



FINAL REPORT OF FAS/FAE NEEDS ASSESSMENT

PLANNING FOR FAS/FAE





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Report of FAS/FAE Needs Assessment

Section One: Introduction

1.1 Preamble

It is widely accepted that the first years of a child's life set apart the child's future education, development and ability to integrate within the community. To date, no study has looked into the requirements for caring for and educating children with FAS/FAE aged 0 – 6 years within First Nations and Inuit communities across Quebec.

Following recent announcements made by the federal and provincial governments about their commitment to improving early childhood development across Canada, the FNQLHSSC Early Childhood Program undertook a Needs Assessment of the current situation regarding FAS/FAE in the Early Childhood Programs of the First Nation and Inuit communities in Quebec.

This assessment project allowed the FNQLHSSC the opportunity to evaluate the future needs of the First Nations communities of Quebec for developing ECE prevention and detection strategies, appropriate intervention programs, and training for the educators and families of children with FAS/FAE. This report contains a summary of those needs and an action plan to respond accordingly.

1.2 Definitions

For the purposes of this report, the following definitions have been applied:

- ADD**
- *Attention Deficit Disorder in which children have symptoms similar to FAS in focusing on activities, but unlike FAS, respond to behaviour modification and can be taught to encode and sort information;*
- ADHD**
- *Attention Deficit Hyperactive Disorder is similar to ADD with added impulsivity;*





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- Alcohol Related Birth Defects (ARBD)**
- *Alcohol-related birth defects in which there is a confirmed maternal use of alcohol; often used to describe both FAS and FAE;*
- ARND**
- *Alcohol-related neural disorders in which there is a confirmed maternal use of alcohol;*
- AECE**
- *Attestation of Early Childhood Education – provided after the successful completion of a one year CEGEP program in this field;*
- CECE**
- *Certificate of Early Childhood Education – a professional certificate provided after successfully completing a two-year CEGEP program in this field;*
- CHR**
- *Community Health Representative;*
- DDST**
- *Department for Developmental Standardized Testing;*
- ECE**
- *Early Childhood Program which can include both Head start and Daycare programs;*
- Foetal Alcohol Syndrome (FAS)**
- *A group of physical and neurological birth defects caused by exposure of the foetus to alcohol during its development in the womb;*
- FNEC**
- *First Nations Education Council;*
- FNHS**
- *First Nations Head Start;*
- Foetal Alcohol Effect (FAE)**
- *A term used to describe the presence of some but not all FAS characteristics, is also described as Partial FAS;*
- IECAM**
- *Education Institute for the Atikamekw and Montagnais Council*
- KRSB**
- *Kativik Regional School Board;*
- Makucham**
- *Name of specific community gathering;*
- NNADAP**
- *National Native Alcohol and Drug Abuse Program;*





1.3 Objectives

The objectives of the project were as follows:

- To assess the current situation with FAS/FAE identification and management in communities and in the Early Childhood programs;
- To identify problems encountered by Early Childhood educators in caring for young children with FAS/FAE;
- To determine the training and resource needs for the educators, interveners and clinicians working with young children with FAS/FAE
- To identify any documentation, strategies and projects developed in First Nation and Inuit community Early Childhood programs which can be of benefit to others;
- To use the results of the assessment to develop an action plan to assist in providing more appropriate information, training, resources and strategies to deal with this problem
- To develop a Resource Guide to be distributed to all the community Early Childhood Programs.

1.4 Methodology

The following steps were undertaken to assess and convey the information contained in this report:

- *A review of the literature available was conducted prior to formulating a framework on which the survey questionnaire was based;*
- *A review of information from the FNQLHSSC regarding the extent and scope of the various types of Early Childhood Programs available in the communities was also completed;*
- *A framework was developed for the needs assessment, and submitted for approval prior to commencing the questionnaire;*
- *The survey questionnaire was prepared, and submitted for approval, and, after any required revisions, for translation;*
- *A Mail-out of the survey questionnaire to the communities was undertaken with a covering letter;*
- *Follow-up phone calls were later undertaken in the communities to expedite the responses, and to facilitate any difficulties in acquiring the information for the survey;*
- *A database was developed to accumulate the data, and to generate statistics for analysis;*
- *An outline was developed for the Resource Guide so that a listing of the various types of resources could be entered based on the results of exploration, and feedback from the surveys;*
- *A call-back to the communities was made either for clarification or further information, where necessary, regarding the analysis of the responses;*





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- *A preliminary statistical report was generated from the database based on the information from the surveys;*
- *The analysis of the related data of this statistical report, and the discussions with the community workers formed the basis of this final report;*
- *A Resource Guide based on recommendations from the survey, and from explorations of literature in the field was finalized;*
- *An Action Plan was drafted into the report to meet the needs identified by the surveys.*

All the raw data and community information has been kept confidential or anonymous, and only general statistics and common trends or comments are used in the final report. The surveys and other information remain the property of the FNQLHSSC.





Section Two: General Information

2.1 General

Fifty-one (51) surveys were mailed out in March 2002 for the needs assessment, with an accompanying letter to either the Director of Health, to another Community Officer, to the Tribal Council or local authority, or directly to the Daycare or Head start Program. Of these surveys, 23 were returned completed, of which the last was received on June 12th, 2002. The Kativik Regional Government took a decision for the Inuit communities not to participate at this time, and two First Nation communities also declined to complete the survey because of time restrictions.

