Fetal Alcohol Spectrum Disorder
and Homelessness

TRAINING MANUAL
Acknowledgements

Thanks to the FAS @ Street Level conference committee for their contribution in developing the program, sourcing the speakers, planning the conference and providing input into this training manual.

Advisory Committee Members:
Margaret Cheung, Anne Johnston Health Station
Karen Clark, St. Michael’s Hospital
Danielle D’Agostino, Communications Consultant
Elaine Ebach, Toronto Public Health
Sue Goodfellow, Turning Point
Alice Gorman, Toronto Public Health
Teesha James, University of Toronto Nursing Student
Kim Meawasige, The Ontario Federation of Indian Friendship Centres
Jim O’Neill, St. Michael’s Hospital
Brian Philcox, FASworld
Susan Santiago, Motherisk, Hospital for Sick Children
Dr. Brenda Stade, St. Michael’s Hospital
Terry Swan, Native Child & Family Services of Toronto
AD HOC Member: Dr. Michael Sgro, St. Michael's Hospital

This manual was written and/or and prepared by Dr. Brenda Stade, RN, St. Michael’s Hospital; Karen Clark, St. Michael’s Hospital; Danielle D’Agostino, Communication Consultant.

Thank-you to Kim Meawasige, The Ontario Federation of Indian Friendship Centres; Brian Philcox, FASworld; Terry Swan, Native Child and Family Services for identifying many of the case studies in this manual.

Thanks to all of those who contributed including :

Dr. Susan Astley, University of Washington
Dr. Tony Barozzino, St. Michael’s Hospital
Dr. Jean Barwell, St. Michael’s Hospital
Dr. Joseph Beyene, Hospital for Sick Children
Bonnie Buxton, FASworld Canada
Dr. Sharon Cirone, SHOUT Clinic
Mary Cunningham, FASworld Toronto
Kaye Hayes, FASworld
Tom Hayes, FASworld
Shelley Hill-Garey, Ontario Federation of Indian Friendship Centres
Dr. Gideon Koren, Motherisk, Hospital for Sick Children
Constable Annette Laporte, RCMP
Margaret Leslie, Breaking the Cycle
Patti McDonald, Ontario Federation of Indian Friendship Centres
Sylvia Maracle, Ontario Federation of Indian Friendship Centres
Chris Margetson, FASAT
Terralyn McKee, The Pas Family Resource Centre
Brian Philcox, FASworld
Dr. Michael Sgro, St. Michael's Hospital
Dr. Barry Stanley, Family Therapist
Dr. Bonnie Stevens, Hospital for Sick Children
Terry Swan, Native Child and Family Services
Dr. Wendy Ungar, Hospital for Sick Children
Dr. William Watson, St. Michael's Hospital

Special thanks to the youth panel whose sharing at the conference helped to shape many of the sections of this manual:
A.J. Ballard
Colette Philcox
Rob Wilkinson

This training manual has been prepared with funds provided by Human Resources Development Canada. The information herein reflects the views of the contributing authors and presenters of the conference.
# Table of Contents

**Chapter 1: Introduction** ................................................................................................. 7  
  - Purpose of the training manual  
  - How to use this training manual

**Chapter 2: Burden of Prenatal Exposure to Alcohol** .................................................. 10  
  - Learning Objectives  
  - Introduction  
  - Quality of Life  
  - The Burden of Cost  
    - Overhead #1: Introduction.............................................................................. 13  
    - Overhead #2: Quality of Life....................................................................... 14  
    - Overhead #3: Burden of Cost...................................................................... 15

**Chapter 3: What is Fetal Alcohol Spectrum Disorder? How is it Diagnosed? How can I recognize it?** ................................................ 17  
  - Learning Objectives  
  - Introduction  
    - Overhead #4: Prenatal exposure to alcohol and the developing fetus ..... 18  
    - Overhead #5: Healthy brain versus brain of infant severely affected by alcohol................................................................. 19  
  - Diagnostic Categories  
    - Overhead #6: Common facial features of FAS........................................... 21  
    - Overhead #7: Diagnostic facial features of FAS......................................... 22  
    - Overhead #8: FASD: Diagnostic Categories.............................................. 24  
      - How would I recognize FASD in a homeless youth or adult?  
      - Cognitive and behavioral signs of adolescents and adults with FASD  
    - Overhead #9: Cognitive and behavioral signs of adolescents and adults with FASD ................................................................. 27  
    - Overhead #10: FAS development array of abilities................................. 31  
      - Secondary disabilities often associated with FASD  
    - Overhead #11: Secondary disabilities often associated with FASD ....... 33  
    - Case Study  
    - Overhead #12: Why Diagnose? ............................................................... 37

**Chapter 4: General Strategies for Working with Individuals with FASD** .................. 39  
  - Learning Objectives  
  - General strategies for working with individuals with FASD
Chapter 5: Learning Styles of Individuals with FASD

Overhead #13: General strategies for working with individuals

Case Study

Chapter 6: Considerations for Law Enforcement Workers

Overhead #14: Six strategies for teaching individuals with FASD

Case Study

Chapter 7: Working with Families

Overhead #15: Why police need to be sensitized and educated

Case Study: One Family’s Story

Chapter 8: Next Steps: Building a Response Network

Overhead #16: Strategies for working with families

Conclusion

Chapter 9: Resources

Chapter 10: References

Appendix A
Chapter 1:

Introduction
Introduction

This training manual is an important step in acknowledging that Fetal Alcohol Spectrum Disorder (FASD) is a significant factor in causing homelessness and also that FASD presents unique challenges to homeless people. Much of the materials presented in this manual were presented at the FAS @ Street Level Conference that was held on November 24 and 25th, 2003 in Toronto.

It is essential that frontline workers in the homeless sector are able to recognize FASD in homeless individuals and can begin to offer much needed support. This manual is the first step in advocating for people with FASD who are homeless. Thanks to the Homelessness Secretariat and Human Resources Development Canada for acknowledging that this is an important issue. We hope that the production and distribution of this training manual will begin a process of sharing of materials, and a dissemination of knowledge of how to work with homeless youth who may have FASD.

Purpose of the Manual

The purpose of this manual is to provide conference attendees with the information and tools they need to deliver a training program to their colleagues and other front-line workers who work directly with homeless people. Through the training, it is intended that other front-line workers will have an:

- Increased understanding of physical and/or behavioral characteristics of FASD;
- Increased understanding and skill to identify and refer for diagnosis individuals who may suffer from FASD;
- Increased understanding and skill to implement effective strategies with individuals with FASD.
- Increased understanding of available community resources for individuals with FASD.

How to use this training manual

This training manual will help you prepare and deliver a training session on FASD and homelessness to your colleagues. It contains:

- Background information
- Case studies
- Overheads and/or handouts
- List of resources
The training manual is also available electronically at www.ccsa.ca/fas; http://www.stmichaelshospital.com; and www.motherisk.org

There are 7 key sections:

1. Burden of prenatal exposure to alcohol
2. What is Fetal Alcohol Spectrum Disorder?  
   How is it diagnosed?  
   How can I recognize it?
3. General strategies for working with individuals with FASD
4. Education of individuals with FASD
5. Considerations for law enforcement workers
6. Working with families
7. Next steps: building a resource network in the community

Each section has learning objectives identified and provides background information on the specific topic. Feedback from the conference indicated that participants found case studies and “real life stories” from individuals with FASD to be quite touching and illustrative of what FASD is and how it affects day to day life, so we’ve included case studies where applicable. We’ve also included overhead pages (which are identified at the top of the page) which can be copied onto acetate sheets for overhead projection or can be photocopied and provided as handouts to the trainees. We recommend that you present all of the overheads representing each chapter and use the text in the manual to explain each one.

We encourage you to review and present the contents of this manual in its entirety. You may require approximately 8 hours to present the material and allow ample time for questions and/or discussion. You may want to consider breaking it out into two or three separate training sessions, or host a series of ‘lunch and learn’ sessions, where you can review the material in each section over several days. Either way, it’s important for you to share the information with your colleagues and other front-line workers.

Appendix A presents a detailed description of how to conduct an eight hour training workshop based on the materials contained in this manual.
Chapter 2:

Burden of Prenatal Exposure to Alcohol
Burden of Prenatal Exposure to Alcohol

Learning Objectives

The learning objectives of this section are:

1. To identify the incidence of prenatal exposure to Canada.
2. To identify the impact that prenatal exposure has on the quality of life of individuals living with FASD.
3. To describe the societal costs of FASD.

Introduction

In Canada the incidence of Fetal Alcohol Spectrum Disorder (FASD) has been estimated to be 1 to 6 in 1000 live births (Canadian Pediatric Society, 2002; Coles, 1993; Health Canada, 1996; Marchessault, 1988; Roberts & Nanson, 2000). Caused by prenatal exposure to alcohol, the disorder is the leading cause of developmental and cognitive disabilities among Canadian children and its effects are life lasting (Health Canada, 1996; Canadian Pediatric Society, 2002).

Quality of Life

Prenatal alcohol exposure results in a tremendous impact on the quality of life of individuals living with FASD. In a recent study (Stade et al., 1993) measuring the quality of life of individuals ages 8 to 21 years living in communities throughout Canada, the health-related quality of life scores of those with FASD ranged from -0.22 to 0.96, with a mean of 0.47, and compared to a range of 0.91 to 0.95, with a mean of 0.93, for children from the general Canadian population.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>FAS/FAE</td>
</tr>
<tr>
<td>Canadian Population</td>
</tr>
</tbody>
</table>
Children, adolescents, and young adults spoke about how FASD impacted on their day-to-day life. For example:

#1
An 8 year old understood the nature of his disability. He stated:

“(It’s) hard, hard to keep out of trouble, and I am not that smart. I have to think. I have to stop and think.”

“I think differently from everyone. Everybody makes fun of me.”

“It (the affects that FAS has on his life) is very sad.

#2
A 10 year old girl aware of the impact that prenatal exposure to alcohol had on her day-to-day learning stated:

“Learning is hard. The teachers don’t explain things (in a manner that allows her to understand).”

#3
When asked how FAS affects his day-to-day life, a 14 year old stated:

“… I have trouble concentrating. I am concentrating on one (activity), then I get distracted.”

#4
An 18 year old stated:

“I realize it was not a choice. It was not a choice I could have made. (His exposure to alcohol before birth). It is a choice I had made FOR me.”

He demonstrated his frustration when he very poignantly stated:

“FAS is an unfair thing. Seeing normal kids do things that are hard for me to do.”

“In the world it (FAS) is a mental disability. FAS is an unfair thing.”

“They (teachers, employers) expected me to do things I couldn’t. I have a hard time doing some things. Others do things easier, get through work…”

#5
A 21 year old explaining how FAS affects his quality of life stated:

“It (FAS) really does effect quality of life. It affects school, work, friendships…How does it affect me? Differently. I do things differently…My brain is rewired differently (than others).”
The Burden of Cost

A recent study (Stade et al., 2003) examining the societal costs of FASD demonstrated that the annual cost of FASD in Canada for ages 1 to 21 years at the individual patient level is $14,342.

A very conservative cost of FASD annually to Canada for those aged 1 to 21 years is $344,208,000.

The largest single component of costs was education costs, accounting for 32.6\% of the total. Medical costs including services of health professionals, medical devices, hospitalization, medications, and diagnostic tests contributed to 30.3\% of total costs.
Introduction

1. In Canada the incidence of Fetal Alcohol Spectrum Disorder (FASD) has been estimated to be 1 to 6 in 1000 live births.

2. FASD is the leading cause of developmental and cognitive disabilities among Canadian children.

3. FASD is life lasting.
Quality of Life:

1. Health-related quality of life scores of those with FASD ages 8 to 21 years ranged from -0.22 to 0.96, with a mean (average) of 0.47.

