

AN ASSESSMENT OF A CRUCIAL INITIATIVE

**Youth-at-Risk School and Community C.A.R.E*--The
Nogemag Model
Education of the Heart, Hand, Mind and Spirit**

Development, Demonstration and Dissemination

DON CLAIRMONT 2007

ATLANTIC INSTITUTE OF CRIMINOLOGY

DALHOUSIE UNIVERSITY

CENTRAL OBJECTIVES AND WORK PLAN OF THE NOGEMAG MODEL PROJECT

As stated in the project plan, the project's objectives were specific – refinement of the Medicine Wheel model and tools and their dissemination, the research on the prevalence of FASD, and the presentation and publication of the Nogemag model. The real 'clients' of this project were identified as the professionals who are using or could use the tools and the parents who have had children in the programs. While FASD-disabled clients were indeed interviewed – these data are analyzed below - basically this project was about creating the Medicine Wheel Model tools that were successful in the Elsipogtog schools and disseminating them to people in other First Nation communities. There was also a concern to determine how to generalize the approach, to make what might be called, “a better whole-system model” through community mapping sessions with various groups (largely educational teachers, specialists and administrators and community health activists) among New Brunswick's First Nations and throughout Atlantic Canada. The community mapping sessions, which featured a strongly visual dimension, identified four central needs in the various communities, namely access to diagnosis in culturally appropriate way, outreach programs, the need for much greater orientation and training about FASD to role players in the justice system, and developing more programs for young people. Another significant objective was to contribute to knowledge and protocols that should be developed, in response to the FASD issues, in various institutional areas, Justice being a special concern. A major objective also was to contribute to the state of knowledge throughout the world on FASD, FASD programming, and FASD tools; this was to be accomplished through presentations at conferences, papers and a video on the Nogemag model in Elsipogtog. This project has been quite ambitious as is evidence in the next section where the work plan and chronology are detailed.

The Nogemag model work plan is detailed below. The emphasis is on development, demonstration and dissemination of the model, summed up as the Medicine Wheels tools, which incorporates the individual, family, institutional areas and the community. The Medicine Wheel framework is attached as appendix B. Examination of the work plan (see below) indicates the central thrusts of extensive planning, continuing development of linkages with FASD-disabled individuals, their families, the community at large and salient professionals, networking and partnering with diverse communities and professional bodies in Atlantic Canada, delivering workshops on the Nogemag approach and FASD-orientation to professionals, obtaining feedback and refining the Nogemag approach, and advancing awareness of FASD and the Nogemag approach through a multi-media approach (e.g., presentations, papers, video). There is so much to this project that it is difficult to assess it.

WHAT WAS DONE IN THE ASSESSMENT

Essentially this assessment was very modest as the resources available were minimal and the evaluation was basically a voluntary effort. The chief research strategy was close collaboration with the Nogemag director through frequent meetings and discussions. Work plans, objectives, a chronology of the project's activities and the video documentary of the Nogemag approach were made available to the researcher. Interview guides were prepared for the FASD clients, their support people and the local service providers but only the client data were analyzed (see the write-up below). Questionnaires developed and distributed by Dr. Cox to Justice professionals were put into machine readable form and analyzed (see the write-up below). Interview guides developed by the writer to guide the personal one-on-one interviews carried out with a small sample of key persons constituted the chief method adopted to assess the larger impact of the Nogemag approach. There was no review of the FASD literature since the writer had completed such a review in his 2003 assessment of the earlier Nogemag initiative with youth deemed problematic for regular schooling (Clairmont, 2003). In addition, as described in the appendix, spread sheets (i.e., excel) were prepared for diverse data sets and also for the Medicine Wheel Tools to assist in their utilization in Elsipogtog and elsewhere.

THE CHRONOLOGY OF THE NOGEMAG MODEL PROJECT

A basic start to appreciating this complex project was to obtain a chronology of the activities carried out and the outcomes associated with them. The project director provided the chronology (SEE APPENDIX 2). It is an extensive eleven page chronology and can only be touched upon here. Extending from the Spring of 2005 to the Spring of 2007, the chronology describes the various trajectories of the NCPC project, namely the testing, refinement and formalization of the Medicine Wheel Tools, the establishment and solidification of community support leading to the development of the Elsipogtog Eastern Door FASD program with its singular diagnostic and treatment capacity, the partnering with other key role players to effect the emergence of an FASD strategy and diagnostic capacity at the provincial level, the constant dissemination of the Nogemag approach and Medicine Wheel tools to other aboriginal communities in Atlantic Canada and to mainstream communities as well, the extension of training and presentations beyond the primary educational focus to justice, social work and health professionals, the presentations at national and international conferences, and the multi-media outreach reflected in the video documentary, website, and academic papers. These trajectories were often being elaborated concurrently but it appears valid to say that in the early phases of the two year period emphasis was on the refinement of the Medicine Wheel tools and the institutionalization of the FASD initiative at the community (i.e., Elsipogtog) level while at the later phases the emphasis was on partnering, networking and dissemination of Nogemag model beyond Elsipogtog.

THE DEVELOPMENT OF THE NOGEMAG APPROACH

In the 2003 assessment noted above, reference is made to the earlier work with troubled and disabled students and FASD effects which laid the foundation for the development of the Medicine Wheel Tools and which made that approach so valuable to be disseminated elsewhere. It seems fair to say that the foundations arose “in response to a school evaluation done by a professor from UPEI, before the interventions in 1996, which noted the high level of behavioral and learning problems in the local Elsipogtog school and also the possibility of undiagnosed FAS”. It was estimated at that time that perhaps as many as 20% of youths in grades 1 to 3 were affected by FASD. An evaluation in 2002 called attention to significant improvements in the early grades as a result of the new initiatives. A subsequent evaluation concluded that the school has achieved an effective transformation and commented positively on the Medicine Wheel approach. An external evaluation, after the interventions, was completed May, 2006 by Bowie and Quigg. That team also evaluated the provincial schools in the district. According to that evaluation,

“Some extraordinary achievements have been accomplished and put in place through Dr. Cox’s work. Because of the extensive nature of her documentation pertaining to the ‘Medicine Wheel Developmental History’ and the Medicine Wheel Student Index-An Education of Heart, Hand, Mind and Spirit’ (Appendix B) findings and documentation pertaining to specific student problems are channeled to the appropriate support staff or community agency for action and intervention.”

The school has no area in which it is not functional and for the most part receives the highest ratings of Effective or Very Effective in every category evaluated. The leadership and staff have accomplished some impressive changes since the last evaluation....they are to be commended highly for what they have been able to accomplish”.

Additional data provided by Elsipogtog school officials underlined the significant of the FASD-based intervention. As the director reported, “In 1997 before we started the interventions 80% of the kids grades one to three read below grade level. A year later and until now - from 1998-2006 - 70-90% of kids read on or above grade level--quite a turn around. Also our kids now score as well or sometimes better on provincial assessments than kids in Provincial schools. Also the drop-out rates of the kids who were diagnosed FASD and other special needs are not significantly different than the rates of the other children in the school. By adapting programs many of the kids with learning problems are learning basic skills and going to high school and even graduating”. The 2003 assessment provided by this writer indicated that the special FASD-based program developed for youth unable to function appropriately in regular school was highly successful in enabling these students to re-enter the school program and do well in it, In addition that 2003 assessment reported that there seemed to be a reduction in the youth crime rate that could be attributed in part to the Nogemag interventions.

