address FASD, and should be explored further.

Wholistic Aboriginal Learning Environments

Children with FASD often present a challenge to educators, but a positive relationship to learning environments throughout childhood and adolescence will help to prevent the

onset of secondary disabilities later in life. It is therefore vital that educators and schools work to create an accommodating learning environment for children with FASD. Alongside well-known mainstream approaches, such as low-stimulus classrooms with few students and highly consistent schedules, Aboriginal program workers and educators have found that cultural elements can be beneficial to FASD-affected students.\textsuperscript{36} For example, drumming and dancing can improve balance and coordination, Aboriginal languages can be easier to understand as they are not as abstract as English or French, and an emphasis on combining nature with the classroom has been proven to have a calming effect.\textsuperscript{37} Wholistic Aboriginal learning environments benefit students with FASD by combining emotional, physical, and cognitive learning through an emphasis on respect for differing strengths and a connection to culture.

\textit{Respite Care}

Respite care is one of the top three unmet needs of families dealing with FASD, alongside education and transitional supports between services. From an Aboriginal perspective, respite care can be seen as taking the place of childcare that would traditionally be offered by extended family and the community. When respite care is accessible, it provides caregivers with an opportunity to decrease stress and improve health through self-care, reconnect with friends and family, complete household chores, and attend support groups and seminars to learn more about FASD. Respite care allows children with FASD to remain in the care of their families longer, thereby improving their well-being and positive development versus being in care. Barriers to effective respite care include inadequate funding, a shortage of respite workers trained in FASD, a lack of knowledge about how to access respite care, and high staff turnover rates.\textsuperscript{38}

\textit{Adult FASD Services}

Adult-specific FASD services play a vital role in the prevention or mitigation of secondary disabilities that can lead to homelessness, incarceration, and experiences of violence. This significance, however, is not reflected by Canada’s current approach to FASD; there is a severe shortage of FASD services specific to adults and only three adult-specific diagnostic clinics in Canada, all of which are located in the Western provinces and territories. To allow for an increase in adult FASD services, Badry and Bradshaw (2011) suggested the need to adapt child assessment tools for use in adult populations. Through their research, they found that the \textit{Asante Centre Probation Officer Screening and Referral Form for Youth}, the \textit{Maternal History of Substance Abuse Guide}, and the \textit{Medicine Wheel Assessment Tools} could all be effectively adapted for use with adults. They also suggested that tools adapted for use in adult populations should focus less on the identification of phenotypic abnormalities and more on the secondary disabilities that develop through non- or misdiagnosed FASD.

\textsuperscript{36} OFIFC (2008). \textit{FASD Toolkit for Aboriginal Families}. (Toronto, ON).
\textsuperscript{37} OFIFC (2002). \textit{Aboriginal Approaches to Fetal Alcohol Syndrome/Effects}. (Toronto, ON).
\textsuperscript{38} L.B. Whyte (2010). \textit{Towards a Provincial Strategy: Advancing Effective Respite Services in Fetal Alcohol Spectrum Disorder}. Prepared for FASD ONE.
Navigating the Justice System

While the challenges associated with the diagnosis of adult FASD and the lack of a national database mean that it is impossible to definitively know the scope of FASD within the justice system, Rudin (2012) asserts that individuals with FASD constitute a large portion of offenders. Approximately sixty per cent of individuals with FASD come into contact with the law at some point in their lives, leading to FASD rates that are ten times higher in correctional populations than in the general public. Unfortunately, these individuals are often at a disadvantage in the justice system due to their propensity to confess to crimes that they did not commit, become confused during the judicial process, and breach probation, leading to additional and more severe convictions. Poor memory is a common characteristic of people with FASD and can be mistaken for lying as opposed to a genuine inability to recall events during questioning. These observations are corroborated by Goh et al. (2008), who concluded that the incarceration of youth and adults with FASD is not only inhumane, but also poses significant challenges to the justice system.