There was some difficulty in receiving results back from the communities due to their own workloads, the reporting at the end of one fiscal year, and the start of the new fiscal year. It was necessary to follow up with phone calls, and lately with letters. In some instances, the surveys had been forwarded to another person in the community, and it was necessary to try to find where the survey was, or to refax the entire survey, as it had been mislaid. However, those who completed the surveys did so in earnest, and with commendable effort to provide proper information.

The community surveys received represent 43,979 persons or 69 % of the First Nations populations of Quebec (total status population of 63,315 based on statistical information available from the year 2001). The number of children from 0 – 6 years of age in Early Childhood programs was not reported on three (3) of the surveys, and incompletely on five (5) others. Therefore, the total of 2,966 reported in the statistical summary report should in reality be adjusted upwards.

In addition, it should also be noted that not all of the questions on the survey were answered. To maintain consistency in the count of responses, an additional “No Response” (N/R) was added to the answer sheet in the database. Therefore each question always tallied 23 responses including N/R.

With only the exception of Section Four where there were many who did not reply to the questions as they did not know of any resources, the percentages reported in Section Two and Section Three are calculated based only on the responses. Those percentages in Section Four are calculated based on the total number of surveys, which is twenty-three (23).





2.2 Community Background Information

Sixty-one percent (61%) of the communities surveyed reported having members speaking their own language, and the distribution of the other spoken language of communication in the communities that responded was given as 65% spoken French and 43% spoken English.

Eighty-two percent (82%) of the communities who responded still exercise traditional hunting customs, and although 7 communities were uncertain of the extent, the rest of the communities report that an average of thirty percent (30%) of the families in their communities still follow traditional nomadic practices.

In regards to traditional cultural practices, although one community did not report, the other twenty-two communities did report that eighty-six percent (86%) of their members still followed traditional cultural beliefs.

The demography of the communities that replied to the survey included 14 communities (64%) that can be described as “isolated or remote or both”. Of the fourteen described:

- Three (3) of these are isolated in the bush, and have no proper access road, other than a bush or dirt road.
- Eight (8) of these communities are further than 300 kms from any urban centre.
- Three (3) are remotely located from a southern urban centre where appropriate services would be found.

Of the remaining communities responding to the survey, three are considered to be “semi-urban”, and seven (7) communities are classified as “urban”.

The majority of the communities recounted employment rates below 60%, and one of the communities reported having only seasonal employment of less than 20%. Only three (3) communities cited employment levels between 60% and 80%. To say this differently, where the average annual unemployment levels in Canada are around 11%, the average unemployment levels in 43% of the First Nation communities in Quebec is at least 60%.

As a result of the unemployment rates, although 6 communities did not respond to the question, the majority of those who did (82%) report having more than 20% of their community members on Social Assistance programs, and 12% report having as many as between 80% – 100% of their community members on Social Assistance.





Ninety-five percent (95%) of those communities surveyed refer to social problems that require careful consideration in the preparation of programming for children 0–6 years of age. The social issues cited in the surveys included:

- Drug and alcohol abuse (90%),
- Single parent families (85%),
- Family breakdown (70%),
- Poverty (55%),
- Nutrition (50%),
- Feuding (50%),
- Chronic unemployment (40%),
- Community adversity (35%),
- Political unrest (10%).
- Also added to the list by the respondents were: teenage pregnancies (especially below the 14-16 years age group), gambling, housing, and a generalized lack of formal education.

The social profile of the communities indicated that there is an availability of recreational facilities in 91% of the communities responding, but they also report a lack of adequate housing and infrastructure in 62% of the communities surveyed.

The average household is reported as representing 5.26 persons, of which there is a reported average of 3.71 children per family. With only one exception, families in most communities are reported equally for both single parent and two-parent families, but with the greater percentage of families being “extended families”.

2.3 Early Childhood Program

2.3.1 Extent and Scope

The types of Early Childhood Programs vary with each community, but in total represent the following: Private Daycare Centres including those in schools; Head start programs both in centres and in schools; Daycare Centres; Early Childhood Centres; Kindergartens in schools; and two respondents reported under “other” types of programs.

As seven (7) of the communities did not report their populations for their early childhood programs, it is impossible to approximate the average staff ratios and workloads. However, it is of note that in reviewing the staffing of the early childhood programs, and with the exception of one combined specialized childcare centre, we find that the presence of “specialists” is limited to only the Head start programs, or to the two programs referred to as “other”.





2.3.2 Staff Training Levels

The most predominant types of training for the Educators working in the Early Childhood programs is shown as being either an A.E.C.E. or a C.E.C.E., and then closely followed by “other training” and “life experience”. Staff members were also listed with a Bachelor in Social Work, a Bachelor SW Psycho-Educator, a BA teaching registered nurse and public health officer, and a Psychologist.

Ninety percent (90%) of those surveyed recounted having a provision for in-service training for the educators. The majority of the training is delivered through attendance at conferences or workshops, and less than half of the communities mentioned being able to provide various types of training by onsite trainers, or “formation sur mesure” programs such as with a local CEGEP. Other than this, the type of local training often mentioned is First Aid or CPR Certification. Three communities also referred to using videos and TV programs.

2.4 Community Support Services

2.4.1 Health Services

All of the communities but one reported having some form of Health Services as follows: fifteen (15) have a Health Centre, five (5) have a Nursing Station, and three (3) have a Medical Dispensary. In addition to these, some communities also included having an Ambulance Service, an Elders’ Home and a Hospital.