2. Health-related quality of life scores of children from the general Canadian population ranged from 0.91 to 0.95, with a mean of 0.93, for children from the general Canadian population.
Burden of Cost

1. The adjusted annual cost of FASD in Canada for ages 1 to 21 years at the individual level is $14,342.

2. Cost of FASD annually to Canada is over 344 million dollars.

3. The largest single component of costs was education costs at 32.6%

4. Medical costs contributed to 30.3% of total cost.
Chapter 3:

What is FASD? How is it Diagnosed? How can I Recognize it?
What is Fetal Alcohol Spectrum Disorder? How is it diagnosed? How can I recognize it?

Learning Objectives

The learning objectives of this section are:

1. To define what FASD is.
2. To identify diagnostic categories.
3. To describe how to recognize an individual who may have FASD.

Introduction

Fetal Alcohol Spectrum Disorder (FASD) is a serious neuro-developmental and/or physical disorder that can result in disabilities that have lifelong physical, mental, behavioural and social consequences.

FASD is caused by prenatal exposure to alcohol. The amount of alcohol necessary to cause FASD remains unknown. There is **NO SAFE AMOUNT** of alcohol when pregnant.

Alcohol crosses freely through the placenta. The first 3 to 7 weeks after conception is the period when alcohol can cause the greatest physical abnormalities. However, alcohol continues to impact the fetus throughout gestation, particularly the developing brain (see figure 1).
**Figure 1**

Prenatal Exposure to Alcohol and the Developing Fetus

Alcohol passes the placental “barrier” freely with devastating impact on the developing fetus.

<table>
<thead>
<tr>
<th>Periods in which Major Physical Abnormalities occur</th>
<th>3 - 7 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periods at which Functional Defects and Lesser Physical Abnormalities occur</td>
<td>8 weeks - 4 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre Embryo</th>
<th>3 weeks</th>
<th>4 weeks</th>
<th>5 weeks</th>
<th>6 weeks</th>
<th>7 weeks</th>
<th>8 weeks</th>
<th>9 weeks</th>
<th>16-36 weeks</th>
<th>38 weeks</th>
<th>4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Heart</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Upper Limbs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Eyes</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Lower Limbs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Teeth</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Palate</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Genitals</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Ears</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Overhead #5

Figure 2 shows the brain of a normal baby and one of a baby severely affected by alcohol. Notice the difference in size development of the brain. The alcohol affected brain is smooth and lacks the number of “sulci groves and gyri (convolutions)" which allow a brain to work effectively. Notice the partial absence of the corpus callosum, the section tissue that divides the 2 hemispheres.

Figure 2

Brain of Healthy Infant versus Infant Severely Affected by Alcohol
The word “spectrum” in FASD acknowledges that Fetal Alcohol Syndrome is a continuum, with differing degrees of expression of dysfunction and malformation. An individual would NOT receive a medical diagnosis labeled FASD. The term is too broad to serve as a meaningful diagnostic category. Rather, the following five categories have been developed for diagnostic purposes.

**Diagnostic Categories**

**Category 1:**
Fetal Alcohol Syndrome with confirmed maternal alcohol exposure is characterized by a triad of signs:

1) prenatal and or postnatal growth restriction (height and weight at or below the 10th percentile).

2) characteristic facial anomalies including short palpebral fissures, flat philtrum, and thin vermilion border of the upper lip (see figure 3 & 4).

3) central nervous system dysfunction. The central nervous system is composed of the brain and spinal cord. Damage to this area may be demonstrated by intellectual impairment and/or structural abnormalities, microcephaly, developmental delay, and a complex pattern of behaviours including extreme hyperactivity, aggressiveness, and poor judgment.
Overhead #6

Figure 3 shows some facial features that may be found in FAS.

**Figure 3**
Although children may demonstrate several facial features associated with FAS, several of these features are found in other conditions. The facial characteristics specific to FAS are small eyes, thin upper lip and flat philtrum the area between the nose and the upper lip (see figure 4).

**Figure 4**

**DIAGNOSTIC FACIAL FEATURES OF FAS**
Children and adolescents with full FAS often display facial characteristics, speech and language difficulties. Other clinical manifestations of FAS may include cardiac anomalies, urogenital defects, skeletal abnormalities, visual and hearing problems.

**Category 2:**
**FAS without confirmed maternal alcohol exposure.**

If the triad of signs described in category 1 is present, an FAS diagnosis is possible even without confirmed maternal drinking.

**Category 3:**
**Partial FAS with confirmed maternal alcohol exposure.**

Individuals with confirmed maternal alcohol exposure may have only some of the characteristic facial abnormalities, and either growth retardation, central nervous system neuro-developmental abnormalities, or behavioral or cognitive abnormalities.

**Category 4:**
**Alcohol-related birth defects (ARBD).**

Patients in this category will have congenital malformations such as cardiac anomalies, joint and limb anomalies, and neurotubal defects.

**Category 5:**
**Alcohol-Related Neuro-developmental Disorder (ARND)**

Patients in this category will have evidence of central nervous system neuro-developmental abnormalities and/or complex patterns of behavioral or cognitive abnormalities. Children, adolescents and adults with ARND may not demonstrate any of the facial features associated with the full syndrome.
Fetal Alcohol Spectrum Disorder: Diagnostic Categories

- Fetal Alcohol Spectrum Disorder is an umbrella term - not a diagnostic term.

- Five diagnostics categories include:
  
  Category 1: The full Fetal Alcohol Syndrome with maternal alcohol exposure

  Category 2: FAS without confirmed maternal alcohol exposure

  Category 3: Partial FAS with confirmed maternal alcohol exposure

  Category 4: Alcohol-Related Birth Defects (ARBD)

  Category 5: Alcohol-Related Neuro-Developmental disorder (ARND)
How Would I Recognize FASD in a Homeless Youth or Adult?

During puberty the nasal bridge, jaw and the midface grows and has a less flattened appearance. Thus, the short nose, small jaw, and flat midface often seen in the younger FAS child is not as apparent.

Although the adolescent may have characteristic signs of FAS such as a thin upper lip, an indistinct philtrum, and short palpebral fissures, these signs may be less apparent within the new look of the adolescent face. Thus, for those working with homeless youth and adults, even individuals with the full syndrome may be difficult to identify based on appearance.

Cognitive and behavioural signs of FASD listed below may be found in other conditions. An individual displaying these signs with a history of prenatal exposure to alcohol should be assessed in a FASD diagnostic centre. Certainly, no one person will display all these behaviours.

Cognitive and Behavioral Signs of Adolescents and Adults with FASD

- Learning disabilities
- Significant cognitive impairment to normal IQ
- Short term memory deficits
- Expressive language better than receptive
- Attention problems; ADHD

Poor judgment and deficits in executive functioning which may include:

- self-monitoring
- planning
- time perception
- internal ordering
- working memory
- inhibition
- verbal self-regulation
- motor control
- regulation of emotion
- motivation

Individuals with FASD often need an external brain – a person such as a family member, friend or professional who can help them plan, organize and compensate for deficits in executive functioning.

Social and sexual exploitation or inappropriate social behavior

Sexually impulsive (aggressive or vulnerable)
Increased expectations of the client by other people
Increased dissatisfaction towards the client by others
Withdrawal and isolation
Unpredictable behavior
Unable (not unwilling) to accept responsibility
Self-centered - behave as if the world revolves around them
Always having to have their own way and willing to do anything to have it
Demand and expect immediate gratification
Skilled at shifting blame
Engaging and charismatic - creative at re-framing reality (lying stealing, etc.)
Moral chameleons - excessive vulnerability to peer influence
Hyperactive in non-goal directed activity
Unable to stay focused on task i.e. to follow rules, finish household chores, school assignments or keep commitments
Shortsighted

Mood Swings

- Impulsive and uninhibited
- Passive and withdrawn one minute, switching to volatile temper tantrums the next
- Unpredictable; may need 24 hour supervision

Genuine Innocence and Detached Attitude

- Toward the predicaments they get themselves and their families into.
- Toward authority when caught breaking the rules of society.
- Toward their behavior and consequences.
Cognitive and Behavioral Signs of Adolescents and Adults with FASD

- Learning Disabilities

- Significant cognitive impairment to normal IQ

- Short term memory deficits

- Expressive language better than receptive

- Attention problems; ADHD

- Poor judgment and deficits in executive functioning—they need an external brain (someone to work with them to help them plan, organize, and make sound decisions)

- Social and sexual exploitation, or inappropriate behavior

- Increased expectations of the patient by other people
Cognitive and Behavioral Signs of Adolescents and Adults with FASD

- Increased dissatisfaction towards the patient by withdrawal and isolation

- Unpredictable behavior

- Unable (not unwilling) to accept responsibility

- Self-centered - behave as if the world revolves around them

- Always having to have their own way and willing to do anything to have it

- Demand and expect immediate gratification

- Skilled at shifting blame

- Engaging and charismatic yet creative at re-framing reality (lying stealing, etc.)
Cognitive and Behavioral Signs of Adolescents and Adults with FASD

- Moral chameleons; excessive vulnerability to peer influence

- Hyperactive in non-goal directed activity.

- Unable to stay focused on task, ie to follow rules, finish household chores, school assignments or keep commitments.

- Shortsighted
Cognitive and Behavioral Signs of Adolescents and Adults with FASD

Mood Swings

- Impulsive and uninhibited
- Passive and with drawn one minute, switching to volatile temper tantrums the next.
- Unpredictable - may need 24 hour supervision

Genuine Innocence and Detached Attitude

- Toward the predicaments they get themselves and their families into.
- Toward authority when caught breaking the rules of society.
- Toward their behavior and consequences.
The following slide shows the difference in ability level. A 21 year old may be physically mature as other 21 year olds but his life skills may be quite low. Even children and adults with a normal or above average IQs, in general, function at a much lower level. However, people with FASD are individuals, and some will function quite well in society with specific supports.
Often in the adolescent and adult with FASD secondary disabilities emerge. Secondary disabilities are believed to result from complications of undiagnosed or untreated primary disabilities.

**Secondary Disabilities Associated with FASD:**

- Mental health problems (90% all ages)
- Disrupted school experience - suspensions
- Expelled or dropped out (60%, 12 years and older)
- Trouble with the law (60%, 12 years and older)
- Confinement including inpatient treatment or incarceration (50%, 12 years and older)
- Inappropriate sexual behavior (50%, 12 and older)
- Alcohol and drug use problems (30%, 12 and older)
- Needing dependent living situations (80%, 21 and older)
- Problems with employment (80%, 21 and older)
Secondary Disabilities Associated with FASD

- Mental health problems (90% all ages)

- Disrupted school experience - suspended expelled or dropped out (60%, 12 years and older)

- Trouble with the law (60%, 12 years and older)

- Confinement including inpatient treatment or incarceration (50%, 12 years and older)

- Inappropriate sexual behavior (50%, 12 and older)

- Alcohol and drug use problems (30%, 12 and older)

- Needing dependent living situations (80%, over 21)

- Problems with employment (80%, 21 and older)
• To better illustrate how individuals are diagnosed, the following case study are presented. It can be handed out and used as tools for discussion when teaching others.

CASE STUDY #1

• 19 year old male
• Referred by biological father
• Father having difficulty coping with him

MEDICAL HISTORY
• Good general health
• Biological mother drank beer/vodka coolers throughout the pregnancy daily
• No congenital anomalies

SCHOOL HISTORY
• Learning problems in school from start of school
• Diagnosis of ADHD
• Given extra help in early years
• Increasing behavioural problems as school progressed
• Diagnosed low I.Q.
• Transferred to several different school programs
• Continued to struggle
• Increased violence at school
• Started drug use
• Joined a gang
• *Kicked out* of school at age 15

EMPLOYMENT HISTORY
• Can’t hold a job
• Forgets to show up
• Can’t wake up after alcohol binges
• At times, has lived on the streets

PROBLEMS
• Minimal education
• Low I.Q.
• Drug addiction
• No job
• Poor impulse control
• Poor attention
• At risk for continued homelessness

Making a Diagnosis
• Physical exam and history - Normal Examination, no anomalies, no growth restriction including head circumference, weight and height both as an infant and at current age. Normal genetic testing.
• Facial features- No FAS features – lip good shape, philtrum developed, eyes normal size
• Psychological testing- Low IQ, poor attention, and problems in executive functioning
• Documented history of prenatal alcohol exposure

What is the diagnosis?
Diagnosis

This young man was given the diagnosis of Alcohol Related Neurodevelopmental Disorder.