As of 2008, multiple tools had been developed to assess for FASD in youth correctional facilities, including the ARNDD Behavioral Checklist, the FASNET Assessment, the Fetal Alcohol Exposure Risk Assessment for Adolescents and Adults, the Fetal Alcohol Behavior Scale (no longer used), the GGPC FASD Screening Tool, the FASD Youth Justice Project Manitoba (for youth aged twelve to eighteen), the Brief Screen Checklist, and the Saskatchewan FASD Functional Screening Tool. However, the effectiveness of these tools has not been formally validated. In 2012, the Asante Centre FASD Screening Tool for Youth Probation Officers in Ontario was implemented. An evaluation by Bloom (2012) found that the tool was effective in assisting officers to understand the unique needs of individuals with FASD. The tool was also found to succeed in teaching officers to ensure the best possible outcomes for individuals with FASD by creating realistic goals, arranging referrals for diagnostic assessment, involving the individual and caregivers in planning, and accessing external community service providers for added resources and support. Further evaluation is being done by Bloom to review the effectiveness of this tool over time.

The Aboriginal Corrections Policy Unit of Public Safety Canada and the Ma Mawi Wi Chi Itata Centre in Manitoba facilitated a workshop in 2010 to discuss FASD in the justice system. Eighty per cent of the participants (from Aboriginal and mainstream justice

services that work with youth and adults in custody) said that they had worked directly with someone with FASD. Participants also agreed that cultural programming is necessary for addressing FASD, particularly in Aboriginal populations, and that a wholistic approach to care within the justice system must be adopted. Cultural oversight by federal and provincial Aboriginal organizations, such as that provided by Friendship Centres, was highlighted as an area that should be promoted and expanded. Further recommendations included the prioritization of early diagnosis within the justice system and training and education concerning FASD for all workers within the system to allow them to better identify and refer those with FASD.

The criminal justice system in Canada must redefine the way it screens for, and responds to, FASD. Steps should be taken to educate workers on FASD not only to protect the human rights of those with the disorder, but also to create a system that is responsive to individuals’ needs, understands their strengths and weaknesses, and provides the supports necessary for success. This paradigm shift would allow for the criminal justice system to contextualize situations by recognizing that individuals with FASD suffer from brain damage that may impair their ability to consider consequences, assess situations, and make decisions based on sound judgment.44

Dealing with Homelessness

In 2004, the FAS @ Street Level advisory committee in Toronto (which included participation of the OFIFC) developed the FASD and Homelessness Training Manual to acknowledge FASD as a significant cause of, and challenge to, homelessness. This guide is intended to help service providers who work with people experiencing homelessness to better identify FASD. Funding from the Homelessness Secretariat and Human Resources and Development Canada enabled this group to be the first to recognize the linkages between, and unique challenges of, homelessness and FASD.

The Structural Barriers to Independent Living for Adults with Fetal Alcohol Syndrome research project carried out by Up North Training Services (UNTS) in the Yukon was funded by the Regional Homelessness Research Committee to further explore the root causes of homelessness and to inform the Government of Canada’s Homeless Initiative. Target research groups included adults with FASD and individuals exiting the criminal justice system. The UNTS (2002) found that adults with FASD know how they want to live but need help in acquiring the resources and supports to realize their vision. The project illuminated the challenges that are faced by service providers when assisting adults with FASD to find housing, including the lack of understanding about FASD, lack of housing providers that are willing to rent to those with FASD, services that do not meet the needs of those with FASD, and governments that are not working collaboratively to accommodate those with FASD. Finally, the project highlighted the need for support systems to ensure that individuals, with or without FASD, do not become homeless upon exiting the justice system.

Homeless individuals with FASD often do not have access to supportive services to mitigate secondary disabilities, thus resulting in decreased well-being and an increased risk of involvement with the justice system. The previously discussed research deficits and inadequate rates of diagnosis mean that it is difficult to assess rates of FASD in homeless populations. Therefore, training for service providers in the homeless sector is vital to ensure that potential cases of FASD are identified, assessed, and treated to improve well-being and increase access to supportive services. Safer and Boland (2008) suggest that people with FASD need to be provided with supportive housing and work opportunities to allow for positive growth and development and to avoid homelessness.