Most of the communities also referred to having medical or nursing clinics that provided prenatal care and vaccination services. More than half of the communities also stated having the services of a baby clinic, and a mental health worker; and, fifty-five percent (55%) have a blood clinic. A few reported having the services of a physiotherapist, nutritionist, occupational therapist, psychologist, and a dentist. Programs also mentioned as available included diabetes clinics, female health services, mother and child programs, HTA, and CHR.

2.4.2 Prevention Services

The majority of the responding communities all reported having prevention programs in Diabetes, Nutrition, NNADAP, Brighter Futures, HIV/AIDS and Prenatal programs. Since prenatal programs are available in fifteen (15) communities, and NNADAP in twenty (20) of the responding communities, they would provide an excellent focus for FAS/FAE prevention and screening programs.





In addition to the above, communities also cited Shelter programs, and those for the Youth, the Elders, and programs in Weight Loss, and Healthy Lifestyles as well as tobacco control, family violence, homecare, child health services, and “health for hunters”.

2.4.3 Educational Services

In addition to all of the responding communities having preschool programs, ninety percent (90%) of the communities reported having an elementary school, and eighty-five percent (85%) have a high school program. These would also provide a focus for successful community prevention programs.

As well as the regular in-school programming, and language immersion programs in ten communities, fourteen also cited having adult education services and eleven having postsecondary support programs. Three of the communities also have vocational schools.

2.4.4 Recreation Programs

Sports and Socials are cited as forming the majority of the recreational programming in the communities. In almost seventy-three percent (73%) of the communities, there are also Bingo, Dances and Winter Carnivals that are organized. Some communities also enjoy organized summer camp programs, competitions and games, and some in particular have a Fitness Centre, a pool hall, a bowling alley, and a community gathering “Makucham”.

2.4.5 Cultural Programs

Although less than the majority of the surveyed communities report having either a cultural centre (35%) or a language resource centre (32%), nevertheless, the majority do enjoy cultural activities such as traditional socials, cultural festivals, crafts and hunting practices, as well as singing and drumming, traditional teachings and ceremonies, and especially traditional crafts mentioned in twenty of the responding communities.

2.5 Availability of Professionals

2.5.1 Health Care Professionals

Ninety-one percent (91%) of the communities who completed this section of the survey enjoy access to the services of a medical doctor, and ninety-five percent (95%) those of a nurse, although the frequency and the extent of this service is not documented.





In addition, seventy-seven percent (77%) of the communities can also access the services of a dietician, sixty-four percent (64%) the services of a paediatrician, and seventy-three percent (73%) those of a dental hygienist. About forty-five percent (45%) of the communities moreover have or can access the services of a pharmacist, a medical specialist, and a physiotherapist. Eight of the communities (or 36%) also added the availability of the services of a dentist, X-ray technician and occupational therapist under “other”. The communities indicated that the services of the dental hygienist, medical specialist, paediatrician, and physiotherapist were usually only on an annual basis.

2.5.2 Other Specialists

Although two communities did not complete this section, all but one of the communities stated either having, or having access to, the services of a psychologist.

Additionally, seventy-one percent (71%) have access to a speech therapist, fifty-seven percent (57%) to an occupational therapist, and sixty-two percent (62%) to a family counsellor. Some also mentioned access to the services of a Child Psychologist, a Social Worker, a Psychotherapist, a Neurologist, an Ears/Nose/Throat Specialist, a Gastro-Enterologist, and a Prosthetist-orthotist.

2.6 Community Information Networks Available

2.6.1 Print

The most popular (76%) and frequently used forms of print communication in the communities are equally those of flyers, posters and newsletters. Other sources of print information cited are pamphlets (71%), the library (43%), and newspapers (33%) such as the “*Matinimitik*”. All of which should be considered in the use of information blitzes for FAS/FAE prevention programming.

2.6.2 Telecommunications

The most popular form of telecommunication is the community Radio Station (82%) followed by the use of Internet services (77%), E-mail (73%) and satellite (68%). In addition some use is made of cable (45%), and infrequently of videoconferencing (14%). One community mentioned the use of telemedicine.





2.6.3 Internet

The majority (65%) of the communities surveyed cite a level of “less than 40%” for the use of the Internet in Community Services and Programs, and similarly for use in the homes.

Although these numbers regarding Internet use seem to be in opposition to those provided in the previous section under telecommunications (at 77%), the interpretation could be that the previous section was more of a reflection on the use of the Internet as a form of communication (using E-mail), or for limited information such news and weather, as opposed to other broader uses such as for internet searches, shopping and website usage.

2.7 Detailed Recommendations for Section Two

Recommendation No. 1:

The financial consideration of the need for translation of materials into French, and the need to adapt the prevention and intervention concepts into the local community language must be taken into account when accessing funding or providing funding for communities. In some communities, this can mean providing materials in three languages.

Recommendation No. 2:

The factor of isolation and ease of access needs to be considered in regards to the accessibility of the community to specialists and trainers, or the elevated travel costs entailed in bringing the educators to training sessions. This is an important consideration when planning intervention strategies for FAS/FAE in the more isolated or remote communities.

Recommendation No. 3:

The levels of unemployment and social assistance in First Nations communities are considerations for preventative programming, and also in deliberating the financial resources of First Nations parents and communities raising children with FAS/FAE.

Recommendation No. 4:

Social issues such as drug and alcohol abuse, single parent families, and family breakdown require careful consideration in the preparation of any type of preventative programming or general interventions for children 0 – 6 years of age.