He had the prenatal history alcohol history primarily because he was referred by his biological father. It is often difficult to get a prenatal exposure history particularly for a homeless youth or adult. The history is very distant, the family, either biological or adoptive, may not be involved to provide a history. It is crucial to obtain a prenatal alcohol exposure history to make a diagnosis.

Why Diagnose?

• Validation
• Different approach to the individual
• Opening doors for services and support both for the individual and family
• New understanding leads to new strategies at home and other environments
• Facilitates funding in school and obtaining a disability pension if needed
• Better medical management
• In the child and adolescent, helps to prevent secondary disabilities
• In the individual whose birth mother is able to get pregnant a diagnosis may prevent the birth of another alcohol affected child.
Why Diagnose?

- Validation
- Different approach to the individual
- Opening doors for services and support both for the individual and family
- New understanding leads to new strategies at home and other environments
- Facilitates funding in school and obtaining a disability pension if needed
- Better medical management
- In the child and adolescent, helps to prevent secondary disabilities
- In the individual whose birth mother is able to get pregnant, diagnosis may prevent future alcohol affected children.
Chapter 4:

General Strategies for Working with Individuals with FASD
General Strategies for Working with Individuals with FASD

Learning Objectives

The learning objectives for this chapter are:

1. To identify strategies for working with individuals with FASD.
2. To apply those strategies to a case study exercise.

The following are general strategies that can be used by homelessness service workers to support and interact with individuals with FASD.

General Strategies for Working with Individuals with FASD

Observe Patterns of Behaviours
Identify patterns which reflect developmental stages which may be independent of chronological age. May be delayed in some areas; work with them at their level.

Identify Strengths, Skills and Interests
Work with them to identify and build on strengths. Help them to “get to know themselves” in order to learn about their own skills and interests. They will learn and relate through their strengths and interests.

Reframe the Interpretation of Behaviours
Move from seeing behaviours as willful misconduct and manipulation. Understand their underlying neuro-developmental disorder. They are not lazy or unmotivated but frustrated and exhausted.

Provide Structure Rather Than Control
Recognize power struggles: Disengage – Deescalate – Reevaluate – Create. Structure enhances respect, involves the individual in developing an internal structure and empowers the individual. Involvement in the creative process increases the possibility of retention and success.

Establish Routines and Consistency
Introduce and modify gradually, as developmentally appropriate. Try to forget their chronological age and work to their abilities. Usually unable to learn “incidentally” or adapt quickly.

Build Transitions Into Every Routine
Gently forewarn. Resistance and difficulty with any transition is to be expected and dictates a lengthy and gentle “change time.”

Model Behaviours

Demonstrate – Articulate – Communicate – reinforce the range of emotions, their resolutions and other behaviours. Indirect learning, by implication, is often unavailable to them. Don’t just tell them, show them too.

Provide Simple Instructions or Cues

Use simple words. Do not use figures of speech, euphemisms, vague or misleading terms. Never assume the individual with FASD understands. Combine with above modeling when possible. Provide one direction at a time. Processing deficits may not allow for retention or following a series of instructions. It is often necessary to instruct more than once, especially in transition times such as time to turn off the television and come to dinner.

Identify Behaviours Which Indicate the Accumulation of Frustrations

Persistence, irritating behaviours, anger avoiding and playing dumb are all behaviours to watch for. Help to develop skills for resolving frustration. Keep it as concrete as in, “What does that make you want to do?” Think about things like hunger, exhaustion and sadness as part of the equation. They may not recognize physical or emotional indicators of distress or be able to access them.

Recognize individual tolerance and triggers, and anticipate the onset of the loss of control. Factors such as hunger, thirst, blood sugar levels, time of day, or fatigue make a big difference.

Help Develop Skills for Expressing Feelings

Art, music, drama provide a bridge to verbalize feelings.

Provide Specific Support for Social Skill Development

Teach social skills in context. Put words on the things that are usually taken for granted. Monitor social ostracism. People with FASD typically miss social cues such as body language and facial expressions.

Understand the Various Forms of Communications

Identify the range of behaviours which may reflect the individual’s attempts to communicate. They may attempt to communicate through increased movements, subtle verbal or nonverbal cues, aggression, or withdrawal.

Include as Many Sensory Modalities as Possible To Facilitate Integration of Information and Experience

Be sure to include references to sight, sound, touch, taste, smell, emotion, action, and colour when sharing information and experiences. These individuals with FASD learn best from a MULTI SENSORY, concrete approach.

Information Processing Deficits and How They Manifest

Individuals with FASD may not have the ability to translate information into appropriate action. They fail to generalize information. They have difficulty
perceiving similarities and differences. Recognize that spotty learning as normal, and work with the individual to devise strategies to compensate for deficits. An individual with FASD may require specific cues to access previously stored information. Repeating efforts to teach to the deficits will continue to be exercises in futility.

Reevaluate Expectations and Goals for the Individual: Clarify Whose Needs are being met By the Goals

It’s important to work together to revise goals and expectations and modify as required through observations. Appropriately modify goals without compromising or limiting potential. Be sure to include social skills in goal setting. Remember: there is no “norm” for FASD. There is a broad range of types and degrees of effects.

Clarify Goals and Values for Education/Job Training and Independence

Advocate – Anticipate – Co-ordinate - Accept

Assure Integration of Culturally Relevant Values and Traditions

Teach skills in context of individual’s natural environment. Integrate experience, relevancy and good teaching. They tend to learn through action or experience. Since their ability to integrate information is impaired, it is important to link information with internal structure.

Environment

Ensure the physical environment is safe, organized, consistent, predictable and comfortable. Choose dim, quiet, calm spaces, avoid clutter and decrease sensory stimuli. Do not place an individual with FASD in a high traffic area, such as close to entrances or exits.
General Strategies for Working with Individuals with FASD

- Observe Patterns of Behaviours
- Identify Strengths, Skills and Interests
- Reframe from the Interpretation of Behaviours
- Provide Structure Rather Than Control
- Establish Routines and Consistency
- Build Transitions into Every Routine
- Model Behaviours
- Identify Behaviours Which Indicate The Accumulation of Frustrations
General Strategies for Working with Individuals with FASD

- Help Develop Skills for Expressing Feelings
- Provide Specific Support for Social Skill Development
- Understand the Various Forms of Communications
- Include as Many Sensory Modalities as Possible To Facilitate Integration of Information and Experience
General Strategies for Working with Individuals with FASD

• Integrate Awareness of All Components of Information Processing Deficits and How They Manifest

• Reevaluate Expectations and Goals for the Individual

• Clarify Goals and Values for Education/Job Training and Independence

• Assure Integration of Culturally Relevant Values and Traditions

• Ensure Physical Environment Is Appropriate
The following case studies can be handed out and used as tool for discussion when teaching others. Consider how these case studies would apply to your shelter or to the services your facility/organization provides.

Case Study #1

Robin is a 16 year old boy from Northern Ontario. He entered a downtown Toronto shelter 2 weeks ago. He shares a room with 3 other boys who are jumping on his bed and playing loud music. The room is placed near the elevator door and is quite noisy. His roommates are older and street wise. They make fun of Robin because he is timid and naive.

The staff at the shelter finds Robin's behaviours difficult to manage. He will at times scream for long periods with no apparent reason. He has difficulty following the shelter rules and often comes back after the curfew. He is lazy and will not help out with chores. He refuses to give them information about his past or how to contact his family.
Analysis

What the staff of the shelter doesn’t know is that Robin was diagnosed with FAS when he was a small child. Robin may be screaming because he is overwhelmed with the sensory stimulation provided by his roommates and from the noise of the elevator. He may not be following the shelter rules because he never “heard” those rules. He’s not be participating in house chores because he doesn’t know how to. The directions he was given are too overwhelming for him. Robin may not be providing staff with information because he doesn’t remember.

Strategies to Help Robin

Reduce the stimulation in his environment - move away from elevator, provide a room with fewer roommates and less noise.

Explain the house rules using simple words and sentences and lots of repetition.

Write the rules on a paper for him.

Help Robin to participate in house chores by providing one direction at a time.

Do not assume he is lazy.

He may not be refusing to provide history. Rather, he may be unable to provide the necessary detail and be hesitant to offer what he does know. Use as many sensory modalities as possible to elicit information from Robin.
Case Study #2

Tina is a nineteen year’s old Aboriginal girl with FAS who has been in and out of different foster homes in her early years. At age nine Tina entered her last foster home where she was adopted at age 12. Tina’s life prior life to adoption was abusive. Her birth her mother and mother’s partner were involved heavily in street life, alcohol drugs and prostitution.

Tina was the second oldest of seven child raised in her adoptive home. Three younger siblings, diagnosed with FAS, were also Aboriginal and represented two different Nations - Ojibway and Cree. Tina’s adoptive family was very open about disabilities and created a living situation to accommodate and improve the quality of life of the children they were raising. Education systems, family services and social services had been less supportive.

Tina had a difficult time telling the truth to peers and caregivers. On several occasions she found herself in difficult situations when she was confronted with her lies. Tina was very quiet and withdrawn and sometimes viewed by others as over dramatic. Tina’s short term memory and immature behaviour created many barriers for her in social situations. Her closest relationship was with her biological sister who was one year younger then her.

She left home at age nineteen. She lived with her oldest sister and niece before coming to live in a shelter. Tina’s relationship with her sister’s began to break down due to her stealing and telling of lies. Both sisters tried to deal with the situation, one day at a time, but Tina became self destructive. Tina’s older sister could no longer live with her, and Tina entered a shelter.

Tina’s was seeing two young men at the time she arrived at the shelter. Many times she created lies about both of them and forgot what lies she told support staff. This again created a difficult situation for Tina. Tina began making plans to leave the shelter to live with her birth mother and partner who she had not seen since she was nine. The adults lived in Vancouver and who were still involved in crime, prostitution drugs and alcohol.
Analysis

Tina may have been nineteen years old physically, but her level of functioning was clearly at a much lower level. Tina showed the cognitive and behavioural signs that are found in adolescents and adults with FASD - learning disabilities, short term memory deficits, poor judgment, withdrawal and isolation, unable to accept responsibility. Tina also displayed genuine innocence and a detached attitude toward the predicaments she found herself in and put her family in. Similarly, she showed a detached attitude toward authority when breaking rules of society. Tina had many secondary disabilities associated with FASD including mental health problems, disrupted school experience, problems with employment and needing dependent living.

Although Tina was moved in foster care several times before age nine, she had had a structured safe environment in the same home from the age of nine to eighteen. Tina’s major issues are that she was engaging and charismatic yet creative at re-framing reality - lying, stealing - and very skilled in shifting blame.

Strategies to help Tina

Tina would benefit from a Case Manager, with a “wrap around effect”. Thus, everyone involved in Tina’s plan of care would regularly communicate with each other and Tina. This would reduce the conflict in the information Tina was giving to the people supporting her, and it would allow those helping her to confront her about her storytelling.

Tina would also benefit from a referral to a therapist that would assist her with other unresolved issues in her life. This should include brief crisis intervention regarding decision to move out to Vancouver to be with her biological mother.