Approach to Planning and Representation

A culturally-appropriate strategy to address FASD must be implemented in Ontario. Without a strategy and dedicated funding for the prevention and treatment of FASD, the issue will continue to be a substantial economic burden, costing individuals over $1.5-million in a lifetime and over $5-billion a year for the country as a whole. Without mandated FASD curricula or standardized diagnostic guidelines in Canada, non- and misdiagnosis will continue to occur, which will in turn increase the risk of the onset of secondary disabilities. Not only do secondary disabilities such as mental illness and substance abuse cost more economically, they more importantly cause undue stress and emotional suffering on the part of the individual with FASD, the family, and the community.

The importance of a culturally-appropriate strategy to address FASD cannot be underestimated. The history of trauma shared by Aboriginal people has resulted in a group that is often socioeconomically disadvantaged, distrustful of a justice system that does not understand their needs or unique past, and disconnected from their cultural beliefs. An effective strategy to address FASD must be approached from a strengths-based perspective that highlights the value of each individual while making room for differing abilities. Prevention and treatment of FASD in Aboriginal communities should provide an opportunity for individuals to take advantage of both Western and traditional methods through service providers that are culturally-competent and willing to work as a team. In addition, a woman-centered component to an FASD strategy would allow for the mother and child to receive the resources, support, and treatment that they need, while preventing future cases of fetal alcohol exposure.

With this understanding, it is important that provincial and federal strategies to address Fetal Alcohol Spectrum Disorder (FASD) respond not only to the lack of FASD-related services in urban Aboriginal communities, but to the need for these services to be founded in Aboriginal culture. The fragmented, under-funded, and Western approach that dominates current FASD policy, strategy, and service development in Ontario is not suitable for urban Aboriginal people as it does not capitalize on the unique strengths of Aboriginal culture. Significant rates of substance abuse, community and family dysfunction, and poor social, political, and economic conditions in urban Aboriginal
communities indicate an urgent need for culturally-based services and strategies that address the wholistic needs of urban Aboriginal communities dealing with FASD.

Short-term outcomes should focus on educating individuals about FASD to encourage new, positive behaviours and should include increased education and training through professional curricula mandates. Research and diagnostic criteria should be developed to ensure the accurate representation of FASD prevalence in Canada, illuminate the realities of FASD in Aboriginal populations, and increase the level of knowledge transfer across populations. The development of culturally-appropriate, validated FASD screening and diagnostic tools for use in Aboriginal populations and across age groups should be prioritized to mitigate the risks associated with non- and misdiagnosis.

Intermediate outcomes should focus on positive behavioural change and increased social action, and should include decreased incidences of the development of secondary disabilities. Early diagnosis, improved collaboration between services, and strengthened relationships between families, communities, health professionals, service providers, and educators will support the attainment of these goals. Healthy community relationships will increase the ability of women to disclose alcohol use during pregnancy and will help health professionals to connect pregnant women and families with the appropriate services. Improved awareness of FASD and the dangers of alcohol use during pregnancy will support effective treatment and prevention of the disorder, while an understanding of the underlying socioeconomic causes of FASD will allow for the development of effective culturally-based strategies that focus on strengths rather than weaknesses.

Long-term outcomes should focus on positive social, cultural, economic, political, and environmental change and should include improved access to effective, holistic, culturally-appropriate, and self-determined FASD services. Decreased incidences of FASD in all populations, including Aboriginal communities, can be attained through the prevention of alcohol consumption during pregnancy, which will in turn reduce the socioeconomic burden of FASD on families, communities, service providers, educators, health professionals, and governments. Additional long-term outcomes of an effective FASD strategy will include fewer FASD-affected children in care, increased government legislation and policy that accurately reflect the realities of FASD and the cultural needs of Aboriginal people, and the development of a national database to track the prevalence of FASD and the effectiveness of services.