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As a positive influence, the prevalence of traditional festivals, socials ceremonies and teachings, hunting practices and crafts within the communities should also be given careful consideration in the preparation of preventative programming, support services, or general interventions for children 0 - 6 years of age.

Recommendation No. 5:

A lack of specialists in the Early Childhood Programs implies the dire necessity for a generalized FAS/FAE training for all of the staff, and the need for developing a system of sharing specialists or having a travelling specialist-consultant for the Daycare and Early Childhood Centres.

Recommendation No. 6:

Since all of the other communities stated either having or having access to the services of a psychologist, this type of professional should be targeted as part of an implementation plan for a screening program, or an intervention strategy.

Recommendation No. 7:

The popular use of the Radio Station should be considered in preventative programming. The use of E-mail to forward documentation to the Early Childhood Centres should be considered as an efficient and effective option for providing information on FAS/FAE.

Also the high proportion of Prenatal and NNADAP programs in the communities should also be considered for various types of FAS/FAE information/prevention programming, and specifically for targeting high-risk populations.





Section Three: FAS/ FAE

3.1 Current Situation Early Childhood Program

3.1.1 Suspected or Known Incidence

In responding communities, children with special needs are integrated in sixty-seven percent (67%) of the Early Childhood programs. The reasons given in the surveys for non-integration included a lack of financial and human resources, infrastructure, diagnostic tools, and registering special needs children.

Only fifteen percent (15%) of the Early Childhood programs have specific written protocols for the management of children with special needs, and as well, only sixteen percent (16%) include an extensive assessment or evaluation when the child is registered into the program. Twenty-one percent (21%) reported having the financial and human resources available for special needs children.

The communities had some difficulty responding to the question on suspected or known incidence of FAS/FAE. Twenty-two percent (22%) of the communities did not respond, seventeen (17%) of the communities replied that it was unknown, and six percent (6%) said there was none. Of the remaining respondents, forty-four percent (44%) reported a known or suspected incidence of “between 1% and 3%”, and eleven percent (11%) reported a high level of suspected incidence of “between 4% and 6%”.

In regards to the question on specifying an Assessment or Screening Tool used to refer known cases, eleven (11) of the communities did not respond. Those who did respond referred to the following: Stanford Binet L.S., Medical diagnosis, DISC, D.D.S.T., Development Tools, Miller, Carolina, and Parent Completed Ages and Stages. Seventy percent (70%) of the communities did not respond to the question of who made the assessment; however, among those who did, the majority cited a health care professional or other specialist such as a psychologist, neuro-psychologist or teacher.

3.1.2 Staff Training in FAS/ FAE

Ninety percent (90%) of the responding communities confirmed that the educators in the Early Childhood programs are aware and have access to some information on FAS/FAE. However, seventy percent (70%) also report that the educators have not received any training on strategies or interventions in working with children with FAS/FAE. Those that have received some





training were limited to a workshop or conference either given by the First Nations Education Council or the Cree Regional Authority.

3.1.3 Parent Support Services

Seventy-five percent (75%) of the responding communities report not having any support group or direct services for parents of FAS/FAE children. Those communities who have services recount the following: a Home Educator from the Head start Program, a parent support group, awareness posters and pamphlets, a weekly parenting program from Head start and Brighter Futures, and a parenting support group facilitated by a psychologist.

3.1.4 Worker Support Services

Eighty percent (80%) of the responding communities do not have support services available for the workers of the Early Childhood Programs. Twenty percent (20%) do. Those that do have support services name the following services: Regional Coordinator support, Multi-Sectorial meetings with Health, Social Services, etc., and information and support from Social Services. Only one community reported having volunteers to assist the educators with Special Needs children.

3.1.5 Programming – Good Practices

Although five (5) of the communities did not respond to this question, seventy-eight percent (78%) of those who did replied that they did not have different programming or scheduling for special needs children, and in particular for children with FAS/FAE.

Some of the Good Practices that were mentioned in the survey were:

- Take into account all differences, not just FAS/FAE;
- A worker should not label a child;
- Involve parents in every aspect of the assessment, diagnosis and prescription;
- Structure and consistency;
- Augmentative communication;
- Behaviour techniques combined with frequent visual cues; etc.

3.1.6 Intervention Strategies

The majority of the staffs (68%) of the responding Centres have not been trained to use any particular intervention strategies with FAS/FAE children. Although some recommendations were made for training on strategies, none seem to be very current.





3.1.7 Major Coping Difficulties

In identifying the major coping difficulties for the workers, the responding communities reported the situation as follows:

- Lack of training (75%)
- Lack of resources (69%)
- Lack of parental support (63%)
- Lack of screening and identification (56%)
- Lack of information (56%)
- Behavioural difficulties (56%)
- Lack of availability of specialists (56%)
- Lack of awareness (50%)
- Inappropriate programming (50%)
- Limited skills (44%)
- Isolation (44%)
- Finding appropriate interventions (38%)
- Inconsistency (38%)
- Environment (31%)
- Fatigue/Stress (25%)

3.2 Community/ECE Prevention Projects

3.2.1 Group Education/Awareness

Thirty-nine percent (39%) were able to provide examples of group education and community awareness programs on foetal alcohol syndrome and effects.