A referral should go out to an Aboriginal Organization, where she could receive other services such as employment training, supportive housing, and counseling. These services could assist her in improving her quality life. Tina qualified for disability assistance and should receive guidance in applying for this service.
Chapter 5:

Learning Styles of Individuals with FASD
Learning Styles of Individuals with FASD  Chapter 5

Learning Objectives

Learning Objectives of this section are to:

1. Describe learning styles that are effective for individuals with FASD.
2. Describe specific strategies used to facilitate learning of individuals with FASD.
3. Apply this knowledge about learning styles of individuals with FASD to a case study.

Introduction

Consider the following situations:

A student in your class had a car accident and now travels by wheelchair. You must move the furniture in your class to accommodate him every day. A child has developed diabetes and requires insulin shots which you must administer. Would you think twice about denying either of these students what they need? No, of course not. They can't get along without them. It’s not that they won't, but they can’t.

Jimmy and Jessica both have FASD and can't memorize, remember, divide, sit still, understand consequences or produce a whole host of other pro-social behaviours. Their brain damage is caused by maternal alcohol use and is permanent and irreversible. It is not that they won't do something, but they can’t. When we realize and accept these individuals for what they are, hope for their future is possible.

Remember individuals with FASD have strengths. Allow them to develop those strengths in order to build self-esteem and prevent secondary disabilities.

Learning Environments

FASD can be thought of as an information processing disorder of enormous proportions when attempting to predict its educational consequences for students.

Children, adolescents and adults with FASD benefit most from a tactile learning environment followed by a visual environment. For example,
**Tactile Learners** –

- benefit from posters and models in the classroom
- enjoy "hands-on" activities
- must write things down several times in order to remember
- like to play with things such as keys, coins or pens while listening
- chew gum or snack while studying
- learn by taking things apart and putting them together
- enjoy classes with physical activity and movement

**Visual Learners** –

- like making notes from the blackboard
- like writing things down
- are good at graphing, chart and mapping/following map directions
- prefer reading to listening
- picture or visualize things in their heads
- are good at jigsaws, puzzles and mazes

**Six Strategies for Teaching Individuals with FASD**

Six strategies that have been found to be quite successful when teaching individuals with FASD are:

1. Structure and routine is critical – nothing unexpected should happen.
2. Less talk and more multi-sensory learning opportunities (related to learning styles).
3. Be concrete and don’t assume anything. Teach and re-teach.
4. Facilitate language. Use specialists to help with language development.
5. Gross motor programming is important. These students need to move.
6. Reduce stimulation, use visual cueing.
Six Strategies for Teaching Individuals with FASD:

1. Structure and routine is critical – nothing unexpected should happen.

2. Less talk and more multi-sensory learning opportunities (related to learning styles).

3. Be concrete and don’t assume anything. Teach and re-teach.

4. Facilitate language. Use specialists to help with language development.

5. Gross motor programming is important. These students need to move.

6. Reduce stimulation, use visual cueing.

Remember always to foster the development of strengths displayed by individuals with FASD.
The following case study describes a rather typical phenomena in the school system - an undiagnosed teenager with FASD struggling to cope in a standard school program. The case study can be handed out and used as tool for discussion when teaching others. Consider how this case study would apply to the services your facility/organization provides.

**Case Study**

Jeannette is an attractive and seductive 16-year old in grade 10 at the secondary school where you are the vice-principal. Her average class size is 30 teens and she attends 4 classes a day. Jeannette is much more interested in the boys than her courses. She creates disruptions in most of her classes where she frequently arrives late. She often appears to be depressed and refuses to answer questions. She has been identified as Learning Disabled by the IPR Committee and qualifies for one period a day of withdrawal Special Education for Math, Science and organizational skills to help her do projects and homework. However, she often does not show up for these sessions and has taken to skipping off to the mall with her “carbon copy” peers. She often will not return that day and her teachers are grateful when she is absent.

Her parents are at their wits’ end. They know she is abusing drugs and alcohol. She shoplifts frequently and is partying hard. They realize that she is now totally out of their control. On weekends she disappears and they never know where she is or if she will come home alive from her many risky activities. The stress on their marriage is extreme but they are getting some help from an excellent parents support group they have joined.

Jeannette is failing every course except art where she displays a particular giftedness and creativity with conventional and computer-generated artistic projects. It is now April, when vice-principals often ask students who will not “make it” to leave school. Jeannette is doing nothing here but annoying her teachers and damaging the learning environment for her peers. You ask her to leave and get a head start on finding a summer job. Her parents support you in this action. Jeannette is demitted and spends the summer partying and sinking deeper and deeper into depression.
Analysis:

This is a classic FASD manifestation that we see all the time in secondary schools. (The boys tend to rage more than the girls and are more likely to get expelled for a Safe Schools issue such as “attacking” a teacher or bringing a weapon to school.) Teachers need to be able to shift the paradigm and see the Jeannette’s of this world as brain-damaged, rather than seductive little nuisances making there lives hellish. ‘It is not that they won’t but they can’t.’ They need to adapt their teaching styles and the environment to meet Jeannette’s needs. Jeannette may be disruptive because she just can not process the information provided in the classroom, or the constant changing of rooms. She may not show up for her special sessions because she can not remember to.

Strategies that may help Jeannette are:

1. Place Jeanette in a class of less than 10 teens.
2. Arrange to have her not have to move from class to class.
3. Use tactile and visual methods to convey information and concepts.
4. Have the resource teacher come to get Jeanette or provide cues so she does show up for one-on-one sessions.
5. Help build Jeannette’s self-esteem by allowing her to spend more time doing art.
6. Work with her family to help her get to school on time and reinforce concepts and new learning at home without overwhelming her with homework.
7. Refer Jeanette to a school psychologist/counselor to help with her depression.
Chapter 6:

Considerations for Law Enforcement Workers
Learning Objective

The learning objective of this section is to:

1. To describe 4 reasons why police need to be sensitized and educated in the area of FASD.

The following text was taken from a handout provided at the FAS @ Street Level Conference during a workshop conducted by Constable Annette Laporte of the Royal Canadian Mounted Police “D” Division, and by Terralyn McKee, Executive of the Pas Family Resource Centre.

Background

In the government’s speech from the throne on January 31st, 2001, efforts were pledged toward reducing the incidence of FAS. In the 2001 “Shared Vision Statement” of the RCMP “D” Division and the Province of Manitoba, understanding and improving services toward FAS issues was a priority. We endeavored to determine how and where the RCMP could improve services with this audience. We found that not only do police officers have a vital role to play, but also that the officers themselves needed to become better educated with respect to Fetal Alcohol Spectrum Disorder (FASD). Moreover, a need to change the methods in which police services are delivered to individuals with FASD was identified. As a result, the RCMP “D” Division partnered with The Pas Family Resource Centre as well as many other organizations and experts to develop an educational and training initiative on FASD specifically for law enforcement officers.

LAW ENFORCEMENT

Why do police need to be sensitized and educated in the area of FASD?

1) To better serve communities:

Research as to how and where police officers can assist in the area of FASD indicates that police officers need to be sensitized and trained in dealing with FASD. This means providing officers with the knowledge and skills to help identify and support those with FASD rather than constantly “throwing the book” at these individuals. Considering that a high percentage of individuals with FASD become involved in the criminal justice system, police officers have a role to play as service providers to this population. Information regarding this issue that is available at the community level and to the judicial system, must also be available to police. The police require this information in
order to improve policing services so that the rights of victims, witnesses and suspects with FASD are safeguarded. These individuals and their families need help from within the system.

2) To ensure the integrity of investigations, to be forthright within the judicial process and to protect the rights of the people being served:

Individuals prenatally affected by alcohol have a variety of disabilities including: distinguishing right from wrong; inability to understand the concept of ownership; learning disabilities; and difficulty understanding abstract concepts such as “waiving their rights”. Many FASD individuals often have the functional capacity of an eight year old. Recognizing that police officers are front line workers and come in contact with a high number of victims, witnesses and suspects who may be prenatally affected by alcohol, it is evident that there is a significant need to train police officers on FASD. In order to redress the conditions that these individuals may be inadvertently subjected to as they are processed through the justice system, some of the areas to be revisited include: statement taking; understanding and exerting legal rights; ensuring compliance with Canadian Charter of Rights and Freedoms provisions on arrest; sentencing considerations/alternative measures; and victim/witness assistance.

3) To have a beneficial impact on the legal system:

In 1997, Dr. Julianne Conry and Dr. Diane Fast of British Columbia conducted research that revealed that over 23.3% of the individuals in a youth correctional facility had Fetal Alcohol Syndrome or a related disorder. It is estimated that up to 70% of individuals with FASD will become involved with the criminal justice system. The criminal justice system – including law enforcement – plays a pivotal role in addressing the damaging secondary effects of FASD. These secondary characteristics place FASD individuals at a proportionately higher risk for school drop out, delinquent behaviour, homelessness, alcohol and drug addictions, mental health issues and further involvement with the law as either offenders or victims. Because law enforcement officers and members of the court deal with the effects of FASD on a daily basis, training and education in FASD is imperative if the cycle of alcohol related effects is to be addressed and broken.

4) To help with prevention effort to reduce incidence of FASD in the country:

Police officers are the one common denominator present in every single community in Canada, including Canada’s most northern isolated settlement in Nanavut, Grise Fiord. This means that police officers are highly responsible for prevention initiatives in the communities they serve. Training police on the topic of FASD would, therefore, enable prevention and awareness to be present throughout the entire country. This would most definitely have a beneficial impact on the future of the nation with regard to the reduction of
FASD and related disorders. It would also ultimately translate into reduction of crime, given the number of FASD individuals who become involved in the justice system at present.

5) To mobilize supports to FASD affected individuals from the many services and agencies available in areas such as medical, social, educational, cultural, community, employment, housing and justice:

It is also proposed that police, being front line workers, could play a crucial role in helping to identify potential FASD individuals to the health authorities. While researching this area, one person commented “Police officers are often the first contact for a desperate family who know that something is very wrong with their child. If an officer is trained to recognize FASD characteristics, a diagnosis may be reached faster. Once this takes place, treatment can be initiated and many of the secondary disabilities can be prevented.”

Being front line workers, police often encounter individuals who may have FASD, or families at risk of FASD prior to the social, medical or educational agencies being aware. It is, therefore, possible for police officers to be involved in assisting with early diagnosis by alerting these agencies of their findings or suspicions. Early diagnosis is the key to preventing many of the secondary characteristics associated with FASD. Equipped with FASD training, officers would have the ability to impact tremendously on present and future lives. In the new initiative, a mandated networking component has been incorporated to ensure supports are enlisted when FASD individuals are encountered. The initiative proposes that police officers be required to partner in their respective communities with local health or FASD workers in order to deliver FASD training to fellow officers and community partners.

Awareness, prevention, identification and intervention are key components to creating systems that are better prepared to meet the needs of FASD individuals.

Several materials that will enable Law Enforcement Officers to train other officers are in the final stages of development. They are listed in the chapter entitled “Resources”.

Chapter 6: Considerations for Law Enforcement Workers
J FAS Int 2004;2:e10 June 2004
Page 58
Why police need to be sensitized and educated in FASD

1. To better serve communities.

2. To ensure the integrity of investigations, to be forthright within the judicial process and to protect the rights of the people being served.

3. To have a beneficial impact on the legal system.

4. To help with prevention effort to reduce incidence of FASD in the country.

5. To mobilize supports to FASD affected individuals from the many services and agencies available in areas such as medical, social, educational, cultural, community, employment, housing and justice.
Chapter 7:

Working with Families
Learning Objectives

The learning objectives of this section are to:

1. Identify strategies for working with families of homeless youth and adults.
2. To apply these strategies to a case study.

Introduction

There are many families out there worried about where their child is, bewildered about what they did wrong, and committed to helping their child. Certainly, one acknowledges that some youth come from negligent and/or abusive homes, and some are being parented by parents who themselves have FASD.