Partnerships between urban Aboriginal communities, Friendship Centres, the OFIFC, the PHAC, Health Canada, the federal and provincial government, other provincial Aboriginal organizations, and various stakeholders will be necessary to ensure that a strategy for FASD in Canada or Ontario is developed that reflects the realities of FASD and its relation to Aboriginal people. A collaborative approach will allow for future strategies to ensure that FASD services are better coordinated, accessible, and appropriate for use in Aboriginal communities. Partnerships between stakeholders will also assist in the development of standard assessment tools for proper diagnosis and
tracking of FASD prevalence, and will improve awareness of FASD through community-level initiatives.

**Recommendations**

1. Develop and implement a culturally-appropriate and funded provincial strategy to address FASD in urban Aboriginal populations.
   a. Perform environmental scans across Ontario to identify existing FASD services and resources, and to recognize wise practices. This scan will inform the allocation of funds and the development of new services to fill gaps.
   b. Develop standardized screening and diagnostic tools that are culturally-appropriate.
   c. Create a provincial database to track the prevalence of FASD in Ontario. A database will illuminate the relationship between FASD and socioeconomic factors, track changes in rates of incidence, and inform future strategic development.
   d. Develop provincial and community level advocacy and awareness programs that focus on the preventable, socioeconomic-influenced nature of FASD. These programs will decrease the stigma associated with the disorder and improve community understanding of FASD.
   e. Increase access to services for urban Aboriginal communities by promoting coordination between the various FASD-related service providers. In particular, a positive relationship between Aboriginal and mainstream service providers should be nurtured to allow for easy referral and an open flow of information between Western and traditional methods of care.
      i. Increase number of diagnostic clinics, respite care services, and supports for adults with FASD.
      ii. Encourage coordination between homelessness services and FASD services to ensure that homeless individuals with FASD are appropriately supported.

2. Engage with Aboriginal communities when developing strategies to address FASD. This will ensure that services aimed at Aboriginal people are culturally-competent, accessible, and reflect the real needs of the community.
   a. Develop community task forces in Ontario that include Aboriginal representation to monitor community need and ensure that services are continually adapted to meet the wholistic needs of the community.

3. Funding for off-reserve FASD programs must be stabilized and expanded, so that programs are able to plan for the future, retain skilled staff, and effectively address the needs of the community.
   a. In the 2013 Provincial Budget, the Ontario government committed to investing $42-million per year with the Ministry of Community and Social
Services to help support families and individuals affected by developmental disabilities. Expanded funding for off-reserve FASD programs could be taken from this envelope.

4. Mandate FASD training and education in the curricula of all health professionals, educators, service providers, child welfare workers, and justice system workers to ensure that FASD is properly understood, identified, assessed, diagnosed, and treated. This will increase the capacity of the health, education, child welfare, and justice systems to deal with the complex needs of individuals with FASD. Training and education will ensure that individuals with FASD are given every possible opportunity to succeed by decreasing the risk of the development of secondary disabilities.
   a. Develop standards of practice for FASD care that highlight strengths and resiliencies rather than weaknesses.

5. Prevent fetal alcohol exposure before it occurs by increasing the availability of culturally-appropriate substance abuse screening and treatment programs for urban Aboriginal women, and by encouraging safe sex practices to prevent unplanned pregnancies.

6. Encourage community and corporate participation in the September 9th FASD Awareness Day and create other community, provincial, and national FASD awareness campaigns and community outreach programs.
   a. Utilize the expertise of local Aboriginal leadership and youth to create awareness campaigns that are culturally-resonant.
Sources Cited


Ontario Federation of Indian Friendship Centres. (2002). *Aboriginal Approaches to Fetal Alcohol Syndrome/Effects*. (Toronto, ON).