Some of the examples given include:

- Activities like a Radio Show on FAS/FAE put on by the CHR's and NNADAP workers;
- Prenatal information during clinic visits;
- Prenatal classes;
- Individual counselling with the mother during her pregnancy;
- Monthly newsletter;
- Frontline workers such as teachers, CHR's, NNADAP workers, community workers attend workshops;
- Information pamphlets from NNADAP at Health Centre.

Forty-eight percent (48%) of the communities responded that their Early Childhood Programs provided information through workshops, flyers and pamphlets to parents regarding FAS/FAE.

Thirteen percent (13%) did not respond to this question in the survey.





3.2.2 Training of Workers

Fifty-seven percent (57%) of the communities responded that they provide training to their education, health and early childhood employees on FAS/FAE. In the majority of cases, this training is provided in the form of workshops or conferences on FAS/FAE given by the First Nations Education Council or sponsored through FNQLHSSC or the Cree Regional Authority.

3.2.3 Outreach/Identification of At Risk Population

Only thirty-five percent (35%) of the responding communities testified that they provided an outreach program for the “at risk” population among pregnant women. Most of these programs are centred around the Community Nurse.

3.2.4 Advocacy for Preventing

Nevertheless, seventy-one percent (71%) of the responding communities do provide advocacy programs for the prevention of alcohol consumption during pregnancy. Some examples given included:

- Education in schools;
- Prenatal programs;
- Head start and Brighter Futures sponsored workshops for mothers-to-be;
- NNADAP services;
- Prenatal visits;
- Prenatal nutrition program;
- Youth workers;
- Family violence program;
- Mental health worker program.

3.2.5 Community Development

Only forty percent (40%) of the responding communities reported having community programs designed to specifically promote and foster community development in an attempt to prevent drug and alcohol related problems such as FAS/FAE. Examples of such programs included:

- Drug and alcohol free recreational programs;
- Youth programs such as KYOT, and Kids Club;
- A community contract for the well-being of the children and parents;
- Brighter Futures and Head start.





3.2.6 Home Visits

The promotion of Home Visits as a means of reducing the risk of alcohol-related disorders is reported as being undertaken in twenty-five percent (25%) of the communities. Examples cited are

- The use of home visits for prenatal care, and also for newborns;
- Prenatal classes in the homes;
- Visits by social service workers.

3.2.7 Establishing Networks/ Coalitions to Address Issues

Networking between services or coalitions with outside agencies are established in only twenty-one percent (21%) of the communities responding to the survey.

Such examples include:

- The daycare centre and the community education program;
- The FNHS program with NNADAP for awareness programming for FAS/FAE;
- Networking through the community nurse's program with other services in the community.

Outside coalitions mentioned included one with the local CLSC Roberval. One comment cited that this networking needs to be better supported by band council Chiefs, and the problem recognized as a growing situation.

3.3 Community/ECE Identification Projects

3.3.1 Building Trust Relationships

Only one community reported having a program in this area. Most feel that this should be handled through the health and community services, not through the Early Childhood Programs.

3.3.2 Observations

Twenty-seven percent (27%) of those completing this question had some form of program for the clinical observation of suspected children. The examples given were:

- Observations by a paediatrician;
- DDST Administered screening and observation;
- The children receiving vaccine at the Health Clinic that are screened for growth and development;
- Parental consent for observation and evaluation at the Centre.





3.3.3 Screening and Assessment

Thirty-three percent (33%) of those responding to this question stated that they have some form of screening and assessment as part of their regular services. A further example was given of all newborns receiving a full neurological assessment; and working with the First Nations Education Council to have a screening clinic.

3.3.4 Referrals

Twenty-four percent (24%) of responding communities also cited that they do provide referrals of suspected cases to other services such as a visiting paediatrician; or a local multi-disciplinary team from social services, health and education.

3.3.5 Case Management

Only one community reported being involved in the management of one case of FAS/FAE, and in working with social services and the education program on this as a project.

3.4 Community/ECE Intervention Projects

3.4.1 Supporting and Promoting Positive Parenting Practices

Sixty-eight percent (68%) of the communities that responded to this question have cited that they provide projects for supporting and promoting positive parenting practices. Some examples are as follows:

- Part of health and Social Services programs;
- Minokin Social Services Centre;
- Workshops on parenting skills;
- Dad's program;
- Head start;
- Parenting programs for prenatal care;
- "Nobody's Perfect", Sesame, Brindami;
- Weekly cultural parenting workshops.

3.4.2 Helping Parents/Workers Develop Specific Skills in Behaviour

Forty-four percent (44%) report helping workers and parents develop specific skills in behaviour management. Some examples given are as follows:

- First Nations Head Start Programs;
- Brighter Futures Programs;
- Workshops in discipline;





- “Nobody’s Perfect”, Sesame, and Brindami.

3.4.3 Counselling for Parents

Only two (2) communities reported providing any counselling for parents of children with FAS/FAE, and included referrals to support groups.

3.4.4 Facilitating Respite Care

Once more only two (2) communities alluded to facilitating the provision of respite care for parents and guardians/workers. Some referred to undergoing development of programs in this area.

3.4.5 Drop-In Services for Parents

Three (3) of the communities reported providing drop-in services for parents through the Daycare Centre and the Head start Program.

3.4.6 Facilitating Appropriate Assessments, Diagnosis and Interventions

Two (2) of the communities surveyed are working in the area of facilitating appropriate assessments, diagnosis and interventions through a monthly paediatric clinic.