The following pages outline some strategies for working with families who can be reunited with their child.

Strategies for Working with Families

- Facilitate learning about FAS and other alcohol related effects.
- Provide parents with knowledge of child development and behaviour to help them recognize the unique pattern of each individual child.
- Ensure that appropriate assessments, diagnoses, and interventions are provided and that families are enabled to contribute.
- Design interventions that are family-centred and that provide families with specific skills in behaviour management.
- Provide knowledge of community resources and assistance to access those resources.
- Provide access to respite, counseling and emotional support that address early losses or abuse in the life of the parent, as well as guilt about the diagnosis of FAS (even adoptive parents experience guilt) — a safe environment to share feelings without fear of being judged.
- Recognize that parents who have grown up in communities with heavy alcohol use may themselves have FASD and require special assistance.
As the individual with FASD ages, so does his parents. Thus, the parents of an adult with FASD may need to identify a professional advocate for their child, identify other living arrangements and other sources of financial support.
Strategies for Working with Families

- Facilitate learning about FASD.

- Provide parents with knowledge of child development and behaviour.

- Ensure that appropriate assessments, diagnoses, and interventions are provided and that families are enabled to contribute.

- Design interventions that are family-centred and that provide families with specific skills in behaviour management.

- Provide knowledge of community resources and assistance to access those resources.

- Provide access to respite, counseling and emotional support.
Strategies for Working with Families

- Recognize that parents may themselves have FASD and require special assistance.

- Older parents of an adult with FASD may need to identify a professional advocate for their child, identify other living arrangements and other sources of financial support.
To better illustrate what life is like for a family of an individual with FASD the following “story” is presented. It can be handed out and used as a discussion tool when teaching others. Consider how this case study would apply to your shelter or to the services your facility/organization provides.

Case Study: One Family’s Story

When we adopted a beautiful baby girl, we thought of all the good times we would have helping her to grow up into the lovely woman we dreamed she would become. But our dreams turned into nightmares when in her teen years she embraced the wild life complete with alcohol, drugs, sex, dropping out of school and troubles with the law. We thought “Tough Love” would be the answer. Little did we know that she could not understand consequences and that none of our efforts with discipline would have any success at all. Nor did our many attempts at family counseling work.

She seemed unable to work and earn money, so she moved in with partners who could support her financially but who became physically abusive. She became an alcoholic and life for her was insane. We felt the pain and grief of loss -- loss of all hope of having a normal relationship with our daughter.

She was in her late 20’s when we read an article in Elm Street Magazine written by Bonnie Buxton describing her adopted daughter’s problems and how she discovered that fetal alcohol spectrum disorder (FASD) was the explanation for these problems. We began to suspect that our daughter had also been affected by prenatal exposure to alcohol, and when we learned that her biological mother was addicted to alcohol we were even more sure.

We joined a parent support group -- FASworld Toronto organized by Ms Buxton and her husband Brian Philcox. We have been attending this group for four years learning all we can about FASD. We have attended two FASD conferences -- one in Vancouver and one in Toronto -- both of which educated us immensely. A workshop given by Chris Margetson also helped us understand persons with FASD. We began to see that our daughter was not “non-compliant” but rather “non-competent” and if we had known this when she was younger, we would have dealt with her quite differently. However, “better late than never”. When the bottom fell out of our daughter’s life and she came to us for help, she realized she had to address a drinking problem, and follow through on the diagnostic process. Miraculously, she was able to stop drinking and when she learned that she was pregnant, she was highly motivated to refrain from drinking as she didn’t want to harm her baby.

We were able to steer her to the new FASD diagnostic team at St. Michael’s Hospital in Toronto. We escorted her to many appointments for testing, because she wouldn’t have been able to follow through on her own. She eventually received a diagnosis of alcohol-related neurological disorder (a form of FASD)
and probable bipolar disorder. With our help and that of the hospital, she was able to submit the necessary papers to the Ontario Disability Support Program. With her own source of income, she will no longer be dependent on abusive relationships for support. Finding an apartment for her, her boyfriend and her new baby was extremely difficult but with considerable effort on our part, this has been accomplished and they are safely settled in and coping.

In order to cope, the person with FASD requires help -- “the external brain” -- and at this point our daughter is willing to let us help with banking, shopping, getting to appointments, etc. However, we are not young and won’t be here forever. The resources of the community are very limited. Our support comes from FASworld, and from our church, family, and friends, but our daughter needs much more support. With help, there is hope for adults with FASD. Without help there is only “the street” and homelessness.
Analysis

In this story, with the help of a support group, the family was able to benefit from the majority of the strategies listed above. As they become unable to serve as her “external brain”, they will need a personal advocate for their daughter and more intense community supports to transfer the burden from them to others in the community.
Chapter 8:

Next Steps: 
Building a Response Network in the Community
Next Steps:
Building a Response Network in the Community

Objective

1. To identify key steps in building a response network in the community.

Introduction

As this is relatively new territory we will have to look critically at the services we are providing and advocate for changes that make these services more accessible to homeless people with FASD. This manual is only a beginning step in advocating for people with FASD who are homeless.

Steps in Building a Response Network in the Community

1. Only recently has “FASD” and “Homelessness” been seen as one problem rather than two distinctly separate problems. It is necessary to identify homelessness service providers, parents, teachers, health professionals, law enforcement officers, government representatives and others in communities throughout Canada who are enthusiastic about working together on the major problem of FASD and homelessness.

Steps in Building a Response Network in the Community

1. Only recently has “FASD” and “Homelessness” been seen as one problem rather than two distinctly separate problems. It is necessary to identify homelessness service providers, parents, teachers, health professionals, law enforcement officers, government representatives and others in communities throughout Canada who are enthusiastic about working together on the major problem of FASD and homelessness.

2. It is necessary to create a taskforce in each community that consists of these key players. These taskforces may work out of already existing community committees or programs. For example, in Toronto the steering committee who worked on the FAS @ Street Level Conference, and some of the participants who attended the conference may wish to develop a taskforce.

3. It is necessary that each task force in each community identify issues specific to that community. For example, some communities may lack diagnostic services, others may lack appropriate housing, and others may be only learning about the link between FASD and homelessness.
4. It is necessary for each task force to communicate with each other, share their work, insights and experiences.

5. Finally, representatives from each taskforce should consider meeting with officials from the Homelessness Secretariat to develop a National Strategy.
Steps in Building a Response Network

• Identify homelessness service providers, parents, teachers, health professionals, law enforcement officers, government representatives and others in communities throughout Canada who can work together on the major problem of FASD and homelessness.

• Create a taskforce in each community that consist of these key players. These taskforces may work out of already existing community committees or programs.

• Each task force in each community must identify issues specific to that community.

• Each task force must communicate their work regularly with each other.

• Representatives from each taskforce should consider meeting with officials from the Homelessness Secretariat to develop a National Strategy.
Conclusion

This Training Manual was an important step in acknowledging that Fetal Alcohol Spectrum Disorder (FASD) is a significant factor in causing homelessness and also that FASD presents unique challenges to homeless people.

It is essential that frontline workers in the homeless sector are able to recognize FASD in homeless individuals and also are able to begin provide interventions and referrals that better meet the needs of this population.
Chapter 9

Resources
## Resources

### Canada’s FASD Diagnostic Centres

<table>
<thead>
<tr>
<th>Centre Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta Children’s Hospital, Fetal Alcohol Syndrome Clinic</td>
<td>1820 Richmond Road S.W., Calgary, Alberta T2T 5C7</td>
<td>(403) 943-7224</td>
</tr>
<tr>
<td>Alvin Buckwold Child Development Program, Kinsmen Children’s Centre</td>
<td>1319 Colony, Saskatoon, SK S7N 2Z1</td>
<td>(306) 655-1070</td>
</tr>
<tr>
<td>Anishnawbe Health Toronto – St. Joseph’s Health Centre</td>
<td>225 Queen Street East, Toronto, ON M5A 1S4</td>
<td>416-360-0486</td>
</tr>
<tr>
<td>Asante Centre for Fetal Alcohol Syndrome</td>
<td>22326 (A) McIntosh Ave., Maple Ridge, BC V2X 3C1</td>
<td>604-467-7101</td>
</tr>
<tr>
<td>Glenrose FASD Clinical Service (University of Alberta)</td>
<td>10230 - 111 Avenue, Edmonton, Alberta T5G 0B7</td>
<td>780-471-7963</td>
</tr>
<tr>
<td>Native Child and Family Services of Toronto – St. Michael’s Hospital</td>
<td>464 Yonge Street Suite 201, Toronto, Ontario M4Y 1W9</td>
<td>(416) 969 8510</td>
</tr>
<tr>
<td>St. Michael’s Hospital</td>
<td>Fetal Alcohol Spectrum Disorder Diagnostic Clinic</td>
<td>61 Queen Street, Toronto, ON M5B 1W8</td>
</tr>
<tr>
<td>Substance Exposure Resource Team</td>
<td>Sunny Hill Health Centre for Children</td>
<td>3644 Slocan Street, Vancouver, British Columbia V5M 3E8</td>
</tr>
<tr>
<td>The Children’s Hospital of Winnipeg, Health Sciences Centre</td>
<td>Clinic for Drug and Alcohol Exposed Children (CADEC)</td>
<td>840 Sherbrook Street, Winnipeg, MB R3A 1S1</td>
</tr>
<tr>
<td>The General Hospital, Health Sciences Centre, Medical Genetics Program</td>
<td>300 Prince Phillip Drive, St John’s, NF A1B 3V6</td>
<td>709-777-6300</td>
</tr>
<tr>
<td>The Hospital for Sick Children, Motherisk Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reading Materials Relevant to FASD and Homelessness


Videos Relevant to FASD and Homelessness

David with FAS (1996), Kanata Productions, National Film Board of Canada & CBC

A 45-minute video about David Vandenbrink, a 21-year-old man with FAS whose condition went undiagnosed for 18 years.

Video can be ordered by phone, (867)920-2644 or fax, (867)920-2348

Different Directions: Understanding Fetal Alcohol Syndrome (2000)
- to be confirmed by Margaret Leslie

Fetal Alcohol Syndrome/Fetal Alcohol Effect: Stories of Help and Hope

Good for understanding brain differences related to presenting behaviors. Information and experiences from professionals, biological, foster, and adoptive parents, and adolescents who have prenatal alcohol exposure.

To Order Contact: Hazelden 1-800-328-9000

Fetal Alcohol Syndrome: Life Sentence

Fetal alcohol syndrome is the result of permanent organic injury to the brain of the fetus, caused by maternal drinking during pregnancy. That injury leads to learning disabilities, poor judgment, antisocial behavior, and worse, if a recent study is correct. This program discusses FAS within the context of that study which suggests that 20 to 25 percent of all prison inmates may suffer from the condition. The program examines how early identification and treatment of children with FAS can help prevent extreme antisocial behavior in adulthood. (24 minutes, color).

To Order Contact: Cambridge Educational's (1-800-468-4227).

Honour of All, Part 1 and 2; The Story of Alkali Lake (56:40 minutes)

Stripped of their native culture and religion after the coming of the white men, the people of Alkali Lake were left with a void in their lives that begged to be filled. Thus they were ripe for the introduction of the devastating force of alcohol. This story of heartfelt recovery from almost complete cultural and spiritual destruction is true. All the incidents depicted occurred between 1940 and 1985.

To Order Contact:
Four Worlds International Institute for Human and Community Development
Four Directions International
347 Fairmont Boulevard, Lethbridge, AB T1K 7J8
Phone: (403) 320-7144 Fax: (403) 329-8383
Journey Through the Healing Circle; an innovative series on Fetal Alcohol Syndrome (2000); Produced by the Washington State Department of Social and Health Services (DSHS)

“Journey Through the Healing Circle" is a series narrated by Native American Storyteller Floyd Red Crow Westerman, who uses animal stories to talk about children with Fetal Alcohol Syndrome (FAS) and the problems families face with these effects.