Over the years the Nogemag approach has become both formalized and elaborated. Good ideas developed elsewhere also have been sought out and incorporated. For example, the Medicine Wheel Difference Game cards have been developed to engage the mothers of FASD-disabled youth in the awareness and response to FASD; apparently, “this model is a cultural adaptation of the PCAP model in University of Washington and that has proven to be highly effective” so it has been adapted, in consultation with community members, to be more effective for First Nation communities. Another specific tool in the Medicine Wheel approach has been the Medicine Wheel Community Development Tool, developed as a way to facilitate family and community dialogue about FASD; in turn it has “led to the development of our Diagnostic, Intervention and Prevention Centre, the Eastern Door”. The whole package of tools together provide for an impressive strategy of intervention and can and has been readily taught to and grasped by key role players in other communities (see below for detailed write-ups).

Taken as a whole the Medicine Wheel product provides for rigorous accountability and tracking. It permits complex analyses and identification of effective treatment referrals. As the Medicine Wheel Tools initiator has observed, “I would like to be able to get the data from the Screening Tool into a form that would keep the holistic feel but at the same time allow for data analysis in the form of correlations between domains and severity--for instance which children are designated as having severe problems in both academic and neurobehavioral domain or which children have severe family problems in terms of alcohol use of parents and also moderate neurobehavioral and academic problems etc. I also would like to be able for referral purposes to gather all the children in all the classes that have problems in each domain so that we can pass lists on to specialists for service. The tool functions as screening tool for basis of service provision as well as giving us an idea of which kids need to be more fully assessed. It also serves as a tool for projection of services for the next school year in terms of funding from INAC. And for them I would like to have graphs to show for instance how many children have been identified as average, and how many with special needs, and how many above average as perceived by teachers. The medicine wheel history form would be great if we could get the information into a data base so that we could keep track of information and all the variables in the history and then how this will interplay with any intervention that we provide--for instance variables of smoking prenatally, alcohol and drug exposure pre-natally, the number of foster placements, the education of parents, etc”. Putting the Medicine Wheel Tools into an excel spread-sheet format was considered a first step in effecting such analyses with the valuable information yielded by the Nogemag approach (see appendices 7 to 11).

THE FASD STAKEHOLDERS IN ELSIPOGTOG

As noted above, interview guides were prepared for different stakeholder groupings in Elsipogtog but only data from the FASD-disabled youth are considered here. Fully 50% of the identified FASD-affected youth were interviewed since the

specific NCPC project objectives focused not on service delivery but on the development and dissemination of the Nogemag model. . A different report will deal with the interview data obtained from support persons (chiefly mothers) and the local Elsipogtog service providers. The views of both groupings should be very interesting. The mothers (and other support group persons) were engaged in focus groups and also involved in an advisory capacity and in the orientation provided to professionals. One very crucial development in the FASD initiative generated under Dr. Cox's leadership has been the Eastern Door project and it will be briefly discussed after the section dealing with the views and experiences of the FASD-affected youth.

THE CLIENT SURVEY: AN OVERVIEW OF THE FASD-DISABLED YOUTH

There were 20 interviews completed, 12 by youth between the ages of twelve and seventeen and 8 by youth aged eighteen or more. What follows is a brief overview of the results where the two age categories are considered separately and entitled YOUTH and YOUNG ADULTS respectively.

Youth

The twelve youth gave a wide variety of responses but here we are looking for some underlying patterns. Two-thirds of the youth were male. About the same ratio was attending school and only one youth was, at the time, beyond grade 9 at school. Such facts suggest some serious schooling issues. The youth presented a rather mixed perspective on the school experience. Half identified a course or specific school program as what they liked most about school but about the same percentage considered that school was difficult for them. With one exception all the youth reported that they received appreciated help at school. Still, only two of the twelve reported that they had never been expelled or suspended. Asked to identify the sources of their problems, nine of the ten who had been expelled or suspended noted "conflict with other students" and eight of the ten noted "conflict with teachers"; surprisingly, very few indicated that a tough learning situation (e.g., "I could not learn", "the school work was too difficult") was responsible for their problems at school.

The youth appeared to be well-integrated with respect to traditional Mi'kmaq culture. The large majority (minimally nine of twelve) reported being fluent in the Mi'kmaq language, going to pow wows and sweats, participating in smudging ceremonies and being interested in greater engagement in Mi'kmaq culture. The majority (nine of twelve) also reported involvement in community sport activities.

The youth reported having significant special social relationships. Eleven of the twelve claimed to have had a special person with whom they were closely tied and who provided them with the entire spectrum of support, material, social and psychological.

Three quarters of the youth indicated that they “get along well with [my] family”. At the same time, half the youth had been placed once or more often in foster homes.

Half the youths reported that they had had “some trouble with the Law” but only one of these youths, over half of whom were only thirteen or fourteen years of age, had ever appeared in court as an offender. The majority (seven of twelve) did indicate that they had had health problems while growing up. Nine of the twelve youth claimed to have heard of FASD but only four reported that they themselves had FASD.

On the whole the youth presented themselves as coping well with life. Less than half reported “getting stressed out” and two-thirds reported engaging regularly in exercise. The large majority (ten of twelve) agreed with the statements, “I am a happy person” and “I am doing the things I want to do”. Most respondents also claimed to have close friends of their own age group. Asked to indicate from a list what challenges they saw ahead for themselves, the top two challenges, acknowledged by two-thirds of this sub-sample, were “holding a good job” and “being a good parent”.

Young Adults

As with the youth, the majority of young adult respondents was male (five of eight). None were currently in school and none had completed high school. And like their younger counterparts, their views of school clashed somewhat with their school experiences. Most reported that they did not find school difficult and that they had appreciated help there (six of eight) but nevertheless only one reported never being expelled or suspended or dropping out. The chief correlate for that experience was indicated to be “conflict with teachers” as reported by the young adults.

The young adults, again consistent with the youth, reported themselves well-integrated in Mi’kmaq traditional activities. All had attended pow wows and wanted to become more engaged in Mi’kmaq culture. All but one claimed to be fluent in the Mi’kmaq language and to have participated in sweats. All but two had been involved in smudging ceremonies and in drumming. The young adults, on the surface at least, generally projected a sense of community integration too. Five of the eight reported having had special people who supported them in a wide variety of ways. With one exception, all these respondents indicated that had got along well with their family. Still three of the eight reported having been placed in one or more foster home.

All but one of the young adults reported that they had had trouble with the Law and that they had an arrest record. Half reported having spent time in a Group Home and an equal number reported having been incarcerated. Few reported any health problems but the majority did indicate that they were dependent on social assistance and had much trouble getting a job (seven of the eight respondents). They generally did report a need for assistance in coping with life; seven of the eight indicated they needed help in budgeting and managing their resources. Virtually all the young adults indicated that they

had heard of FASD and knew someone with this disability. Roughly the same proportion of young adults as youth (i.e., 37% to 33%) considered that they themselves had an FASD disability.

As with the youth, the young adults generally agreed with the statements, “I am a happy person”, and “I have close friends in my own age group”. For the young adults the most often cited challenge for them now was perceived as “holding a good job”.

Conclusion

Clearly there were key parallels between the youth and the young adults.