3.4.7 Providing a Consistent and Constructive Environment

Three (3) of the communities surveyed have completed work in providing a consistent and constructive environment for suspected FAS/FAE children or other special needs children by assisting in workshops and networks with education specialists, and through a home visit program.

3.4.8 Regulating Sensory Stimulation

One (1) community reported working in the area of regulating sensory stimulation in programs for FAS/FAE through assisting in workshops on this area.

3.4.9 Providing Early Intervention Services to Assist Development

Only two (2) communities reported working to provide early intervention services with health and social services through the Head Start Program.



3.4.10 Strengthening Parent/Child Interaction

Three (3) communities have reported working on projects to strengthen parent child interaction through stimulation workshops with the parents.

3.4.11 Assisting Children with School Readiness

Two (2) communities have reported projects working on assisting children with school readiness through the Head start Home School Readiness Program, and with an Education Specialist.

3.5 Detailed Recommendations for Section Three

Recommendation No. 8:

A professional with experience in early childhood programs should be hired to develop a screening assessment for the early childhood or daycare programs. The screening assessment tool would be distributed by the Regional Coordinator to the Centres to be given to all children registering in an Early Childhood Program.

This screening, based on parental consent, and undertaken with input from the parent(s), should be used according to a policy or protocol adopted by the Early Childhood Centre. If indicated by the results, the screening would be used as a referral for further evaluation by a clinician or an early intervention program.

Training should be provided to the manager/head educator of the daycare or early childhood centre on the appropriate use of the screening assessment, and, as per the following detailed recommendation no. 9, on the policy or protocol for applying it.

Recommendation No. 9:

A model of an appropriate protocol for the management of special needs children, and in particular children with FAS/FAE, should be developed by a professional with experience in working with special needs children from 0 – 6 years of age in an Early Childhood setting.

The protocol would be distributed by the Regional Coordinator for adaptation by each Centre for use in their Daycare or Early Childhood Program. The professional would give specific training to each manager and staff on the use of this protocol in the daycare or early childhood centre.

As previously referred to in Recommendation No. 5, the FNQLHSSC should request funding to hire the services of a specialist-educator who would visit





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each of the Early Childhood Programs to assist with the implementation of the management protocol, and to provide support and assistance to the educators in managing the special needs of these children.

Recommendation No. 10:

A child with FAS/FAE is a dilemma for life, and therefore will touch all services. Since training and resources are reported as the major difficulty in coping with children suspected of having FAS/FAE, it is recommended that the FNQLHSSC cooperate with the various First Nations and Inuit agencies in education such as the FNEC, IECAM, KRSB and the CRA for Education to develop a series of “district” training sessions for both Early Childhood and Elementary education programs in different areas of the province.

The idea of “district” training sessions is to facilitate language, minimize travelling distance, equalize opportunity and allow for the mobilization of maximum resources for both the Early Childhood and the Education sectors.

The training sessions while providing general orientations should focus on intervention strategies and resources for educators and teachers of children with FAS/FAE, and special needs in general.

Recommendation No. 11:

Parental support is also an issue, and very important so that the services to the child remain constructive and consistent. To ensure adequate support for parents will require a networking of health, child and education services to develop parental services, and a support group for parents, ideally facilitated by a professional or a clinician.

A support group is important for parents to share their difficulties and successes, and to provide advocacy for parents and their children to access services such as respite care, counselling services, home educator services.

The Early Childhood Centre has a role in providing support and information, as well as referring parents to the services of the support group, or to other services available through health or social services.

Recommendation No. 12:

Prevention of any future occurrence of FAS/FAE is one hundred percent possible. It is recommended that a networking of the resources of each community, initiated by the Health Centre or Community Nurse, be developed to establish a community-based program of prevention and intervention for FAS/FAE.





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The Early Childhood Programs, as determined in each community, will have an important role to play in these prevention and intervention programs by giving information and support to parents, providing referrals, and dispensing successful early interventions with the children in the Daycare or Early Childhood Centre.

Protocols should be developed within each community between education and ECE to provide consistency for the most supportive and successful passage of children with special needs, such as those with FAS/FAE, from Early Childhood programs into the community kindergarten programs.

Recommendation No. 13:

To highlight the importance of the work of prevention and early intervention with FAS/FAE, the FNQLHSSC should work with the First Nations and Inuit educational authorities to hold a Quebec regional conference on FAS/FAE with an agenda on all aspects of prevention, intervention and managing FAS/FAE. The conference would also provide an opportunity for participants to hear the expertise first hand, and to review or order the latest materials and resources in the field.





Section Four: Resources

4.1 Training Programs

In relation to recommending training programs, the communities all referred to those provided by the First Nations Education Council, and the Cree Regional Authority. There was also mention of working with NNADAPP.

Only seven (7) of the communities (30%) reported being able to access training in their Early Childhood Centres due to a lack of available qualified facilitators. It was suggested that the managers and coordinators who took previous training might have to give the workshops. One NNADAP worker facilitated a workshop for one of the First Nations Head Start programs.

4.2 Screening/Assessment Tools

Only four (4) of the communities (17%) confirmed that they had access to screening and assessment tools or services such as Portage. The examples made available in the surveys were:

- Portage Assessment,
- Evaluation checklists,
- Miller, Caroline, Nipising,
- Parent social history.

4.3 Books

Two (2) of the communities responded that they had reference books on FAS/FAE available to the parents and workers of the Early Childhood Centre. The reference books given as examples on the survey were as follows:

- “A Guide for Daily Living for Families and Children with FAS/FAE”;
- “It Takes a Community”;
- “Our Children, Our Future – Put An End to FAS/FAE”;
- “Before My Birth” (video).