"Journey Through the Healing Circle" is now available to parents, schools, and other social service agencies as a series of videotapes, video CDs, and professionally illustrated workbooks.

To Order Contact:
Washington State Alcohol/Drug Clearinghouse
3700 Rainier Avenue South, Suite A, Seattle, WA 98144
Telephone: (206) 725-9696 or (800) 662-9111 Fax: (206) 722-1032
Email: clearinghouse@adhl.org

“What is FAS?” (24 min., 1990)

Designed for families, educators and health care professionals that examines the cause, treatment and prevention of alcohol-related birth defects. Highlights include interviews with mothers and families of F.A.S. children, and commentary from international experts.

To Order Contact:
Altschul Group, 1560 Sherman Avenue, Suite 100, Evanston, Illinois 60201.
Tel. 1-800-323-9084 or 1-800-232-3263.

Worth The Trip

“Worth the Trip” is the first comprehensive video resource about the health, development and learning styles of children and adolescents affected by fetal alcohol. The film presents strategies for meeting the developmental and behavioral challenges faced by children and adolescents with FAS and the parents and professionals who care for them.

To order Contact: Vida Health Communications
6 Bigelow Street, Cambridge, MA 02139
Telephone: (617) 864-4334 Fax: (617) 864-7862

What is FAS? (1989) Program 1
Preventing FAS (1989) Program 2
Living and Learning with FAS (1990) Program 3
Produced by BC FAS Resource Society

To Order Contact:
Available from Image Media Services
Phone: (604) 272-7797 Fax: 272-7798
Other Materials

**FAS and Law Enforcement Power Point Presentation & Training Manual**
A 4-hour power point presentation covering FASD – definitions, features, characteristics, strengths, effects and influencing factors and more. FASD & the law – Canadian Charter of Rights and Freedoms, statements, case law, investigations, restorative justice and more, and A Community Approach – networking, prevention, resources.

**FASD Train the Trainers Course**
A 2-day course created for experienced instructors on FASD. Officers with this training are required to partner with health or FASD workers in their respective communities and deliver training of FASD to fellow police officers and community partners.
Organizations and Agencies

National

Canadian Centre for Substance Abuse
75 Albert Street, Suite 300, Ottawa, ON, Canada K1P 5E7
T: (613) 235-4048 • F: (613) 235-8101 • www.ccsa.ca

The Canadian Centre on Substance Abuse (CCSA), Canada’s national addictions agency, was established in 1988 by an Act of Parliament. CCSA provides a national focus for efforts to reduce health, social and economic harm associated with substance abuse and addictions.

Motherisk, Alcohol and Substance Use in Pregnancy Helpline
The Hospital for Sick Children
555 University Ave., Toronto ON M5G 1X8
Tel: 1-877-327-4636 (toll free in Canada) • www.motherisk.org

Services: By dialing the toll free number in Canada, individuals who have questions or concerns related to alcohol and drug use during pregnancy and lactation will receive information, counselling and access to care in their home communities. Motherisk counselors can also make referrals for FAS diagnosis at the Motherisk Clinic, and can arrange hair and meconium tests for drug and alcohol exposure in newborn babies. Members of the medical profession who have questions or concerns about specific clients and their use of alcohol and/or drugs during pregnancy and while breastfeeding may also wish to consult this team of experts which includes pharmacologists, toxicologists, neurologists and pediatricians. This telephone service is available from 9:00 a.m. to 5:00 p.m. from coast to coast, Monday to Friday.

Association for the Neurologically Disabled of Canada (A.N.D.)
59 Clement Road, Etobicoke ON M9R 1Y5
Tel: (416) 244-1992; 1-800-561-1497 (toll free in Canada)
Fax: (416) 244-4099 • E-mail: info@and.ca • Web Site: www.and.ca

Services: A.N.D. Canada provides functional rehabilitation programs to individuals with non progressive Neurological disabilities. The programs are home-based, non-institutionalized and are individualized to meet the needs of each client and family. Individuals with a broad range of disabilities, including fetal alcohol syndrome, may benefit from the program.
Canadian Association for Community Living (CACL)
Ms. Monica Misra
Kinsmen Building, York University Campus
4700 Keele Street, North York ON M3J 1P3
Tel: (416) 661-9611 • Fax: (416) 661-5701
E-mail: info@cacl.ca • Web Site: www.cacl.ca

Services: CACL is Canada's national association dedicated to promoting the participation of people with intellectual disabilities in all aspects of community life. Please contact for information or referral to local associations and programs.

Canadian Institute of Child Health
Dr. Miriam Levitt, Executive Director
FASEout
300 - 384 Bank Street, Ottawa ON K2P 1Y4
Tel: (613) 230-8838, Ext. 232 • Fax: (613) 230-6654
E-mail: mlevitt@cich.ca • Web Site: www.cich.ca

Services: Funded through Health Canada's FAS/FAE Strategic Project Fund, FASEout is a three year, National Health Canada project designed to take current Best Practices related to FASD off the bookshelves and into use across Canada. Pilot sites from the health, education, judicial and social service sectors will be participating at the national, provincial and regional level, working through an Implementation Guide designed to assist organizations in linking research to policy and practice. By modifying policies and practices this project seeks to enhance national FAS/FAE information, resource networks and programs to provide needed support to children and families affected by FAS/FAE.

FAS Information Service
Canadian Centre on Substance Abuse (CCSA)
300 - 75 Albert Street, Ottawa ON K1P 5E7
Tel: 1-800-559-4514 (toll free in Canada);
Tel: (613) 235-4048, ext. 223 • Fax: (613) 235-8101
E-mail: fas@ccsa.ca • Web Site: www.ccsa.ca/fasgen.htm

Services: Through its National Clearinghouse on Substance Abuse, information resources are provided in answer to individual requests through the 1-800 number, fax, email and written request. Since April 2003, the National Database of FAS and Substance Use During Pregnancy Resources has been available. Funded through Health Canada's FAS/FAE Strategic Project Fund, this is a database of Canadian resources that have been authored, produced or published in Canada or that have Canadian content but have been published outside of Canada and are currently available to be ordered or purchased from the organization responsible. Search the database at www.ccsa.ca/fas.
FASworld Canada
  Ms. Bonnie Buxton
  Brian Philcox, Founders
  1509 Danforth Avenue, Toronto ON M4J 5C3
  Tel: (416) 465-7766 • Fax: (416) 465-8890
  E-mail: fasworldcanada@rogers.com • Web Site: www.fasworld.com

Services: FASworld Canada is a pro-active, non-profit organization which strives to dramatically reduce the incidence of fetal alcohol disorders, reduce the incidence of secondary disabilities among individuals living with mental or physical damage caused by maternal drinking in pregnancy and to assist families and caregivers of people with fetal alcohol spectrum disorder (FASD). FASworld Canada works with health units, family support groups and other interested organizations who form the chapter network in communities across the country. Individuals and groups are invited to apply for membership or chapter status.

Health Canada, FASD Team
  Ms. Mary Johnston, Manager
  Division of Childhood and Adolescence
  Room C967, Jeanne Mance Building
  Tunney's Pasture, Postal Locator: 1909C2, Ottawa ON K1A 1B4
  Tel: (613) 946-1779 • Fax: (613) 946-2324
  E-mail: mary_johnston@hc-sc.gc.ca • Web Site: www.healthcanada.ca/fas

Services: In 1999, funding of $11 million over three years was allocated to enhance activities related to: Public Awareness and Education, FAS/FAE Training and Capacity Development, Early Identification and Diagnosis, Coordination, Integration of Services, Surveillance, and a Strategic Project Fund. Health Canada's Division of Childhood and Adolescence role is to implement activities outlined in the initiative.

Centre for Addiction and Mental Health (CAMH)
  Ms. Sheila Lacroix, Library Coordinator
  Library, 33 Russell Street, Toronto ON M5S 2S1
  Tel: (416) 535-8501, ext. 6982 • Fax: (416) 595-6601
  E-mail: sheila_lacroix@camh.net; library@camh.net
  Web Site: www.camh.net

Services: With the back-up of an extensive collection of resources on the topics of Alcohol and Pregnancy and FAS/E, the CAMH Library reference service responds to requests for information and referrals from professionals, students and the general public. In addition, many of the library resources are available through inter-library loan within Canada.
Regional

FASAT (Ontario)

Ms. Chris Margetson, Executive Director
c/o Homewood Health Center, CADS
100 - 49 Emma Street, Guelph ON N1E 6X1
Tel: (519) 822-2476 • Fax: (519) 822-4895
E-mail: fasat@golden.net • Web Site: home.golden.net/~fasat

Services: This organization has been developed in order to meet the needs of children across Ontario with FAS/FAE by providing training for the professionals and parents who work with and care for them, by advocating and supporting families and by being involved in activities related to prevention.

FASD Aboriginal Support Group

Ms. Marja George, R.N.
Kettle and Stony Point Health Center
P.O. Box 670, Forest, ON N0N 1J0
Tel: (519) 786-5647 • Fax: (519) 786-4541
E-mail: marjag@ksphs.on.ca

Services: Provides support and information to families and individuals affected by prenatal alcohol exposure. Support group meetings are held on the last Thursday of each month.

FASD Durham

Ms. Marian Cook
6 Hogan Cres., Bowmanville ON L1C 4X9
Tel: (905) 697-9064 • E-mail: bcook0459@rogers.com

Services: FASD Durham provides training to service providers and parents and works within the community to meet the needs of children with FAS in the Durham Region; also coordinates a parent support group and the development of an identification and assessment team for Durham Children & Youth.

FASD Education Program

Ms. Su Knorr
c/o Rideauwood Addiction and Family Services
312 Parkdale Ave., Ottawa ON K1Y 4X5
Tel: (613) 724-4881 • Fax: (613) 724-4873
E-mail: knorr@sprint.ca Web Site: www.rideauwood.org
Services: FASD educational workshops are provided to teachers and students of secondary and post-secondary schools until June 2004.

FASD Ontario Region Lead
Ms. Sharri Kimberley
Healthy Child Development Team
55 St. Clair Ave. East, 3rd Flr., Toronto ON M4T 1M2
Tel: (416) 973-5659 • (905) 690-7913 • Fax: (905) 690-7917
E-mail: sharri_kimberley@hc-sc.gc.ca

FASlink
(Fetal Alcohol Spectrum Disorders Information, Support & Communications Link)
Mr. Bruce Ritchie, Moderator
2445 Old Lakeshore Road, Bright's Grove ON N0N 1C0
Tel: (519) 869-8026 • Fax: (519) 869-8026
E-mail: fas@acbr.com • Web Site: www.acbr.com/fas

Services: FASlink is a moderated email discussion group that provides support and information for individuals, families and professionals who are working with and caring for those affected by prenatal alcohol exposure. FASlink serves more than 200,000 visitors to its website annually. The FASlink Archives contain more than 70,000 letters and articles on FAS issues. FASlink's online discussion forum is the primary Canadian FAS communications network and includes members worldwide. FASlink publishes the FASlink CD-ROM and FAS InfoDisk (for download from the website). To join the list serv, send an email message to: majordomo@listserv.rivernet.net and, leaving the subject line blank, type - - subscribe faslink -- in the body of the message.