1. They were predominantly males.
2. They had had – and, in the case of some youths, may be still having – difficulties in school. In both groupings the respondents generally reported liking some courses and programs and receiving valued assistance from school staff; yet, at the same time, they indicated that expulsions and suspensions were common and most youths and young adults reported conflict with teachers and conflict with other students.
3. The respondents in both groupings generally reported fluency in the Mi’kmaq language and being well integrated in Mi’kmaq cultural activities. More generally, the respondents indicated that they were integrated in the community (e.g., had friends, engaged in sports and so on)
4. Generally the youth and young adults reported getting along well with their families though a significant minority in each grouping also reported having been placed in foster homes.
5. Similarly, they generally reported an awareness of FASD but did not think that they were affected by it.
6. Almost all the young adults reported having been in trouble with the law and subjected to arrest and court processing while among the youth – many of whom it should be noted were only thirteen or fourteen years of age – such experiences were uncommon.
7. Generally the respondents in both grouping presented a rather positive self-presentation (e.g., happy, have close friends) but the young adults also cited serious problems getting on with their lives, reporting welfare dependency and difficulty getting and/or holding a job. In both grouping the major challenge the respondents as they reflected on their future was holding a good job.

THE EASTERN DOOR INITIATIVE

According to the coordinator, The Eastern Door, a formalization and elaboration of FASD-initiatives beginning in the late 1990s, became operative in October 2005 and its first client was assessed in June 2006; as of March 2007 five clients had been assessed as FASD-affected and ten other referrals were waiting to be processed. The chief criteria utilized to assess for FASD have been (a) disclosure of alcohol consumption during pregnancy and (b) inappropriate social behaviour. The interviewees advanced the concept of a continuum of FASD disability and on that basis reported that all five positive diagnoses were deemed to be cases of mild FASD-affected youth. The referrals to the Eastern Door diagnostic team have thus far have come from the school system –not surprisingly since the Elsipogtog FASD initiative was rooted in a strategy to respond effectively to problems identified at the school. Respondents expected that referrals will come from family members and guardians as well; as one Eastern Door respondent commented, “It’s a new program and maybe in the future there will be a stream from family members”. The referrals are made to the nurse / coordinator who creates a file and then the Eastern Door team swings into action. The diagnosis generally generates a treatment plan for the family and there is assessment or monitoring of that plan.

The Eastern Door’s paid staff is modest, basically the coordinator (a trained nurse) and an assistant with, at the time of this evaluation, a vacancy for a role providing support to the family and related outreach activity. Other crucial members of the Eastern Door team are the community’s medical doctor, one of Elsipogtog’s psychologist and of course Dr. Cox, the educational psychologist and initiator of Elsipogtog’s FASD activity. The team which assesses referrals for FASD and determines appropriate treatment consists of the coordinator, the doctor, the psychologist and Dr. Cox. Essentially the doctor examines eyes, height and weight (there is no brain imaging and no DNA tests) while the psychologist looks at behaviour and learning. The coordinator provides input on the family history and circumstances while Dr. Cox, among other things, brings to the table school performance and behaviour. In keeping with Canadian Guidelines (see below) both psychological and medical data and assessment are required and for those reasons no diagnosis is carried out with children prior to age six or seven – as one respondent commented, “there could be some medical assessment with children as young as two but such children would have to have special pronounced features which are rare, and in any event Canadian Guidelines rule out psychological assessment at that age”. As one respondent expressed it – “the Eastern Door is a one stop-shop and subsequent developments such as a diagnostic facility at the Georges Dumont Hospital in Moncton will be used to enhance our diagnoses as a kind of virtual team”. The key FASD team at the Eastern Door reportedly meets monthly or bi-monthly. It did start off meeting more frequently but it is demanding work and an additional workload for most participants.

There appears to be a strong consensus among the role players in the Eastern Door project concerning the value of the initiative and of the specific diagnosis, treatment and outreach objectives it has taken on. There is a sense that Elsipogtog is pioneering a

path in FASD work and, considering its small size (roughly 2200 reserve residents), making an amazing contribution to FASD practical and theoretical knowledge in Canada. There is also a healthy diversity of views concerning FASD issues. With respect to the prevalence of FASD among Elsipogtog youth, estimates of prevalence ranged from 10% to 40% of the youth though all agreed that alcohol consumption is extensive (not to speak of drug use and smoking) among pregnant women during the first trimester of pregnancy – described by two respondents as a necessary though not sufficient cause of FASD. Interviews carried out in Elsipogtog have reportedly found that as many as 40% of the pregnant women consumed alcohol during that trimester period. The Eastern Door respondents shared an emphasis on outreach activities and having family sessions though there were varying views on issues such as whether the Eastern Door needs to be located more in the “community” than in the community’s health centre (i.e., located in a less bureaucratic milieu) and on the reliability of some information provided by mothers and other family members. Given the still controversial nature of FASD diagnosis, it is not surprisingly that there has been occasional disagreement concerning some positive diagnoses.

Perhaps the most significant issue facing the Eastern Door initiative is the absence of long-term funding. Reportedly, the funding to date has come from FASD sources and from maternal child care sources for periods of two or three years. Outreach and monitoring case plans typically are very labour intensive and deemed to be under-funded; also, as noted, other central team roles are provided on an extra-workload basis, a combination that leaves the Eastern Door subject to future uncertainty. Other issues might well include the quality of diagnosis and the feedback to the schools but this modest assessment was not able to follow up on these points raised by one or other of the respondents.

NETWORKING AND DISSEMINATION

Given the recency of widespread public awareness with respect to FASD and the path-breaking Elsipogtog activity evident in the Medicine Wheel Tools and the Eastern Door, the NCPC project’s emphasis on dissemination and networking has been very appropriate. After several years of research and consultation a national committee published the Canadian Guidelines for FASD Diagnosis in 2005 (CMAJ 2005;172(5suppl): S1-S21). According to one respondent, there was a national survey of physicians around the publication of the guidelines and it highlighted out the lack of knowledge of physicians on the subject. Certainly there has been sign of significant improvement since the publication. For example, on April 14 2007 there was an article in the Globe and Mail calling attention to a major initiative in Manitoba, namely a \$7.5 million funding by the province for prevention, diagnosis and intervention with respect to FASD, conceptualized as causing preventable birth defects and developmental delays in children. The Nogemag project has made a significant impact on this growing awareness and on the diagnosis and treatment of FASD. In this section there is a modest survey of

that impact in New Brunswick, among First Nation communities and the mainstream society, in the other Atlantic Canada provinces and at the national / international level. Partnering and networking has been a central focus of the project and the results are impressive, especially in relation to the FASD developments in New Brunswick.

The Nogemag impact for New Brunswick is seen in new provincial policy and in new funding. These developments were the fruit of workshops provided by Dr. Cox and her various FASD partners (see below) in diverse New Brunswick milieus, as well as her and others' effective lobbying of bureaucrats and political leaders. Building on earlier networking with FASD advocates in Fredericton, Dr. Cox helped arrange a meeting to advance the FASD agenda in the winter of 2007 with key provincial bureaucrats (a deputy minister and senior Health official), a well-know provincial political leader and a Moncton doctor who had served on the national committee which produced the Canadian Guidelines. A central goal was to obtain policy and financial support for a diagnostic capacity at the Georges Dumont hospital in Moncton, thereby making FASD diagnosis accessible to all people in the province not just those in Elsipogtog; of course it was anticipated that such a diagnostic capacity would strengthen the capacity at Elsipogtog as well. The lobbying met with great success and in May 2007 provincial funding enabled the hiring of a coordinator for a diagnostic program at the Georges Dumont. In addition, provincial officials indicated that they wanted to have a provincial FASD strategy in place by the Fall of 2007. Meetings and presentations to senior provincial administrators and to probation officers were also being planned.