The reasons given for not having books available included that most of the research for information on FAS/FAE is done on the internet; or that the program focuses on many disabilities, and FAS/FAE is not the only problem; or that the programs are just beginning to receive information on this topic.





4.4 Educational and Training Materials

The materials that were listed as being recommended for use in an Early Childhood Program are as follows:

- FNQLHSSC Agenda;
- First Nations Education Council documents;
- Patricia Tanner Halverson Listings;
- “It Takes A Community”, Health Canada;
- Resource Centre for Parents on Parenting;
- “Before My Birth”, video.

Three (3) of the communities (13%) replied that they had training and educational materials available to the educators and parents of the Early Childhood Programs.

When asked why the materials were not available in the Early Childhood Centre, the communities who replied stated that they did not know where to look for materials, or that they were just receiving some materials.

4.5 Materials/Newsletters

In response to the request to list packages of materials or newsletters from agencies that provide useful information on FAS/FAE, the following suggestions were offered from the communities:

- Canadian Childcare Foundation Resources;
- First Nations Education Council Listings;
- Cree Health Board Information;
- Organization of Community Health Representatives;
- “Kariwios”, a publication of Kanusatake Health Centre;
- SAFERA;
- Social Services Pamphlets;
- FAS Toolkit;
- “It Takes a Community”;
- “Before My Birth”, video.

Three (3) of the communities (13%) replied that some of these materials were available to workers and parents of the Early Childhood program. The reasons given for their non-availability was that the communities lacked the necessary tools, or that it was new to the Centres at the moment.





4.6 Internet Sites

The use of the Internet proved to be a more popular information provider as five (5) of the communities responded that websites were available to educators and parents for information on FAS/FAE. The websites that were cited in the surveys are as follows:

- ccsa.ca/fasgen.html;
- cepn-fnec.com;
- hc-sc.qc.ca (Health Canada);
- safera.qc.ca - other related sites;

The reasons stated for not using the Internet sites was the poor functioning of the computer, or the lack of ability to use the computer, or the lack of availability of a computer with modem and Internet service, or the lack of funding to purchase a computer.

4.7 Links/Networks

Only two (2) of the communities (9%) stated that the Early Childhood Program used or benefited from links and networks. The Links/Networks that were suggested were as follows:

- FNEC;
- CHUL (genetique-Dr. Laframboise);
- Education;
- Cree Regional Administration;
- SAFERA;
- Health Canada.

No reasons were provided by the surveys as to why other communities did not use links/networks.

4.8 Organizations, Agencies and Institutes

The organizations, agencies and institutes dedicated to FAS/FAE that were suggested by the survey respondents are as follows:

- FNEC;
- CHUL;
- Cree Child and Family Services (CRA);
- Education, Cree Regional Administration;
- FAS/FAE Support Network of BC;
- FNQLHSSC;
- Health & Social Services;
- SAFERA.





Only four (4) of the communities (17%) stated that they presently benefit from these organizations. The only reason given for not benefiting is that the subject is new, and that work still needed to be done in this area.

4.9 Additional Comments

The additional comments that were provided by the respondents are as follows:

« As far as our community members we don't have any parents or young single mothers that are aware of FAS, FAE. The problems that we deal with are speech problems, attention & comprehensiveness is a problem. Also behavioural is a serious problem. I'm sure that if there were a program that could be given to our members maybe then they would be able to understand and better deal with this problem. »

« I think our community is not informed or have much knowledge about FAS/FAE and would certainly benefit if there was training made available within the community. I strongly believe that there are many children with FAS/FAE but are not detected. »

« In our community we do not have children that have been identified as having FAS/FAE, but we suspect a few children that may. We do not have established programs for these cases. The screening and assistance for these children with FAS/FAE is an urgent matter. »

« The training and supplying of our professionals is a top priority. »

« Screening tests are very lengthy and costly. These tests include Neuropsychology. Also, those from the CHUL regarding diagnosis. Children attending MEQ schools have access to specialized services such as: speech therapy and other special education services. »

« Lack of knowledge and assessing of medical resources. Lack of Educational awareness by the parents. »

« Supply the professionals working in early childhood, health and education with the resources they need. »

« SECTION 4: For this section, we are lacking the training and knowledge necessary to develop FAS programs and training. »

« I received this survey on March 21/2002 and only had few minutes to answer to some questions (vacation until April 2). Our community based program such





as Brighter Futures / Head start deal with children & special needs. We do not have a community-based program for FAS. »

« We do not have any identified FAS/FAE, but we lack info for prevention. »

4.10 Detailed Recommendations for Section Four

Recommendation No. 14:

A Resource Guide was developed as a companion to this needs assessment, and, in researching materials under each of the headings in Section Four, it became very apparent that there is little available in French language other than materials translated by the Canadian Centre on Substance Abuse, Health Canada, SAFERA and the First Nations Education Council.

It is recommended as extremely important that funding for translation be made available to the FNQLHSSC and other agencies such as the First Nations Education Council so that materials from leading authors and agencies in the field, and videos and other types of materials can be made available as quickly as possible to all the First Nations communities of Quebec.

Recommendation No. 15:

The leading reason given for not having materials available to educators and parents was not knowing where to look, and what could be available. It would, therefore, be extremely imperative to have the Resource Guide translated, printed and distributed as quickly as possible to the First Nations and Inuit Early Childhood programs.