FASworld - Hamilton and District
Ms. Margaret Sprenger, President
#2 - 241 Queen St. South, Mississauga ON L5M 1L7
Tel: (905) 821-1590 • E-mail: margsprenger@sympatico.ca

Services: FASworld - Hamilton and District supports individuals and families affected by FASD, holds monthly meetings in Hamilton, disseminates knowledge and understanding of FASD and assists in the establishment of FASD diagnostic centers. You may also contact Rick and Martha Bradford at (905) 578-9091 or Barry and May Stanley at (905) 849-3860.
Ontario

FASworld Toronto
Ms. Mary Cunningham, President
Brian Philcox, Executive Director
1509 Danforth Ave., Toronto ON  M4J 5C3
Tel: (416) 465-7766  •  Fax: (416) 465-8890
E-mail: fasworldcanada@rogers.com  •  Web Site: www.fasworld.com

Services: Originally founded as Fetal Alcohol Support Network (Metropolitan Toronto and Peel), the group has changed its name in order to become the first chapter of FASworld Canada. The group meets on the second Saturday of the month at St. Michael's Hospital in Toronto in order to support families with members struggling with FASD. Membership is open to parents, caregivers, professionals and others interested in FASD prevention. Call Brian for further information.

Fetal Alcohol Information Support Network
Ms. Theone Collins
P.O. Box 20022
150 Churchill Blvd., Sault Ste. Marie ON  P6A 6W3
Tel: (705) 946-0638  •  Fax: (705) 946-3004
E-mail: the1collins.fassm@sympatico.ca  •  Web Site: www.soonet.ca/faisn

Services: The Network undertakes activities to help prevent alcohol related birth defects and provides support and information to those affected.

Fetal Alcohol Spectrum Disorder (FASD) Program
Ms. Maureen Parkes, FASD Coordinator
NorWest Community Health Centres
525 Simpson Street, Thunder Bay ON  P7C 3J6
Tel: (807) 622-8235  •  Fax: (807) 622-3548
E-mail: fas@norwestchc.org

Services: The program provides support for families, individuals of all ages and offers education to families and professionals in the community and offers non-medical assessments, resources, training, and advocate for programs and services for individuals affected by FASD. Referrals are made as necessary for clients to various organizations in the area.

Fetal Alcohol Spectrum Disorder Group of Ottawa
Ms. Elspeth Ross, Co-facilitator
Jill Courtemanche, Co-facilitator
Box 915, Rockland ON  K4K 1L5
Tel: (613) 737-1122  •  (613) 446-4144  •  Fax: (613) 446-4144
E-mail: rosse@freenet.carleton.ca
Services: The group provides support for families, and information and education for families and professionals on the effects of alcohol on people of all ages, and importance of prevention. Monthly meetings are held from October to June at the Children’s Hospital of Eastern Ontario (CHEO). Please contact Elspeth Ross for further details.

**Fetal Alcohol Support and Information Network (F.A.S.I.N.)**
**Mr. & Mrs. Dave and Margie Fulton**
P.O. Box 100, Murillo ON P0T 2G0
Tel: (807) 935-3168 • Fax: (807) 935-2198
E-mail: fulton@northroute.net

Services: F.A.S.I.N. provides support for families and individuals affected by FASD, education and training for professionals and the general community and a resource library for families, students and professionals.

**Fetal Alcohol Syndrome Treatment and Education Centre Inc.**
**Ms. Jill Dockrill**
202 Farley Avenue, Belleville ON K8N 4L5
Tel: (613) 968-8129 • Fax: (613) 968-5263 • E-mail: jillfastec@netscape.net

Services: This is a registered nonprofit organization with a mandate of awareness and prevention of FAS and advocacy for programs and services for individuals affected by prenatal alcohol exposure and is currently working towards establishing a Supportive Living Environment and Education Centre. A support group for primary caregivers, parents and individuals with FAS/FAE called 'Circle of Friends' meets off-site, the first Tuesday of every month.

**Healthy Generations Family Support Program**
**Ms. Judy Kay**
Sioux Lookout and Hudson Association for Community Living
Box 1258, Sioux Lookout ON P8T 1B8
Tel: (807) 737-1447, Ext. 224 • Fax: (807) 737-3833
E-mail: healthy@slhacl.on.ca • Web Site: www.slhacl.on.ca/fasd

Services: Healthy Generations Family Support Program provides services to families raising children with FASD.

**Kenora and area FAS/FAE Committee**
**Ms. Patti Dryden Holmstrom**
c/o Addiction Services Kenora Youth Program Lake of the Woods District Hospital
12 Main St. South, Kenora ON P9N 1S7
Tel: (807) 467-3575 • Fax: (807) 468-6093 • E-mail: pdryden@lwdh.on.ca

Services: The Committee undertakes activities related to prevention and community awareness.
Native Child and Family Services of Toronto
201 - 464 Yonge Street, Toronto ON M4Y 1W9
Tel: (416) 969-8510 • Fax: (416) 969-9251

Services: The following programs are available: Youth with FAS Support Group offers traditional and contemporary approaches to support aboriginal youth with FASD between the ages of 16-24; Children with FASD five day summer camp offers a safe and structured environment for children between the ages of 8 - 12, providing respite for caregivers; Parents with FASD Support Group is offered once a week and provides ongoing support for parents living with FAS (diagnosed or undiagnosed); Parenting Children with FASD is a ten week session that looks at education, behavioural and environmental techniques for caregivers and parents.

New Choices
Ms. Marilyn J. Guest, Program Manager
138 Herkimer Street, Hamilton ON L8P 2H1
Tel: (905) 522-5556 • Fax: (905) 522-6046 • E-mail: mguest@interlynx.net

Services: New Choices is an innovative, collaborative, inter-agency program that offers single access services of information, support, treatment and advocacy to women who are pregnant or parents of young children (0-6 years). The goal of the program is to empower women to make new choices that will reduce the incidence and impact of child development delays caused by prenatal exposure to drugs/alcohol and/or the impacts of a woman's poverty, substance use, mental health, and abuse survivor issues upon her ability to optimally parent, provide and care for, her children. The flexible services are provided in a safe, welcoming environment and include parenting, lifeskills, social recreational, addiction/mental health, and child development assessment, education and therapy. Child care is provided on site.

North Bay Indian Friendship Centre
Mrs. Shelly Sawyer, FAS/FAE Child Nutrition Community Support
980 Cassells Street, North Bay ON P1B 4A6
Tel: (705) 472-2811, Ext. 27 • Fax: (705) 472-5251
E-mail: ssawyer@nbifc.org • fas-fae@nbifc.org • Web Site: www.nbifc.org

Services: The FAS/FAE Child Nutrition program provides one-on-one support, referrals to health care providers and programs that are offered at the Centre, awareness workshops and presentations and includes a nutritional component for the Aboriginal community.

Northumberland Family Respite Services Inc.
Ms. Yvonne Brydges, Director
72 Walton St., Suite 1, Port Hope ON L1A 1N3
Tel: (905) 885-6671 Fax: (905) 885-9758
E-mail: nfrs@eagle.ca
Services: This agency provides support to families of children with FAS/FAE through its respite care program.

**Ontario Federation of Indian Friendship Centres**
**Ms. Kim Meawasige**, FAS/FAE Policy Analyst
219 Front St. East, Toronto ON M5A 1E8
Tel: (416) 956-7575 • Fax: (416) 956-7577
E-mail: kmeawasige@ofifc.org • Web Site: www.ofifc.org

Services: This program will assist with FAS/FAE resources available to urban Aboriginal people in Ontario. It offers both a traditional and contemporary approach to FAS, on-site training and consultations as well as intervention, prevention and programming including community development regarding FAS/FAE.

**Ottawa Children's Treatment Centre (OCTC)**
**Ms. Margo Belanger-Deleo**, Intake Coordinator
René Walinga, Intake Administrative Support
395 Smyth Road, Ottawa ON K1H 8L2
Tel: (613) 737-0871 • 1-800-565-4839 (toll free in Ontario)
Fax: (613) 738-4841 • E-mail: pahearn@octc.ca • Web Site: www.octc.ca

Services: OCTC provides specialized bilingual ambulatory services to children, youth and certain adults with physical and/or developmental disabilities and their families. Clients eligible for the services at OCTC can receive, as required, diagnostic assessment, treatment, consultation and education from specialists like: physiotherapists; occupational therapists; speech-language pathologists; nurses; school, preschool and liaison teachers; psychologists; social workers; technical and medical specialists; developmental pediatricians; neurologists; psychiatrists; orthopedic surgeons; behaviour consultants, early childhood consultants and recreation therapists. Referrals are made to community resources as appropriate.

**Sarnia/Lambton FAS/FAE Support Group**
**Ms. Deborah Dunn**
388 Confederation Street, Sarnia ON N7T 2A8
Tel: (519) 336-1576 • Fax: (519) 336-7150
E-mail: deb000@hotmail.com Web Site: www.rivernet.net/~fas

Services: The purpose of this group is to support, educate and inform. A poster is available for purchase entitled 'Give your baby the best possible start in life'.

**South West Regional Fetal Alcohol Parent Advisory Group**
**Mrs. Susan Kampers**
R.R. #3, 23141 Thames Road, Appin ON N0L 1A0
Tel: (519) 289-0155 • Fax: (519) 289-0635
E-mail: susan.kampers@sympatico.ca
Services: This group provides support and education to families with children diagnosed with FAS and is involved in public speaking within the community.

Thunder Bay Indian Friendship Centre
Ms. Kelly Hicks, Community Support Worker
401 North Cumberland Street, Thunder Bay ON P7A 4P7
Tel: (807) 345-5840, Ext. 253 Fax: (807) 344-8945
E-mail: kelly.hicks@shawcable.com Web Site: www.tbifc.com

Services: Provides support, information and education to families, professionals and community members on the effects of alcohol on people of all ages and the importance of prevention. Also provides referrals and support through the diagnostic process.

Timiskaming Brighter Futures
Ms. Darlene Grossinger or Pat Spadetto
6 Hudson Bay Avenue, Kirkland Lake ON P2N 2H4 • Fax: (705) 567-2466
Darlene: (705) 567-5626 • E-mail: dgrossinger@timiskamingchildren.org
Pat: (705) 567-5926 • E-mail: pspadetto@timiskamingchildren.org

Services: To speak to the prenatal worker, please contact Darlene or Pat as listed above or for Englehart: (705) 544-2422; North Cobalt: (705) 672-3333

Union of Ontario Indians - Anishinabek Health Commission
P.O. Box 711, North Bay ON P1B 8J8
Tel: (705) 497-9127, Ext. 2296; 1-877-702-5200, Ext. 2296 (toll free in Ontario) Fax: (705) 497-9135 • E-mail: mcllau@anishinabek.ca

Services: Provides culturally-based training to aboriginal frontline workers located throughout the Anishinabek Nation. Four regional FASD program workers are available for First Nation workshops and health fairs. An FASD resource library is maintained and a number of culturally-based resources have been developed.

Waterloo FAS Support Group
Ms. Bonnie May
Regional Municipality of Waterloo Infant Development Program
P.O. Box 1612, 99 Regina Street South, 5th Flr., Waterloo ON N2J 4G6
Tel: (519) 883-2223 Fax: (519) 883-8102

Services: This is a support group for parents raising children suspected of prenatal alcohol exposure. Requests for information and for participation in workshops are responded to.
Chapter 10

References
References


Coles CD (2001). Fetal alcohol Exposure and Attention: Moving Beyond ADHD Alcohol Research and Health, 25, 199-203


Streissguth AP, Barr HM, Kogan J, Bookstein FL. (1996). *Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE).* Final Reports, Centers for Disease Control and Prevention Grant No. R04/CCR888515.


APPENDIX A

Details in Conducting a Training Workshop

We encourage you to review and present the contents of this manual in its entirety. You will require approximately 8 hours to present the materials. This will allow ample time for questions and/or discussion. You may want to consider breaking it out into two or three separate training sessions, or host a series of ‘lunch and learn’ sessions, where you can review the material in each section over several days. Either way, it’s important for you to share the information with your colleagues and other front-line workers.