The senior Georges Dumont doctor with ultimate administrative responsibility for the new diagnostic program there noted that the developments in Elsipogtog were the major push factor behind the recent FASD developments elsewhere in New Brunswick. In the case of the Moncton program – not yet up and running at the time of this interview in May 2007 though the doctor and nurse to be involved in the diagnostic centre were in place – he reaffirmed the significance of pivotal network identified above which persuaded provincial authorities to invest in the FASD agenda. It was stressed that the Moncton program provided only diagnostic capacity and the senior administrator was hopeful that there would be sustained funding; he envisioned a future where there would also be a treatment capacity for mainstream New Brunswick comparable to that provided at Elsipogtog for First Nations people. He anticipated that the Eastern Door at Elsipogtog would serve all the bands in New Brunswick. At the same time he acknowledged that treatment along the lines practiced at the Eastern Door was much more demanding of time and resources than diagnosis. The respondent discussed the uncertainty of FASD diagnosis and the need to shore up that capacity and have reliability in assessments. Like the respondents involved in the Eastern Door project he considered the FASD impact to constitute a continuum from modest to severe disability.

REACHING OUT TO THE ABORIGINAL POPULATION

As noted in the chronology Dr. Cox has given workshops and telephone / e-mail information and advice on the Medicine Wheel Tools to virtually all of the directors of Education and many principals and resource teachers” in the New Brunswick First Nations. In New Brunswick the coordinator for FASD awareness among seven First Nation bands was very thankful for the networking established with the Elsipogtog FASD program. He contended that “at least 50% of the people in my communities are affected by FASD and I believe that this is a very conservative figure”. He noted that Health Canada officials informed him of the work in Elsipogtog and he then contacted Dr. Cox in 2005. Subsequently, he attended a workshop presented by Dr. Cox and contacted her on many other occasions “for client consultation and other general information pertaining to FASD, Dr. Cox has never hesitated to help me with my FASD projects and has never asked for any compensation for her time or expertise”. Among the activities for which he sought and received Elsipogtog assistance were designing posters and pamphlets and giving courses and asset mapping related to FASD prevention. He was particularly keen on the Medicine Wheel tools and considered that “that approach should be adopted by all aboriginal FASD workers”. In his summary concept he acknowledged that “Dr. Cox’s work has greatly benefited my people and I am grateful to her and the Elsipogtog Health staff for their guidance and help”.

PRINCE EDWARD ISLAND

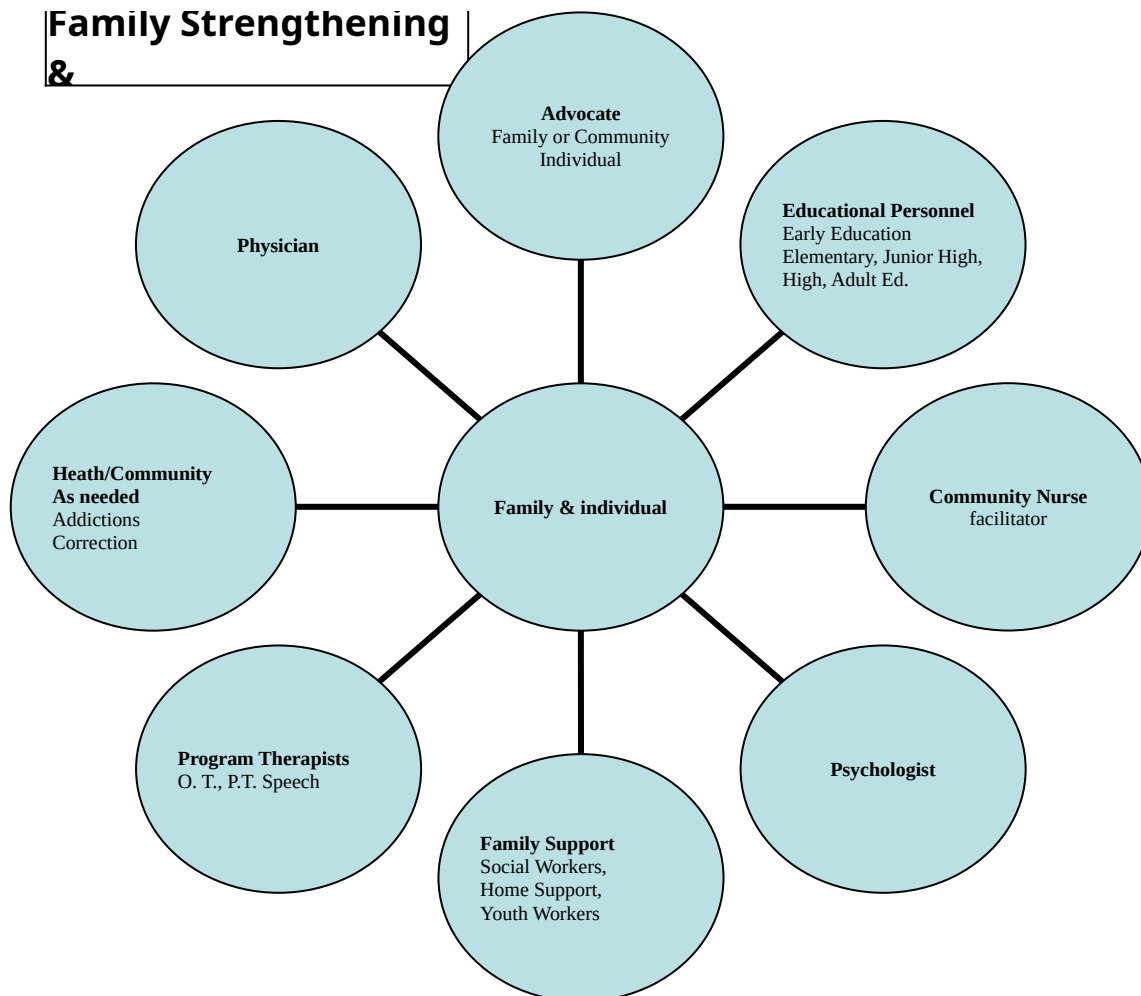
In Prince Edward Island, the driving force behind FASD awareness has been the Aboriginal Women Association. In interviews with two leaders from that organization and another person whose main work is Alcohol and Drug Counselling – all three women were active in aboriginal justice issues as well – the contribution of the Nogemag Model and the pioneering work of Dr. Cox school-based FASD work was readily acknowledged. They reported that the AWA leaders were the major “movers” in drawing attention to the issue and getting some province-wide support. It was considered important that FASD issues were correctly seen as a general social problem and not something limited to aboriginal people. Clearly, these respondents recognized that there were far more significant and sophisticated developments in Elsipogtog but they did cite the existence of a PEI province-wide advisory group, identified a doctor in each of Charlottetown and Summerside who were interested in FASD, even if not engaged in diagnosis, and have produced their own model for responding to FASD (see below). Most of the current momentum in PEI concerning FASD reportedly has been in the last two years and in that regard the influence of Dr. Cox who provided a workshop in PEI and the Elsipogtog work in general (all PEI respondents were aware of the eastern Door program) has been important.

One respondent, coordinating the aboriginal FASD activity there in PEI, and reporting that “FASD is a major social problem in our area and the Island as a whole”, addressed some of the above issues in greater detail. She noted that the AWA initiative began with basic community development work such as talking circles, focus groups and the like, especially on the subject of alcohol abuse and how to intervene effectively. At that time, there was an awareness of the Elsipogtog program “because of the great work done at the school and the Nogemag program” that out-of-school youths with FASD were involved in. “We were very impressed with those initiatives and the values were the same ... everyone had gifts to contribute”. A nationally known medical expert on FASD was brought in to address the PEI group on a diagnostic-intervention model for FASD and he recommended that they establish ties with Dr. Cox and the Elsipogtog program. A subsequent visit to New Brunswick to attend a training session for doctors on FASD, given by Dr. Cox and the medical expert, confirmed expectations – “After seeing the presentation and hearing about the intervention, I knew this program needed to be discussed in PEI. During the presentation, a young adult and a mother spoke and the diagnostic-intervention model focusing on the support and empowerment of the young adult and mother was explained. That is what we wanted in PEI and so called Dr.Cox”. She added, “I believe that, because of the presentations in both FNs in PEI, the community is more involved in our FASD initiative. Both presentations were very powerful and empowering to the community and more and more the community and the Health teams are willing to talk about FASD. Both Health teams have created a “Child Development Model” to reach out to families and children. In addition each team is traveling to Elsipogtog in the future to visit again with the FASD team to further develop their multidisciplinary teams and further develop their model”.