This Resource Guide is a first edition, and should be updated and redistributed annually to ensure that the Early Childhood programs are aware of the latest and most current information and materials. As more work is done in this field, and as educators start developing their own materials and resources, it would be essential to extend future versions of the Resource Guide to include a section on interventions and programming.

Detailed Recommendation No. 16:

Another area of concern is the lack of appropriate screening and assessment tools. At present, screening clinics are only available through paediatric hospitals such as St. Justine's in Montreal, or an agency such as Portage, and screening tools are few, and often newly developed.





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It is recommended that Health Canada and the FNQLHSSC lobby to create more awareness of this problem among the medical profession, and to have research in the area of FAS/FAE put on the agenda for all medical conferences, workshops and colloquia.

Since psychologists, as per Recommendation No. 6, are the singular professional that is stated in the surveys as being accessible to most communities, it is recommended that a colloquium be organized by the FNQLHSSC for psychologists, interested medical professionals and possibly other clinicians servicing First Nation and Inuit Communities to discuss and provide suggestions for screening tools, protocols and case management for FAS/FAE.





Section Five: Summary and Action Plan

5.1 Summary of Findings

The Needs Assessment clearly indicates that there is a lack of information, training and resources for FAS/FAE in most of the Early Childhood programs among the First Nation communities of Quebec. Especially critical, is the lack of information, support networks, and materials available in French language.

It is important that a general reorganization and networking of resources to address these issues occurs on all levels. At the community level, networking is essential to put in place prevention and intervention programs to eliminate the risk of alcohol consumption during pregnancy. Networking is also needed to put in place life-long programs of care for children with FAS/FAE, and support programs for their parents and families.

At the regional level, networking is necessary with the education sector to address issues of punctual training and appropriate resources, and with national agencies to lobby for awareness campaigns among medical and other professionals and clinicians. A regional conference sponsored by the Health Commission and various First Nations and Inuit educational authorities is strongly suggested.

Recommendations based on the findings of the Needs Assessment have been summarized below.

5.2 General Recommendations

The sixteen (16) detailed recommendations can be summarized into the following general recommendations:

- The Resource Guide should be translated and distributed as soon as possible, and updated annually thereafter;
- Translation of key information documents and resources into French must be undertaken to provide information and resources to francophone First Nations communities;
- Regionally-located training sessions for information and intervention should be developed and implemented;
- Efforts should be made in the communities to provide support services to parents of children with FAS/FAE;
- The FNQLHSSC should seek funds to organize a colloquium for professionals on screening protocols and case management; and, to engage the services of an experienced professional to develop a screening protocol and case management policy for special needs in





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- general, and FAS/FAE in particular, for Early Childhood/Daycare programs;
- The FNQLHSSC should seek funding to hire the services of a specialist-educator to travel to each of the Early Childhood Programs, as needed, to assist with the implementation of a case management policy for special needs, and to provide assistance for the educators in program delivery with FAS/FAE children;
 - Networking of services in the communities is needed to provide appropriate prevention to diminish and eventually eliminate future cases of FAS/FAE in First Nations and Inuit Communities; and for intervention programs to provide appropriate services for the life of the child, and support for the family and care-providers;
 - Funding should be provided for the provision of a Quebec regional conference on FAS/FAE to be sponsored by both the health and education sectors;
 - The medical profession has a key role to play, and as such should be targeted by national agencies to become more actively involved in this problem.





5.3 Action Plan

General Recommendation	Planned Activities	Resp.	Time Frame*
Translation and distribution of the Resource Guide.	Approval, translation, printing and distribution	Regional Coordinator	August 2002
Annual updating of Resource Guide.	Insert new resources and materials	Regional Coordinator	August 2003, annually thereafter
Translation of key information documents and resources into French	Acquisition of key documents; Translation of documents Distribution to ECE Centres	Regional Coordinator Translation Services	September 2002
Regional training sessions for information and intervention	Meeting to establish service agreement Hiring of trainers Organization and coordination of training sessions Evaluation Follow-up report on training Implement recommendations	Regional Coordinator Director HC Director FNEC Director CRA Director IECAM Director KRSB	February 2003
Provision of support services to parents of children with FAS/FAE	Community activity	Health Directors/ Directors of Child and Family Services	September 2002
Organization of a colloquium for professionals on screening protocols and case management;	Establish logistics Send invitations/agenda Facilitate	FNQLHSSC Regional Coordinators	Spring 2003





General Recommendation	Planned Activities	Resp.	Time Frame*
	Record proceedings Implement Recommendations		
Engaging the services of a specialist-educator to travel to each of the Early Childhood Programs	Tenders Hiring Protocol for service Request Services/assistance	FNQLHSSC Regional Coordinator	February 2003
Networking of services in the communities to provide appropriate prevention and intervention programs	Community programs	Directors of Health/ Directors of Child and Family Services	March 2003
Coordinating a regional conference on FAS/FAE to be sponsored by both the health and education sectors	Logistics Requests for proposals Agenda Invitations Coordination Facilitation Follow-up	FNQLHSSC FNEC CRA IECAM KRSB	March 2003
Engagement of the medical profession by national agencies to become more actively involved in this problem.	Awareness Lobbying Promotion	FNQLHSSC and Health Canada	On going

***Note:** The timeframes indicated in the Action Plan are tentative, and will vary dependent upon the availability of financial and human resources.