There are individuals who would be happy to serve as resources for you when preparing to hold a training session. These individuals include:

- Dr. Brenda Stade, RN, St. Michael’s Hospital
- Kim Meawasige, The Ontario Federation of Indian Friendship Centres
- Brian Philcox, FASworld Canada
- Terry Swan, Native Child and Family Services

Materials and equipment you will need:

- Acetates for photocopying overheads
- Overhead projector
- Flipchart and markers
- Handouts that you feel are relevant which you can photocopy from the manual
- Copy of the case studies for each participant
- Pen and writing pad for each participant

It is recommended that you keep the group small – between 10 to 15 participants. This will allow for more discussion and questions. If more than one person attended the conference, it may be helping that the training workshop being conducted by two trainers. There is a great deal of material to become familiar with and present.

**Conducting a Training Workshop** below gives a detailed description on how to present the materials in an eight hour day.
## Conducting a Training Workshop

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content – Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:15 – 08:30</td>
<td><strong>Chapter 1: Introduction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Introductions</td>
<td>Welcome participants and introduce self. Go through &quot;housekeeping&quot; items such as</td>
<td>Some participants may arrive late. It is often best to serve a coffee before starting so that although starting time for participants is 0:8:00, the actual starting time is 0:8:15.</td>
</tr>
<tr>
<td></td>
<td>- Suggestions For Seminar Participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Expectations (flip chart)</td>
<td>Ask participants to introduce themselves.</td>
<td>Some participants may contribute much more than others. That is okay, particularly in at the beginning of the workshop when the group is just getting comfortable.</td>
</tr>
<tr>
<td></td>
<td>- Overall purpose of the training (flip chart)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(The instructor has the flexibility of asking participants to introduce themselves in any way s/he feels comfortable. It is important to make the participant’s feel comfortable before starting the training).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask participants their expectations for the day and list them on a flip chart.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>After the introduction, the trainer may want to determine the extent of experience that the participants have with FASD and homelessness?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For example, the trainer may ask:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many of you are familiar with Fetal Alcohol Spectrum Disorder?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have ever felt those you are working with have FASD?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you developed strategies for working with those with FASD?</td>
<td></td>
</tr>
</tbody>
</table>
## Conducting a Training Workshop (cont.)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-09:00</td>
<td><strong>Chapter 2: Burden of Prenatal Exposure to Alcohol</strong></td>
<td>Write the objectives on the flip chart for this section, and review with group.</td>
<td>In this and in all sections the participants may ask questions you can not answer.</td>
</tr>
<tr>
<td></td>
<td>- Learning Objectives (Flip chart)</td>
<td>Present introduction to FASD, information about quality of life and cost by presenting</td>
<td>It may be helpful to either consult one of the resource people above or have one of</td>
</tr>
<tr>
<td></td>
<td>- Introduction (Overhead)</td>
<td>overheads 1 through 3.</td>
<td>the resource people attend a practice session or your first session.</td>
</tr>
<tr>
<td></td>
<td>- Quality of Life (Overhead)</td>
<td>Use the text presented in the trainers manual to explain the overheads.</td>
<td>Be prepared for overhead malfunctioning.</td>
</tr>
<tr>
<td></td>
<td>- Burden of Cost (Overhead)</td>
<td></td>
<td>Ensure an extra bulb or machine is available.</td>
</tr>
<tr>
<td>09:00 – 10:15</td>
<td><strong>Chapter 3: What is FASD? How is it diagnosed? How can I recognize It?</strong></td>
<td>Write the objectives on the flip chart for this section, and review with group.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Learning Objectives (Flip chart)</td>
<td>Present information about the medical aspects of FASD/ diagnosis by using overheads #4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Introduction (Overhead)</td>
<td>through 12.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Impact of alcohol on the developing fetus (Overhead)</td>
<td>Use the text presented in the trainers manual to explain the overheads.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diagnostic Categories (Overhead)</td>
<td>Hand out copies of the case study to enhance learning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- How would I recognize FASD in a homeless youth or adult? (Overhead)</td>
<td>Divide the group in to 2 or 3 smaller groups and ask each to review the case study and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Secondary disabilities (Overhead)</td>
<td>arrive at a diagnosis. Allow 15 minutes for this activity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Case Study (Handout)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Why Diagnose (Overhead)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conducting a Training Workshop (cont.)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:15 – 10:30</td>
<td>Break</td>
<td>Trainer may want to use time to answer questions or review notes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30 – 11:45</td>
<td>Chapter 4: General Strategies for Working with Individuals with FASD</td>
<td>Write the objectives on the flip chart for this section, and review with group. Present information about the general strategies for working with those with FASD by speaking to overhead # 13. Use the text presented in the trainers manual to explain the overheads. Hand out copies of the case study to enhance learning. Divide the group into two smaller groups and ask each to review one of the 2 case studies. Ask the group to analyse the case study and to consider strategies to help the youth presented in each. Ask each group to consider how the case study would apply to their shelter or facility. Allow 15 minutes for analysis. Ask a member of each group to read out the case study and present the group strategies.</td>
<td>This section presents general strategies. Thus, there is a potential for participants to get off topic. It may be necessary for trainers to focus the participants and this can be best be done by working through the material presented in the chapter, and then ask the participants to move on to the case studies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:45 – 12:30</td>
<td>Lunch</td>
<td>Trainers should be available to answer questions.</td>
<td></td>
</tr>
</tbody>
</table>
## Conducting a Training Workshop (cont.)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content – Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
</table>
| 12:30 – 13:30 | **Chapter 5: Learning Styles of Individuals with FASD**  
• Learning Objectives (Flip chart)  
• Introduction (Overhead)  
• Learning environments (Overhead)  
• Six strategies for teaching individuals with FASD (Overhead)  
• Case Study (Handout) | Write the objectives on the flip chart for this section, and review with group.  
Present information about the learning styles of individuals with FASD.  
Present overhead #14 to describe the six strategies for teaching those with FASD.  
Use the text presented in the trainer’s manual to explain the overheads.  
Hand out copies of the case study to enhance learning.  
Divide the group in to 2 or 3 smaller groups and ask each to review the case study and arrive at strategies for facilitating the learning of the young person in the case study. Each group should select a member who will present the group’s strategies to the larger group.  
Allow 15 minutes for this activity. | Material in chapter may not be detailed enough for training a group of teachers.  
It is recommended that when training teachers that this section be augmented by using materials presented in the chapter 8 - Resources.  
Participants who major responsibility is not teaching may not see the value of this section for their work.  
Ask the participants how the information discussed could be applied to their own setting.  
You may notice my now that the same individuals volunteer to present the group’s work. Try to encourage others to participate. |
| 13:30 – 14:00 | **Chapter 6: Considerations for Law Enforcement Workers**  
• Learning Objectives (Flip chart)  
• Why police need to be sensitized and educated in FASD (Overhead) | Write the objectives on the flip chart for this section, and review with group.  
Present information about the why police need to be sensitized and educated in FASD by utilizing overhead #15.  
Use the text presented in the trainer’s manual to explain the overheads. | This chapter gives a general overview.  
Several materials that will enable Law Enforcement Officers to train other officers are in the final stages of development. These materials are cited in Chapter 8 – Resources |
| 14:00 – 14:15 | **Break** | Trainer may want to use time to answer questions or review notes. | |

References  
J FAS Int 2004;2:e10 June 2004  
Page 100
Conducting a Training Workshop (cont.)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Dealing with Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:15 -15:15</td>
<td>Chapter 7: Working with Families</td>
<td>Write the objectives on the flip chart for this section, and review with group.</td>
<td>The case study presented in this chapter is very poignant and may evoke strong feelings in the participants. Allow time to discuss these feelings.</td>
</tr>
<tr>
<td></td>
<td>▪ Learning Objectives (Flip chart)</td>
<td>Use overhead # 16 to present strategies on how to work with families.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Strategies for Working with Families (Overhead)</td>
<td>Use the text presented in the trainer’s manual to explain the overheads.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Case Study (Handout)</td>
<td>Hand out copies of the case study to each participant.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Divide the group into 2 or 3 smaller groups.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask the groups to consider what strategies worked in this case study and what will be</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>needed in the future.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each group should select a member who will present the group's strategies to the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>larger group.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allow 15 minutes for this activity.</td>
<td></td>
</tr>
</tbody>
</table>
## Conducting a Training Workshop (cont.)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content</th>
<th>Content –Trainers Notes</th>
<th>Solving Problems</th>
</tr>
</thead>
</table>
| 15:15 – 16:00| Chapter 8 Next Steps: Building a Response Network | - Learning Objectives (Flip chart)  
- Steps in building a response network in the community (Overhead)  
- Group generate steps (Flip chart) | Write the objectives on the flip chart for this section, and review with group.  
Use overhead # 17 to outline steps in building a response network in the community.  
Use the text presented in the trainer’s manual to explain the overheads.  
Conduct a brain storming session and elicit others steps from the group that could be used to build a response network in the community. Write these steps on the flip chart. Allow 15 minutes for this activity. | Attempt to encourage all participants to contribute in the brain storming activity.  
Keep the group focused a response network that would be relevant to their facility as well as to the larger community. This will help to avoid repetition of the steps presented by trainers. |
| 16:00 – 16:20| Summary & Evaluations        | Review objectives on flip chart and ask if each objective was achieved.  
Review expectations from participants to see if each was achieved.  
Ask if anyone have any closing comments, or other feedback they would like to share with the group.  
You may want to tell the participants that: It’s been a pleasure working with each of you and I look forward to the next opportunity to work together. State that we are now going to take a few minutes to get your written feedback on our evaluation sheet. Handout evaluation forms.  
You might want to state: I would appreciate if everyone could please complete this evaluation sheet and leave it on your desk. This feedback helps us to design better courses for future participants. | Participants may want to leave before completing a written evaluation.  
It helps to set time aside at the end of a workshop for evaluation. |
Thank you for your attention and valuable insights today.
Participant List

Course Date & Location: __________________________________________________________

Trainer: __________________________________________________________

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Organization</th>
<th>Contact Information (e-mail / telephone)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The developers of the training manual would like to gather information on how manual individual's attended a training program. If you are comfortable in doing so, please fax a copy to: 416-864-5344; Attention: Karen Clark.
Evaluation Form

Fetal Alcohol Spectrum Disorder and Homelessness Training

1. Did this training workshop meet your expectations?  □ Yes  □ No
   Comments:

   ______________________________________________________________________________________________

   ______________________________________________________________________________________________

2. What did you find most useful?
   Comments:

   ______________________________________________________________________________________________

   ______________________________________________________________________________________________

3. How do you rate the following:

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very Good</th>
<th>Adequate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Content</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audio/visual presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room – comfort and set-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. How would you rate the workshop: Circle one.
   Strongly agree – 1  Disagree – 2  Neutral – 3  Agree – 4  Strongly Agree – 5

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The workshop met the stated objectives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The workshop met my learning expectations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There was adequate time for questions and discussion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The information was presented clearly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The information was relevant to my job</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. What would you like to have heard more about?

   ______________________________________________________________________________________________

   ______________________________________________________________________________________________

6. General comments and suggestions:

   ______________________________________________________________________________________________

   ______________________________________________________________________________________________

   ______________________________________________________________________________________________
Thank you for your feedback and suggestions.

Trainer Survey

Please take a few minutes to complete this survey and fax it back to: 416-864-5344.

Name: ____________________________________________________________

Organization: ______________________________________________________

Date of training session: ____________________________________________

Number of attendees: ______________________________________________

Was the information in this training manual easy to read, understand and follow?

________________________________________________________________

Were the case studies helpful? _______________________________________

________________________________________________________________

Were the overheads/handouts helpful? _________________________________

________________________________________________________________

What were some of the questions and/or discussions that arose from the training session?

________________________________________________________________

________________________________________________________________

Other comments or recommendations on how to improve this training manual?

________________________________________________________________

________________________________________________________________

Other suggestions for reaching front-line workers with important information on FASD and homelessness?

________________________________________________________________

________________________________________________________________