The Medicine Wheel approach was especially appreciated as “the medicine wheel is the connector to First Nations people. We have used this throughout the years when doing any Health, Education or Personal Development work ... I am certain that it will be a greater part of our intervention on PEI”. The Eastern Door approach in Elsipogtog was also cited enthusiastically for being multidisciplinary, professional and empowering for the individual and the family. “I would like to see it become a model site for FASD intervention in Canada, especially the rural areas. People could come and learn about the diagnostic-intervention process and especially the supportive, empowering work with individuals and families. Invite the aboriginal women’s groups from the Eastern provinces to learn from the Eastern Door program”.

PEI MODEL

Family Strengthening &



Interdisciplinary Model re Child Development Issues

The above model represents the pathway to diagnosis and intervention re Child Development Issues, i.e. FASD. At the heart of this model is the role of the family as ultimate decision-makers. The model is designed to allow the family to go at their own pace in dealing with a particular issue. However, if the family wishes to go directly to diagnosis and has given written permission, a professional is chosen to facilitate the

team process (assessment and diagnosis). Ongoing support and follow-up are essential within this model and begin from the initial request for help. Key to the process is the family in the lead.

LABRADOR

Building upon earlier visits and information exchange, a two-day workshop was held in Elsipogtog for Labradoreans key to educational programs and FASD-related issues there. The partnership and learning opportunity provided to the stakeholders in Labrador was much appreciated by the latter as is evidenced, first in the evaluation comments they rendered upon completing the workshop conference at Elsipogtog in November 2007, and secondly, in the individual interviews conducted with two Labradoreans in mid-2007.

Workshop Evaluations

The grouping from Labrador who attended a two day demonstration session in Elsipogtog School was basically school teachers and officials from Nain and Hopedale, the two largest Inuit communities in Northern Labrador. The nine workshop evaluations indicated four teachers, 2 principals, one health / government official, one government and one 'other service profession'. Five of the nine considered the workshop sessions to be excellent in all respects, namely overall satisfaction, resource materials, presentation of information, and organization of information. One such person, a health/government official commented "[It was] very thorough and all questions were answered. [We] gathered so much for continuing our work and a renewed sense of hope and success". Another commented, "You are doing such good things within this school and community. It was very inspiring. This workshop gave us so much information to share and bring back to our community". Others commented on the depth and commitment of all the presenters of the Elsipogtog school team. Among those persons who did not assess the workshop as excellent on all the dimensions mentioned, the views were still very positive as the categories checked off were always either excellent or very good.

With one exception all the respondents acknowledged that the workshop had increased "your understanding of FASD and other special educational needs programming in the school setting" either "quite a bit" or "greatly"; the latter category was checked off by six of the nine respondents. There was a quite similar response to the question, "did the workshop increase your understanding of culturally appropriate evaluation and assessment tools for special educational needs intervention"; here five response indicated "greatly" and four indicated "quite a bit". Six respondents held too that the workshop had "greatly" enhanced "your skills in terms of using evaluation and assessment tools addressing FASD and other special educational needs"; the other three respondents checked off the "quite a bit" option. Lastly, seven of the nine respondents reported "greatly" when asked, "Did the workshop provide you with an opportunity to meet other school and service professionals to discuss ways of dealing with FASD".

The Labradoreans indicated that the workshops met the expectations they held for the event and enabled them to better meet their needs "in your practice in the area of FASD". The expectations were essentially for information on testing tools (i.e., collecting information on student needs and tracking their progress), how the Elsipogtog

school transformed itself, and for new ideas. Another participant reported that he/she was “looking for a template model to provide services to FASD-affected children”. Several persons specifically had expectations or, better, hopes, that the workshop would inform them on working with the parents of FASD-linked and problem students.

As noted, virtually all the workshop participants reported that their expectations and hopes were met. As one respondent noted, “Super testing tools and ideas that we can integrate within our school. Thank you”. Several respondents appreciated that time constraints limited the transfer of all the information they wanted. One participant commented, “[I wanted] more on how to use the tools to diagnose students and develop strategies to help the students but understand that due to time constraints it was not possible but [at least] was touched upon”. The enthusiasm of the Elsipogtog presenters was especially appreciated given the stress and difficulties of working with the consequential impact of FASD. And all participants were very impressed with “the successes your school is experiencing and the growth the community and school has achieved”. One participant summed up the general view quite well in her remarks, “This has been an amazing opportunity on many levels, emotionally, educationally, socially and spiritually. Being able to share the processes undertaken in Elsipogtog has been a tremendous experience”

The workshop participants also were asked what they needed in their practice in the area of FASD. Here, several persons reported that the chief need was to engage outside agencies in their areas for assistance in diagnoses and finding strategies to help students adjust to everyday living. Others mentioned the need to continue to improve their own awareness and understanding of FASD and to build on the framework provided in the workshop. Others cited the need for resources and, in that connection, it was noted that “more people in a position of responsibility have to have greater understanding of the issues related to FASD”. It was apparent in several remarks that partnerships and information exchange were considered crucial to future success and that the “Elsipogtog program and staff” would loom large in their subsequent networking.

The Special Interviews

The two special interviews were carried out with a senior government employee and a special needs teacher, both of who were quite knowledgeable concerning FASD and its impact for students and teachers. The former has been responsible to the school board for FASD issues – among other duties – for the past eight years. As a program specialist, his task has been to deliver training and in-service to teachers and students across Labrador on FASD. He noted that “in the past two years I organized 95 in-services about FASD across the schools, providing training, intervention and resources materials”. The other person has been “working with children affected by FASD and autism” for twelve years, the past several years as guidance counselor, and noted that “recently we have submitted a proposal to the Department of Education for additional teaching support to provide better service to our FASD population”. Both indicated that there has been limited information available to guide them and that they have had to draw principally on their own experiences. Both respondents also considered that FASD is a major social

problem in their areas. The guidance counselor observed that “our community presents us with similar social issues as in Big Cove (Elsipogtog) – high substance abuse and many suicides”. The senior educator commented that

“Population of Newfoundland and Labrador is 500,000. People with FASD are about 5000. Thus it a very serious issue. In addition, the reality is that diagnosis for it is difficult, meaning that there could be even more than 5000 people who have FASD but have not been diagnosed.”

One of the participants – the senior educator – had become aware of Dr. Cox’s Elsipogtog program a few years earlier when she visited Labrador for an in-service. From there he “stayed in touch”, exchanging information (especially by e-mail) on issues surrounding FASD and attending national and regional conferences on FASD (Ottawa, Moncton) where she made presentations. He contacted her and arranged to bring Labrador teachers to the November 2006 workshop. The guidance counselor was part of the latter group and especially was interested in how her Elsipogtog counterparts were documenting the success of their interventions. Both respondents reported that the involvement with Dr. Cox and the Elsipogtog program has been very significant for their own work; as one said, “Lori has been very supportive responding to any questions about her program such as funding, resources. I am trying to see how their cultural approach can be applied to the Inuit culture”.

The respondents spoke highly of the Medicine Wheel approach adopted in Elsipogtog. The senior educator indicated that while it was “not applicable to me since it is a community approach while my work is a school-based one, it is an excellent program because it seems to be working for the people in Big Cove. They’ve made significant progress in the last 8-9 years”. The counselor saw the approach as “serving as the tool to move our work with FASD towards a culturally relevant approach. We are excited about its potential”. With regards to Elsipogtog’s Eastern Door initiative, both stressed that it appeared to be well received by the community and will be a model for them – “They are willing to share information and we are using the information from it and applying it to us as well”. The counselor in particular emphasized how positive it was to see so many of community members playing such an active role in the school. Overall then, these Labradorean educators indicated that the Elsipogtog program is providing an effective framework for responding to FASD in the school and that “while what works in one community will not necessarily work in another place, it is important for us to study what works there and adopt it to our community here”. Elaborating on that theme, one respondent commented, “Dr. Cox continues to be a constant source of reference in our work. I am inspired by her work in Elsipogtog”.

THE LARGER SCENE

The dissemination and networking has also been evident on the larger national and international level. There have been conference presentations given on the Nogemag approach in Ottawa and in Alaska, a paper discussing the approach and its implications has been submitted for publication, a video has been prepared, public service

announcements are under consideration and so on. The production is impressive. In this section the work with two nationally known FASD persons and the video will be discussed.

Among the persons contacted the following two professionals, one a medical doctor with an established international reputation for his FASD work and the other a veteran Ottawa-based counselor in and coordinator of FASD intervention, provided substantial interviews. Both identified the FASD problem as a very major problem in Canada. As the counselor / coordinator said, “FASD-affected individuals and their families carry a huge burden particularly those with ARND. Given the lack of diagnosis we are not sure of the prevalence but we are sure of the cost to the family, support systems and especially to the individual. It is one of the major social problems we will need to deal with in the years ahead”. The medical doctor underlined that view. Noting his familiarity with FASD work across Canada, he claimed that FASD is a major problem and is not confined to the Aboriginal communities. “Of the 400 positives I have diagnosed to date, about two-thirds are non-aboriginal ... Aboriginals are more conscious of it [FASD] while the Caucasians are hiding it”. The doctor who properly depicted himself as an FASD expert in a world where there were few others on the medical side, reported that greater awareness has been developing in the Justice field (particularly in Corrections) and that he himself has been in court as an expert witness in the case of FASD-disabled adults. Both noted the special contribution associated with Dr. Cox’s work and the Nogemag model. Both met Dr. Cox in the 2002 period and have been partnering and networking with her since that time.

The medical doctor, whose home base is Newfoundland and Labrador, reported that he has been engaged in FASD work since 1974 and has given clinics all over Atlantic Canada and as far west as Manitoba. He reported that he has been familiar with the FASD initiative at Elsipogtog for several years and that, in his view, Dr. Cox is “the best informed / trained practitioner from the psychology side”. He emphasized her contribution is establishing the Eastern Door initiative and also in influencing the FASD diagnostic capacity in Moncton. As well he noted that Dr. Cox’s Nogemag approach has had a positive impact for his own work. “She has done very good work identifying the social factors and that is an important dimension of FASD diagnosis and treatment .. the tools she has created and made available to schools and others are also very valuable”.

The trainer/counselor/coordinator emphasized her front-line activity – “I work with family members and front-line workers to assist FASD-affected individuals dealing with problematic issues. I am professionally engaged as an FASD trainer”. In that regard she highlighted the especial value of the Elsipogtog activity as follows: “Dr. Cox and I have met at conferences and workshops on FASD. She has the amazing ability to pull complex information together and present it in an understandable way for front-line workers”. She recounted how she soon realized the Dr. Cox and her model would constitute an excellent asset for the “FASEout” program (a four year PHAC-funded project) that she was coordinating across Canada and that subsequently Dr. Cox did donate her time and presented at four FASEout workshops in New Brunswick, Nova Scotia and Ontario. The counselor/coordinator appreciated the adaptable character of the

medicine wheel approach and noted that “it has been helpful in our work though it is particularly helpful in working with Aboriginal people”. In her summation she noted that “Dr. Cox has informed me of many issues and in generously sharing her knowledge has helped many in the communities in which she trained”. She added, “She is very dedicated to the challenging work related to FASD and I have full confidence in any program she would administer. Of all the professionals I have worked with over the years in this field, I must say I have the greatest respect for Dr. Cox”.

THE FNIHB VIDEO DOCUMENTARY

This documentary focuses on the Elsipogtog elementary school and how it has improved over time through the special educational programs infused by the Nogemag model. Filmed interviews were conducted with Dr. Cox, school teachers, the principal and parents. The school principal reported how chaotic and unstable the situation was at the school and how under-achieving the students were prior to the introduction of these programs and a system that focused on where the students were at in their learning and what special needs they had. Over time as Dr. Cox’s system – later to be formalized as the Medicine Wheel approach – was implemented, major improvements occurred, especially notable being gains in the average reading levels and in the school’s general milieu for learning. The special Nogemag school, 2002 to 2003, which worked with youths who could not cope with the everyday school program, was specifically designed as an “outside the school system” approach for FASD-disabled youth. Its intent was to prepare these youths for effective participation in the regular school system and, as was noted in a previous evaluation report (Clairmont, 2003), that Nogemag program, though short-lived, did accomplish that goal.

The documentary describes through interviews and re-created scenes how the special school programs operated, the significance of detecting and dealing with FASD, and the significance of the Medicine Wheel as a learning device and for cultural salience. It also calls attention to the generalizability of this Elsipogtog approach, filming the learning experience of a group of educators from Labrador who came to Elsipogtog to see first-hand how it was implemented.

LINKING UP WITH THE JUSTICE SYSTEM

While the focus of the Nogemag approach has clearly been on the school system, other institutional systems such as Health and Justice were also deemed to be crucial venues for informing the key role players about FASD and impacting on policies and protocols. In the Justice system nationally, the greatest awareness concerning FASD has been in Corrections. In Atlantic Canada there was very limited awareness prior to the activities of the Nogemag initiative in Elsipogtog. In fiscal 2002-2003 the issue of FASD was brought to the attention of the local provincial court judge when an Elsipogtog youth was being sentenced and the judge took the input into account in rendering the sentence. In fiscal 2005-2006 crown prosecutors and judges in New Brunswick participated in a survey about FASD, the results of which were analyzed by the evaluator and are discussed at length below. In the spring of 2007 a significant publication was produced by the Nogemag Model and FASD leader (Dr. Cox). The short document, FASD Manual For Legal Professionals, incorporated case law, potential protocol references and contact information, and should prove very useful to the central Justice role players and hopefully improve the quality of the Justice system's response to accused persons and victims who may be FASD-disabled. The considerable "buy-in" among provincial government officials in the Health sector to the Nogemag-inspired FASD initiatives should enhance the Justice progress as well. For example, New Brunswick Public Safety requested Dr. Cox give a session on FASD-related issues to the province's probation officers' assembly in June 2007. Clearly in Atlantic Canada much work has to be done in all Justice segments – alternative / restorative justice, policing, courts, corrections (especially probation) – but thanks to the work in Elsipogtog and the rich development of the Nogemag approach, there are grounds for optimism.

THE CRIMINAL JUSTICE PROFESSIONS AND FASD

The survey, CJS Professionals, was completed by 39 respondents, 20 judges and 19 prosecutors. The 39 respondents, with few exceptions, completed the survey in a mail-back format in 2006. The judges, not surprisingly, were older (81% had graduated prior to 1980 compared to 37% of the prosecutors) and there were more males among them (80% to 58%). The large majority of these respondents reported that they had “first heard about FAS, FAE or other alcohol-related birth disorders” more than four years ago; on this score the prosecutors were more likely than judges to make such an assertion (i.e., 95% to 70%). For the CJS professionals, the mass media has been a crucial source of information about these matters. 53% overall cited this source; indeed one judge gave no other response to the questionnaire other than write across the top, “The only knowledge I have of the topic is what I have gleaned from T.V.”. Still, there was some variation between the two groupings; judges were most likely (69%) to cite their source of information as professional training/orientation and workshop sessions whereas prosecutors were most likely (68%) to cite the mass media. This difference seems likely to be related to the fact that Dr. Cox had presented a workshop on FASD to the New Brunswick judiciary in 2006. A significant minority of respondents in each group – 16% of the judges and 32% of the prosecutors – cited “other justice professionals” as a source of information on FASD and other alcohol-related birth disorders. These findings suggest the importance of carrying out orientation and workshops on FASD especially among the judiciary who may be less impacted by mass media information. Certainly in their open-ended remarks the CJS professionals emphasized that updates on developments in FASD issues would be much appreciated.

In general, most CJS professionals indicated that indeed they have encountered persons “disabled with FAS” in their practice, in the sense that they were informed that accused persons (and occasionally others such as witnesses) may have had that condition; here 84% of the prosecutors and 68% of the judges replied “yes” (75% overall). Slightly over half of the respondents in each grouping also reported that they suspected some accused persons with whom they dealt to be “disabled with FASD”. Among those having such suspicions, 90% of the judges and the prosecutors reported that the factor behind that suspicion was the accused person’s “inability to learn from mistakes” while a smaller majority in each grouping (roughly 75% of the judges and 70% of the prosecutors) based their suspicion on the accused’s physical appearance (e.g., facial shape, small size). A large percentage of respondents in each grouping reported that they had modified their practice routines when dealing with such a person. Fully 70% of the judges and 50% of the crown prosecutors who reported any experience or suspicions, claimed to have adjusted their practice in such situations. Only a small minority of the CJS professionals directly engaged “trained others” in responding to the FASD-disabled. In line with their legal roles, judges were more likely than prosecutors (11% to 5%) to secure such support to facilitate their communication with the suspected FASD-disabled persons, while prosecutors were more likely (26% to 17%) to send someone suspected of FASD for professional assessment. The majority of the judges and prosecutors, who reported an encounter with an actual or suspected accused disabled with FAS, did modify their

decision-making in the event of a guilty plea or conviction. Judges indicated that their sentences here were more likely to entail “increased supervision” (70%) and “extra-judicial sanctions” (60%), while the prosecutors indicated that their sentencing recommendations also would be more likely to be these same two options (70% and 54% respectively). These patterns strongly suggest that persons with FASD and other alcohol-related disabilities are encountered by judges and prosecutors in their practice and that, in large measure, the latter do adjust somewhat their practices and decision-making under such circumstances, but also that there is little recourse to formal assessment and trained support professionals. Several respondents in their open-ended remarks queried, “What treatments will work?”, “what services are available?”

All the above patterns occur in a context where these CJS professionals generally echo the words of one judge, namely “I do not know the symptoms and neither does my support group”. Only three of the 39 respondents, all of whom were all judges, were aware that the term FAE was no longer used as a diagnostic label by medical professionals trained in FASD-related disorders, and only one respondent (another judge) professed to having any knowledge about the diagnosis of ARND.

The CJS professionals were asked about their level of agreement with a variety of statements about FASD. For each statement the response options were from one to four where four represented the strongest agreement. In response to the statement about “FASD being identifiable” 95% of the judges and 72% of the prosecutors indicated much agreement (i.e., checked off 3 or 4); roughly 40% of the judges and 20% of the prosecutors selected the strongest agreement option (i.e., 4). The plurality of judges and prosecutors (47% and 37% respectively) agreed strongly (i.e., chose 4), that “FASD is relevant to my work as a legal professional” and 95% of the judges and 61% of the prosecutors showed much agreement (i.e., selected either 3 or 4) with that statement. Interestingly, and consistently, the judges and prosecutors generally rejected the statement that “: the effect of alcohol on fetus development is unclear”; only a minority in each grouping (31% of the judges and 28% of the prosecutors) indicated much agreement (i.e., chose options either 3 or 4) with that statement. There was more variation in the CJS professionals’ views on whether “clearer criteria were needed to properly diagnose FASD”. Both judges’ and prosecutors’ responses were well distributed over the agreement continuum but judges’ responses were skewed more to the “much agreement” pole (64%) whereas the prosecutors’ views were more to the “little agreement” pole (53%). CJS professionals in both groupings (over 80% checked either 3 or 4) clearly believed that with improved FASD assessment would come more appropriate consequences for unacceptable behaviour. Few respondents in each grouping (6% of the judges and 17% of the prosecutors) expressed much agreement with the statement that “FASD is only an issue for youth”. There was reasonable consensus too about whether “FASD occurs primarily in minority families”; few CJS professionals indicated much agreement with that statement (12% of the judges and 17% of the prosecutors). Overall, then, the CJS professionals’ consensus views were that FASD is identifiable, that the impact of alcohol on fetus development is clearly established and that the FASD phenomenon is not limited to youth and those in minority families. They generally considered that FASD issues are relevant to their own practice and indicated that with

clearer diagnosis would be even more relevant. The question concerning the need for greater diagnostic clarity generated the greatest diversity in the CJS professionals' responses and judges were more likely than prosecutors to agree that more diagnostic clarity was needed.

As noted above the CJS professionals appear to have certainly accepted the significance for their practice of the FASD phenomenon. They also acknowledged their lack of familiarity with recent developments in diagnosis and labeling with respect to FASD-related disabilities. Virtually all respondents also expressed lack of familiarity with "new Canadian guidelines for the diagnosis of the FASD conditions" – only 12% of the judges and none of the prosecutors reported having much awareness of the guidelines. It is not surprising then that only 40% of the judges and 26% of the prosecutors reported themselves "prepared" to deal with FASD cases (suspected or otherwise). The judges indicated in large number that support would be helpful in the guise of more research information becoming available (74%), lists of qualified physicians drawn up in different regions of the province for FASD referrals (74%), better diagnostic information being generated and circulated (74%), and an FASD diagnostic centre being established ((53%). Prosecutors also pointed to the benefits of some supports, especially more research information (68%), but with less emphasis than the judges; a plurality of the prosecutors did call for more diagnostic information being available (37%) and cited the importance of practice guidelines being developed (42%).

Only three respondents in each of the two professional groupings reported that they knew where to refer persons for FASD assessments and only one of the combined judge and prosecutor sample indicated any knowledge of where to refer persons for treatment of FASD conditions. Virtually all the justice professionals did agree that it would be very helpful to have such treatment possibilities. The judges and prosecutors, informed about Correction Services Canada's report on the prevalence of FASD among the inmate population, were asked how prevalent FASD-related disabilities were among offenders they encountered in their practice. The responses ranged from few to as many as 40%, with the plurality category being "between 10% and 19%", clearly indicative of a very significant issue for the justice system. There was also complete consensus that the prevalence of FASD disabilities required a more coordinated approach among justice and health professionals, and that sessions on the topic with other legal professionals to shape a New Brunswick "approach" would be valuable. The large majority of both judges and prosecutors appeared open to prospect of what is increasingly referred to in justice circles as "the problem-solving court"; for example, at least 80% of the respondents indicated that a Mental Health court would be a helpful initiative.

Overall Summary

Overall then this modest survey of CJS professionals indicated quite clearly that they see FASD-related disabilities as a pervasive phenomenon in their practice and that they are not as prepared as they would like to be in responding to it. Where they encounter it, based on information received or their own suspicions, they attempt to modify their practice (e.g., in sentencing) to take the FASD effects into account. The CJS

professionals are clearly calling for more information on the issues, more clarity in diagnoses (while noting that the diagnoses and information in place have established the central claims of the FASD model) and more regular updating. They are seeking ways to take FASD appropriately into account in their practice as well as to identify case law pertinent to FASD. Clearly they have articulated clearly and with emphasis the need for policies and programs to respond to the challenge of FASD disability.

**VIEWS AND IMPACT ON PRACTICES OF JUDGES AND PROSECUTORS
REGARDING FASD**

	20 JUDGES		19 PROSECUTORS	
	Number	%	Number	%
PERSONAL CHARACTERISTICS				
MALE	16/20	80%	11/19	58%
GRADUATED PRIOR TO 1980	14/17	81%	7/19	37%
AWARENESS OF FASD				
HEARD OF FAS/FAE BIRTH DISORDERS MORE THAN 4 YEARS AGO	14/20	70%	18/19	95%
MAIN SOURCE OF INFORMATION ON FASD* MASS MEDIA	8/19	42%	13/19	68%
MAIN SOURCE OF INFORMATION ON FASD* PROFESSIONAL WORKSHOP	13/18	69%	3/19	16%
AWARE THAT MEDICAL PEOPLE TRAINED IN FASD DISORDERS DO NOT USE TERM 'FAE'*	3/18	17%	0/19	0%
FAMILIAR WITH 'ARND' DIAGNOSES	1/16	6%	0/19	0%
THE PERCENTAGE OF FASD-DISABLED PERSONS AMONG ACCUSED IS BETWEEN 0 AND 9 %	4/14	29%	5/17	30%
THE PERCENTAGE OF FASD-DISABLED PERSONS AMONG ACCUSED IS BETWEEN 10 AND 19 %	7/14	50%	6/17	35%
IMPACT ON PRACTICE				
EVER INFORMED OF AN ACCUSED OR OTHER BEING DISABLED WITH FASD	13/19	68%	16/19	84%
EVER SUSPECT THAT AN ACCUSED OR OTHER MIGHT BE FASD-DISABLED	10/17	59%	10/14	53%
FACTORS FUELLING	6-9/10	60%-90%	7/10	70%

SUSPICIONS OF FASD DISABILITY: PHYSICAL APPEARANCE				
FACTORS FUELLING SUSPICIONS OF FASD DISABILITY: ACCUSED'S INABILITY TO LEARN FROM MISTAKES	9/10	90%	9/10	90%
EVER SENT SOMEONE SUSPECTED OF FASD FOR ASSESSMENT: YES	3/18	17%	5/19	26%
EVER USED A TRAINED SUPPORT PERSON TO HELP IN COMMUNICATING WITH SOMEONE SUSPECTED OF FASD: YES	2/17	11%	1/19	5%
EVER MODIFIED PRACTICE DEALING WITH AN FASD-DISABILITY ACCUSED. YES	10/14	70%	9/18	50%
MODIFICATION: INCREASED SUPERVISION	7/10	70%	9/13	70%
MODIFICATION: SUGGESTED EXTRA JUDICIAL MEASURES	6/10	60%	7/13	54%
VIEWS ABOUT FASD (SOLIDLY AGREE WITH THE STATEMENT)**				
FASD IS AN IDENTIFIABLE SYNDROME	16/17	95%	13/18	72%
FASD IS RELEVANT TO MY WORK AS A LEGAL PROFESSIONAL	16/17	95%	11/18	61%
THE EFFECT OF ALCOHOL ON FETUS DEVELOPMENT IS UNCLEAR	5/16	31%	5/18	28%
CLEARER CRITERIA ARE NEEDED TO DIAGNOSE FASD	9/14	64%	8/17	47%
FASD IS REALLY ONLY AN ISSUE FOR YOUTH	1/16	6%	3/18	17%
FASD OCCURS PRIMARILY IN MINORITY FAMILIES	2/16	12%	3/18	17%
FASD ASSESSMENT WOULD LEAD TO MORE	13/15	87%	14/17	82%

APPROPRIATE CONSEQUENCES FOR BEHAVIOUR				
LOOKING TO THE FUTURE				
AWARE OF NEW CANADIAN GUIDELINES FOR FASD	2/16	12%	0/16	0%
PREPARED TO DEAL WITH FASD ACCUSED IN THE FUTURE: YES	7/18	40%	5/19	26%
KIND OF SUPPORT NEEDED: MORE RESEARCH INFO	14/19	74%	13/19	68%
KIND OF SUPPORT NEEDED: LISTS OF QUALIFIED PROFESSIONALS TO CONSULT /REFER	14/19	74%	4/19	21%
KIND OF SUPPORT NEEDED: GUIDELINES	5/19	26%	8/19	42%
KIND OF SUPPORT NEEDED: DIAGNOSTIC INFO ON ACCUSED	14/19	74%	7/19	37%
AN FASD DIAGNOSTIC CLINIC	10/19	53%	4/19	21%
KNOW WHERE TO REFER FOR FASD ASSESSMENT	3/18	17%	3/18	17%
KNOW WHERE TO REFER FOR FASD TREATMENT	0/18	0%	1/19	6%
HAVING TREATMENT ALTERNATIVES WOULD BE HELPFUL	17/17	100%	15/17	88%
A COORDINATED APPROACH TO FASD IS NEEDED	18/18	100%	16/18	88%
SESSIONS WITH OTHER LEGAL PROFESSIONALS TO DISCUSS A PROVINCE-WIDE APPROACH ARE NEEDED	19/19	100%	17/19	90%
IT WOULD BE HELPFUL TO HAVE A MENTAL HEALTH IN MY AREA	16/18	88%	14/19	74%

- Prior to this questionnaire being distributed a workshop on FASD was provided by Dr. Cox at a regular professional training session of the judiciary. Some judges completing this questionnaire attended that workshop. No similar workshop on FASD has been provided for prosecutors.
- In these questions solid agreement is operationalized as having given a 3 or a 4 to the statement on a four-point agreement continuum.

CONCLUSION

There is little doubt that the Nogemag NCPC project has accomplished its objectives and indeed there is little doubt that the FASD work at Elsipogtog has made a substantial contribution in the diagnosis, treatment and prevention of FASD at the community level, the provincial level and beyond. It is a remarkable achievement for Dr. Cox and her team and for this small First Nation community. New organizational structures have been put in place such as the Eastern Door in Elsipogtog and the new diagnostic capacity at the Georges Dumont hospital in Moncton. There has been a heightened awareness of FASD and how it might be tackled, especially at the primary school level, throughout Atlantic Canada. New sources of funding have been mobilized especially at the provincial level. Networks and partnerships have been formed which transcend the aboriginal / mainstream divide and which augur well for a promising future in dealing with FASD. There is much more to be done, including penetrating further the institutional spheres of Justice, Health and community Services. For example, the linkages between FASD work and the therapeutic jurisprudence movement (e.g., mental health courts, drug treatment / wellness courts) need development. The extension of FASD intervention strategies to young adults seems to be another frontier. But there can be no doubt that the pioneering work in Elsipogtog as reported above gives grounds for optimism. One can only hope that the short-term funding arrangements which have facilitated that work will transform into the long-run financial backing that it deserves and requires.